PAPUA NEW GUINEA

UNGASS 2008 COUNTRY PROGRESS REPORT

Reporting Period: January 2006 – December 2007

Prepared by: the PNG National AIDS Council Secretariat and Partners

Submission date: January 31, 2008

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Acronyms

ADB	Asia Development Bank
AIDS	Acquired immunodeficiency syndrome
APLF	Asia Pacific Leadership Forum
ARV	Antiretroviral
AusAID	Australian Agency for International Development
BAHA	Business Coalition Against HIV and AIDS
CHBC	Community and Health Based Palliative Care
COMATAA	Community Mapping and Theatre Against AIDS
DACS	District AIDS Committee Secretariat
EU	European Union
FSVAC	Family and Sexual Violence Action Committee
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GO	Government Organisation
HAMP Act	HIV and AIDS Management and Prevention Act
HIV	Human Immunodeficiency Virus
HRSS	High Risk Settings Strategy
IEA	International Education Agency
IMR	Institute of Medical Research
JICA	Japanese International Cooperation Agency
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MSM	Men who have sex with men
NACS	National AIDS Council Secretariat
NASA	National AIDS spending assessment
NCAO	National Catholic AIDS Office
NCD	National Capital District
NCPI	National composite policy index
NCM	National coordinating mechanism
NdoH	National Department of Health
NGO	Non-governmental organisation
NGP	National Gender Policy
NHASP	National HIV/AIDS Support Project
NHATU	National HIV AIDS Training Unit
NSP	National Strategic Plan
OVC	Orphans and other Vulnerable Children
PAC	Provincial AIDS Committee
PACSO	PNG Alliance for Civil society Organizations
PE	Peer Educator
PLHIV	People living with HIV
PMGH	Port Moresby General Hospital
PMTCT	Prevention of mother-to-child transmission
PNG	Papua New Guinea
POV	Peer Outreach volunteers
SGS	Second-generation surveillance

STI	Sexually transmitted infection
TOT	Training of trainers
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
VCCT	Voluntary confidential counselling and testing
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YOP	Youth Outreach Project

Acknowledgements

PNG country report on progress of HIV and AIDS interventions for 2006/2007 is in fact the 1st report on UNGASS indicators. The First report attempted in 2005 was only a short narrative one which was sent late to Geneva. It fell short of relevant indicators and therefore was not included in the consolidated report to the UN General Assembly.

A lot more effort, time and resources have been put into this report. The National AIDS Council Secretariat believes it has been given due attention by all partners in ensuring the requirements of the report are met. Given time constraint, lack of systematic HIV and AIDS data flow and some resource constraint, it is indeed pleasing to report on the 16 out of 24 indicators as required for this round of the UNGASS process. We are mindful of many of these shortfalls which are lessons learnt for the next UNGASS report in 2010.

Substantive efforts put into the report by all stakeholders, members of the UNGASS Core Working Group and short term consultants resulted in the development of this report. The UNGASS Report preparation process and activity program followed ensured collection of some essential data as well as reaching consensus on the data and other HIV and AIDS information presented here.

The National AIDS Council Secretariat is indebted to many, and would like to acknowledge all those who contributed sections and data to this report. Special mention to the following key members of the UNGASS Core Group.

Dr. Joachim Pantumari (NACS), Mr. Michael Aglua (NACS), Miss. Doreen Mandari (NACS) and Dr.Isimel Kitur (NDOH) are commended for their leading roles not only as members of the Core Group but also as senior program managers in the national response.

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Finally, NACS would like to acknowledge UNAIDS M&E Advisor, Mr. Taoufik Bakkali, especially for providing the overall guidance, without his support this report would not be achieved.

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1. Status at a glance

1.1 The involvement of stakeholders in the data collection and report writing process

All sectors played key roles in the response to the HIV epidemic in PNG. In compiling this report, the National AIDS Council Secretariat invited input from PLHIV, civil society organizations, including nongovernmental organizations, faith-based organizations, community-based organizations, private sector, research institutions, government and donor partners. Their reports and other contributions on the core national-level indicators underlying the UNGASS declaration and narrative are compiled herewith.

A series of consultative meetings were held in Port Moresby with both government and civil society representatives, to plan information gathering for this report, achieve consensus on the results of the National Composite Policy Index, and to review, validate and collate comments on the draft Country Progress Report before it was finalized and submitted.

The working group which composed of the data collection and writing team met weekly to monitor progress on the report. This working group was comprised of members representing different agencies including NACS, Department of Health, National Research Institute, the network of people leaving with HIV (Igat Hope), WHO, UNAIDS, AusAID and two independent consultants. The group coordinated individual and group consultations with stake holders and managed data collection from various sources including government agencies, research institutions, and the National Statistics Office for the recently organized DHS.

A number of civil society organizations contributed narratives about areas of their work and best practices that were included in this report, other information was compiled from quarterly and annual reports regularly produced by national and international institutions.

1.2 The status of the epidemic in Papua New Guinea

- In 2004, PNG became the fourth country in the Asia Pacific region to declare a generalized HIV-AIDS epidemic after HIV prevalence surpassed 1 per cent among ANC clients at the Port Moresby General Hospital in 2002. The main means of transmission appears to be unprotected sexual intercourse with multiple sex partners. Known infections involve almost equal numbers of males and females, but the number of infected young women is rising fastest.
- By the end of 2006, a total of 18,484 people had been diagnosed with HIV. Of these infections, 46 % were in males, 48% in females, and 6% in individuals whose sex was not reported. In 2006 alone, 4017 people

tested positive, 30% more than in 2005. However, it was estimated that there are about 46,275 people living with HIV in the country by the end 2006, which means that more than 60% of the people living with HIV do not know their status.

- The new estimated prevalence rate of 1.28% in 2006 among people aged 15-49, compared to the old estimates of 2% prevalence in 2005, does not represent in any way a decrease in the epidemic but the availability of better data and improved estimation methods.
- By December 2007, the national prevalence was projected to be 1.61%, with an estimated 59,537 people living with HIV. The urban prevalence was estimated at 1.38% with 7,943 people living with HIV. The rural prevalence was estimated at 1.65%, with 51,594 people living with HIV. Eighty-five per cent of PNG's population is rural, many people living in areas where there are few health services, very limited transport and communications, low levels of literacy, and a multitude of cultures and languages.
- The trend of the epidemic in rural areas shows a late but strong increase. It is expected that the HIV epidemic in PNG will become more rural as of 2007, affecting tremendously the national prevalence and adding to the difficulties of addressing the epidemic.

1.3 The policy and programmatic response

- Key polices have been put in place to guide the national response to HIV and AIDS in the country. The GoPNG Medium Term Development Strategy (MTDS) 2005-2010 includes HIV and AIDS as one of the 6 expenditure priorities of the Government. The Government endorsed the National HIV and AIDS Strategic Plan (2006-2011) in December 2005, as the country's master plan for combating HIV and AIDS. Annual operational plans are guided by the NSP. The National Gender policy and Plan on HIV and AIDS 2006-2010 has been developed and launched as a companion document to the NSP to guide efforts to integrate gender issues into the response. The HIV and AIDS Management and Prevention (HAMP) Act 2003, enacted by Parliament in 2003 provides legal framework for addressing discrimination, stigmatisation and mandatory screening with respect of HIV. Other sector specific plans address HIV and AIDS include the National Health Plan, the HIV and AIDS Policy for the National Education System of PNG. A new National Leadership Strategy was finalised at the end of 2007 to progress efforts to mobilise, build capacity and sustain leadership at all levels for effective response. The GoPNG has scaled up its funding for HIV and AIDS increasing from PNG Kina 7, 125,600 in 2006 to K 18 million in 2007.

- Innovative programs and ideas to combat HIV and AIDS have been planned and established. A high risk setting strategy was established in 2005 to target high risk groups including sex workers, MSM, members of the defense and the disciplinary forces, truck drivers and dockside workers. More recently, programs that address the widespread, rural nature of the epidemic are being implemented. Programs of home-based treatment and care, adapted to PNG conditions and traditions, are being expanded through faith-based organizations, civil society and community and family based networks.
- Other innovative programs, implemented by ADB and BAHA, engage the private sector, including large rural-based enterprises to strengthen health infrastructure in rural areas, in prevention, testing, treatment, care and support. BAHA has spearheaded advocacy and the dissemination of vital information on HIV and AIDS and with the assistance of NACS and UNDP develop the Workplace Policy Toolkit for use by private sector organizations. A number of government departments have also developed work place policies including, Education, Community Development, Treasury, Health and Defense as well as a number of tertiary institutions in the country as part of mainstreaming HIV/AIDS within the public sector.
- Significant Efforts are being done to scale up care and treatment services throughout the country. The care and treatment program has expanded beneficiating from a substantive support by a number of development partners. In 2005, PNG received a Global Fund Grant to a tune of $29 million for five years to support care and treatment and other partners have also been providing both technical and financial support. As of December 2007, 2250 patients (adults and children) were on treatment. The number of ART sites increased from two in 2004 to 38 in December 2007
- In Mid 2007, the NDOH introduced a provider-initiated HIV testing and counseling with aim of scalling up HIV testing in health sector. The number of people accessing HIV testing has increased tremendously since then, particularly in ANC and STI clients. In 2007, there was almost 27,000 people who received testing and counceling compared to 3052 in 2006. The number of accredited VCT sites has reached 62.
- The 2005 High Risk Setting Strategy has been repackaged as the Tingim Laip Project supported by AusAID was implemented by civil society groups under the management of the Burnett Institute. A National Gender Policy and Plan on HIV and AIDS was launched at the end of 2007. It is a companion policy document to the NSP which intends to identify and address the different needs and situations of women and men within each of the seven focus areas of the NSP. The goal is to involve and benefit both men and women equally in the national response and to reduce gender inequalities that contribute to the country's high level vulnerability

to the HIV and AIDS epidemic focusing on gender-based and sexual violence.

- The 2006-2007 period has been a period of adjustment as NACS outsourced most of its implementation functions to NDoH, Faith Based Organizations and Civil Society Groups as it directs its focus towards coordination. These functions include care and counseling, education and training, advocacy and prevention through information, education and communication (IEC), peer education, monitoring and surveillance. It is expected that PACs will follow NACS coordinating role, leaving implementation to local civil society community and faith based organizations in provinces and districts. Two important umbrella organizations have been formed to facilitate and assist towards the goal of mainstreaming HIV into the mainstream of society in the formation of the PNG Business Coalition against HIV and AIDS (BAHA) and the PNG Alliance of Civil Society Organizations(PACSO).,
- Significant steps have been taken to set up the Monitoring and Evaluation Unit in NACS and strengthen surveillance in order to better understand the characteristics and levels of the epidemic among the general population and with groups at higher risk in the country. The 2007 Estimation Report on the HIV Epidemic in PNG draws on data from new VCT sites, Antenatal and STI clinics from GO and NGO in both urban and rural sites. NACS made headway in its focus area of Leadership, Partnership and Coordination during the life of the seventh National Parliament through the creation of the Parliamentary HIV and AIDS Committee.

Core Indicators for the Declaration of Commitment Implementation (UNGASS)

2008 reporting

Indicators	Data Available and Reported Yes or No	Method of Data Collection
National Commitment and Action		
Expenditures		
1. Domestic and international AIDS spending by categories and financing sources	No	National AIDS Spending Assessment Financial resource flows
Policy Development and Implementation Status		
2. National Composite Policy Index	Yes	Desk review and key informant interviews
Areas covered: gender, workplace programmes, stigma and discrimination, prevention, care and support, human rights, civil society involvement, and monitoring and evaluation		
National Programmes: blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education.		
3. Percentage of donated blood units screened for HIV in a quality assured manner	Yes	Programme monitoring/special survey
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Yes	Programme monitoring and estimates
5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	Yes	Programme monitoring and estimates
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	Yes	Programme monitoring
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	No	Population-based survey

8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	Yes	Behavioural surveys
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes	Yes	Behavioural surveys
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	No	Population-based survey
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	Yes	School-based survey
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10–14*	Yes	Population-based survey
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	No	Population-based survey
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Yes	Behavioural surveys
15. Percentage of young women and men who have had sexual intercourse before the age of 15	Yes	Population-based survey
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	Yes	Population-based survey
17. Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	Yes	Population-based survey
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	Yes	Behavioural surveys
19. Percentage of men reporting the use of a condom the last time they had anal sex with a	Yes	Behavioural surveys

male partner		
20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	No	Special survey
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	No	Special survey
Impact		
22. Percentage of young women and men aged 15–24 who are HIV infected*	No	HIV sentinel surveillance and population-based survey
23. Percentage of most-at-risk populations who are HIV infected	No	HIV sentinel surveillance
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Yes	Programme monitoring
25. Percentage of infants born to HIV infected mothers who are infected	Will be estimated in Geneva	Treatment protocols and efficacy studies

*Millennium Development Goals indicator

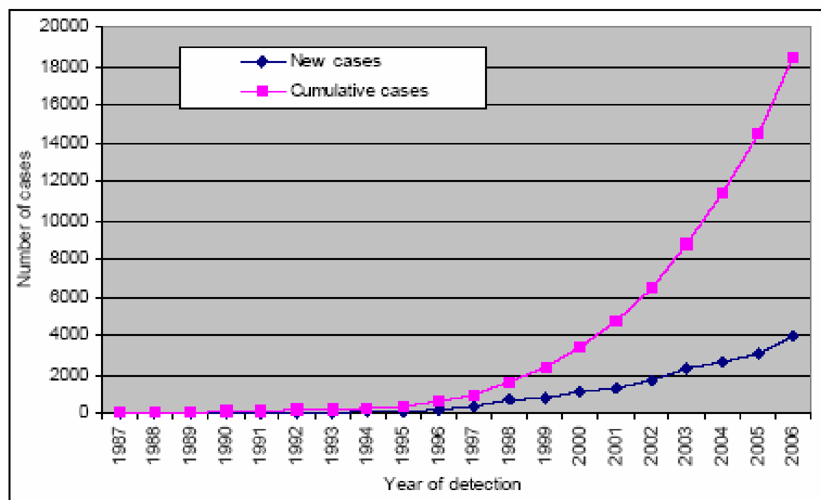
2. Overview of the HIV epidemic in PNG

2.1 Development of a generalized epidemic

PNG became the fourth country in the Asia Pacific region to declare a generalized HIV epidemic, after the prevalence of HIV among antenatal women in the Port Moresby General Hospital passed 1 per cent in 2002. By 2002, a total of 6469 people had been reported as infected with HIV, in a national population that year of around 5.4 million people. AIDS had become the leading cause of death at the Goroka Hospital, while at the Port Moresby General Hospital, 60% of the medical wards were occupied by AIDS patients and 20% of in-patients with TB were HIV positive.

Given the limited and poor quality of information about the extent of HIV infection in the PNG population, it was always appreciated that the known infections considerably under-measured the true state of the HIV epidemic. Even so, the trend in reported infections shows an exponential growth since HIV was first recorded in PNG in 1987 (Figure 1). All key HIV and AIDS indicators are increasing as per the 2007 HIV estimates and projections.[1]

Figure 1: New and cumulative annually reported HIV infections in Papua New Guinea, 1987–2006



Source: NDOH and NACS, 2007

By the end of 2006, a total of 18,484 people had been diagnosed with HIV. Of these infections, 46% were in males, 48% in females, and 6% in individuals whose sex was not reported. In 2006 alone, 4017 people tested positive, 30% more than in 2005.

[1] NDOH and NACS 2007.

Despite the lack of comprehensive information about the age and sex of people diagnosed with HIV, as age was not recorded in one-third of the data; where age was recorded, the majority of HIV infections were in people aged between 20 and 35, with higher numbers of HIV infections found in female youth and younger women.

At the end of 2006, the national HIV prevalence was estimated to be 1.28% among youth and adults aged 15-49, with an estimated 46,275 people living with HIV. The trend of the epidemic is showing a high increase, especially in rural areas where 85% of the PNG population lives. It is predicted that from 2007 HIV prevalence among the rural population will become higher than in urban areas. The overall 2006 prevalence figure was lower than estimated, but the expected growth rate is now sharper than previously projected. It appears that the epidemic has taken an exponential trend.

2.2 Projected growth of the HIV epidemic

When the epidemic in PNG was declared generalized in 2004, this assessment rested by necessity mainly on the observed prevalence trend among pregnant women who attended the ANC clinic at the PMGH. Although the number of mothers tested annually has steadily increased since 1992, these data provided only an urban, non-representative picture of the epidemic. But since this was the only available source of data, it was also considered as the estimated national HIV prevalence until 2005 where data from other sites was made available. In 2005, national estimates were based on data from only a few government facilities, largely from the PMGH ANC. Workbook software, which was more appropriate for low and concentrated epidemic, was used to produce the national estimate that year of 2%, without using a calibration rate or weighting the observed rates by the number of people tested in each site. This was the best estimation possible at that time.

In 2006, ANC data were included from both urban and rural sites including government and non-government such as Catholic health facilities for the first time. The availability of historical data covering the period 2002 to 2006 and a larger number of sites, made it possible to use the Estimation and Projection Package (EPP) software.

The availability of this data from both urban and rural areas was key to the successful 2007 estimation exercise using the EPP. A calibration rate of 80% was used to balance the known over-estimation caused by the use of ANC data when estimating HIV prevalence among the general population. Table 1 shows estimations of HIV prevalence from 1993, with projections to 2012 at national, urban, and rural levels.

Table 1: Estimated HIV prevalence, 1993- 2012

	NATIONAL		URBAN		RURAL	
	%HIV+	Num HIV+	%HIV+	Num HIV+	%HIV+	Num HIV+
1993	0.05	1,310	0.1	438	0.04	871
1994	0.06	1,771	0.14	597	0.05	1,175
1995	0.08	2,387	0.18	807	0.07	1,580
1996	0.11	3,204	0.24	1,081	0.09	2,122
1997	0.15	4,282	0.31	1,433	0.11	2,848
1998	0.19	5,694	0.4	1,875	0.15	3,819
1999	0.24	7,530	0.5	2,412	0.2	5,118
2000	0.31	9,898	0.62	3,043	0.26	6,855
2001	0.4	12,931	0.75	3,754	0.34	9,176
2002	0.51	16,796	0.88	4,521	0.44	12,275
2003	0.64	21,714	1.01	5,308	0.57	16,405
2004	0.81	27,978	1.13	6,076	0.75	21,902
2005	1.02	35,988	1.24	6,787	0.98	29,200
2006	1.28	46,275	1.32	7,415	1.27	38,860
2007	1.61	59,537	1.38	7,943	1.65	51,594
2008	2.03	76,665	1.43	8,369	2.14	68,297
2009	2.56	98,757	1.45	8,698	2.76	90,059
2010	3.22	127,121	1.46	8,942	3.55	118,179
2011	4.05	163,245	1.46	9,119	4.53	154,126
2012	5.07	208,714	1.44	9,244	5.74	199,471

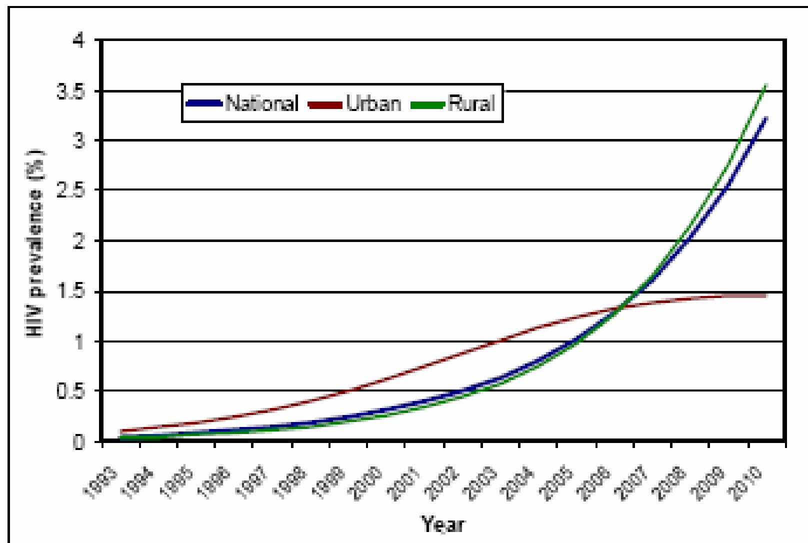
Source: NDOH and NACS, 2007

By December 2007, the national prevalence was estimated to be 1.61%, with an estimated 59,537 people living with HIV. The urban prevalence was estimated at 1.38% with 7,943 people living with HIV. The rural prevalence was estimated at 1.65%, with 51,594 people living with HIV. In 2007 there was an estimated 14,638 new HIV infections.

The trend of the epidemic in rural areas shows a late but strong increase. It appears that the HIV epidemic in PNG will become more rural as of 2007, affecting tremendously the national prevalence, given that 85% of the population is rural. The graph below shows the estimated and projected trends of the epidemic in PNG. The trend of the national epidemic is very close to the trend of the rural epidemic given the high percentage of the rural population. The

numbers of people requiring treatment is estimated to increase from 3204 to 5712 between 2005 and 2007. In 2007, an estimated 3,700 people would die of AIDS. This will impact on the vulnerability of children and youth, with an estimated 3730 children (aged 0-17) becoming orphaned due to AIDS during 2007. [2]

Figure 2: Urban, rural and national trends in the HIV epidemic, PNG, 1993-2012



Source: NDOH and NACS, 2007

The new estimated prevalence rate of 1.28% in 2006, compared to the old estimates of 2% prevalence in 2005, does not represent in any way a decrease in the epidemic. The new prevalence estimates, when compared to previous estimates, show that while the HIV prevalence is lower, there is a sharper increasing trend in the epidemic than has been previously documented. [3] The reasons for the differences in prevalence estimates are essentially due to the methods of estimation that were applied, the assumptions that were made, the quality and the quantity data used, and an increase in the number of sites.

[2] NDOH and NACS, 2007

[3] NACS and NDOH, 2007

Table 2: Previous and new estimates of HIV prevalence in PNG

Year	Type of site	Data source	Previous estimates	New estimates
1999	Urban	PMTCT	0.6%	0.24%
2004	Urban	PMTCT	1.7%	0.81%
2005	Urban	PMTCT	2%	1.02%
2006	Urban/ Rural	PMTCT	--	1.28%

Source: NDOH and NACS, 2007

2.3 Characteristics of the epidemic

Two-thirds of all of the recorded infections lack information about mode of transmission. From the little that is known, unprotected heterosexual sex is the main means of transmission, with perinatal transmission and homosexual sex indicated in a much smaller percent of cases.

Table 3: Reported modes of HIV transmission, 1987-2006

Mode of Transmission	Male	Female	Sex not stated	Total	%
Heterosexual	2712	3386	194	6292	34.04
Homosexual	18	8	0	26	0.14
Perinatal	118	97	4	219	1.18
Blood transfusion	0	0	0	0	0.00
Contaminated needle	0	0	0	0	0.00
Mode not recorded	5682	5333	932	11947	64.63
Total	**8530**	**8824**	**1130**	**18484**	**100.00**

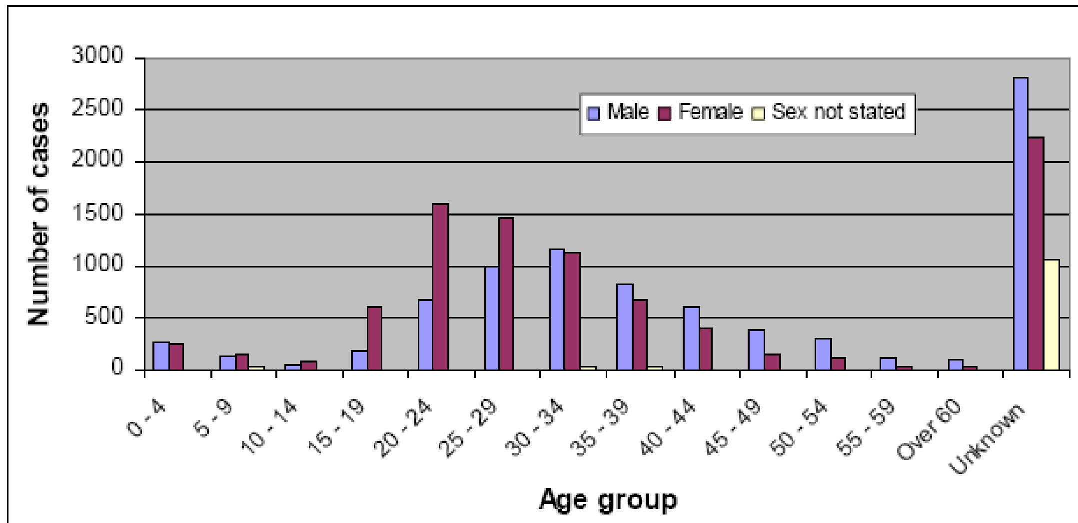
Source: NACS and NDOH, 2007

Sexually transmitted infections, which are known cofactors in HIV transmission, are widely prevalent in PNG, even among rural populations that were at first considered to be at 'low-risk' of HIV infection. From what evidence is available, the epidemic is widespread in the general population, particularly increasing in rural dwellers, and the present concentration of HIV infections in more at risk populations has not been established.

Men and women appear to be infected in almost equal numbers, although the number of infected young women is highest and appears to be growing fastest. Most known HIV infections are in the 20 to 29 age-group, although one-third of all reports lack data about the age of the infected person. Of the remaining 67%, the

most common age at diagnosis for males is in the 25-29 year and 30-34 year age groups. From what data is known, the peak of female infection (20–24 years) is at an earlier age than males (30–34 years). Close to 60% of known infections in men and male youth are diagnosed under the age of 35; 74% by the age of 40; 85% by the age of 44, and 92% by the age of 50. The most common age at diagnosis for females is 20-29 years. Of known infections among females, 39% occurred by the age of 24; 61% by the age of 29; 78% by the age of 34; 88% by the age of 39 and 94% by the age of 44.[4]

Figure 3: HIV infections detected in PNG by age, 1987 – 2006

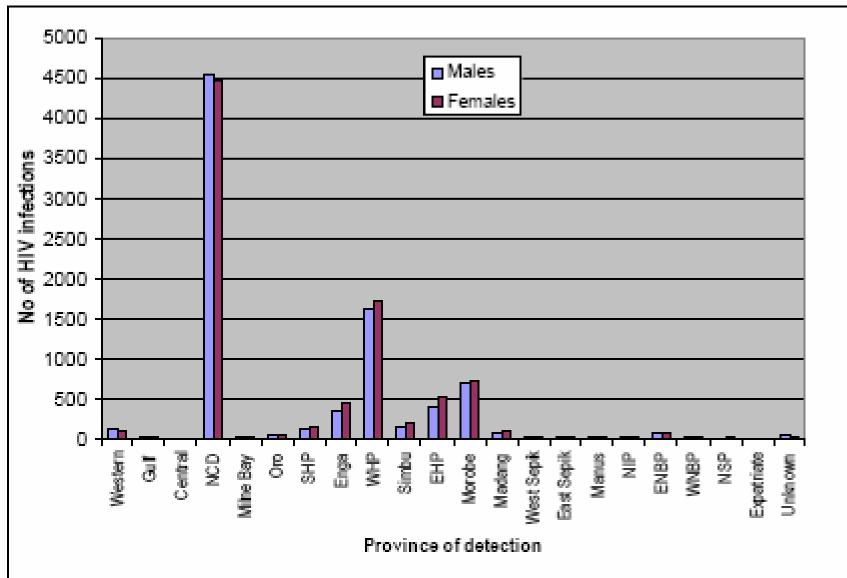


2.4 The geographic distribution of the epidemic

Until quite recently, very limited HIV surveillance data gave a poor understanding about the progress of the epidemic and its geographic distribution across the country. HIV has now been diagnosed from every province. Since the Port Moresby general hospital was the only site providing testing for HIV in country for almost 10 years, over 50% percent of all reported HIV infections come from the National Capital District, 19.48% from the Western Highland Province, 9.05% from Morobe and the remaining 20% from the other provinces.

[4] NACS and NDoH, 2007.

Figure 4: HIV infections reported in PNG by province of detection 1987 – 2006



It was at first unclear whether the concentration of known HIV cases in Port Moresby and some other towns showed that the epidemic was mostly urban-based, or only reflected the concentration of testing and higher level health facilities there. Pockets of HIV infection are known to exist along the Highlands Highway and around rural enterprises such as mines and plantations where there are active markets for the exchange and sale of sex. However, it is only recently that a clearer picture has emerged that the epidemic is largely rural-based, and that its fast growth reflects the predominantly widely distributed rural PNG population.[5]

2.5 Behavioural research on sexual practice

Understanding what is actually driving the HIV epidemic in PNG is quite unknown in most at risk groups and the general population. In 2005, the National AIDS Council conducted a number of behavioural studies on selected high risk populations including the military (Murray & Taurama barracks, Port Moresby) and prison inmates (Bomana, Port Moresby). A lack of inclusion criteria and probability sampling limits the comparability of these early study results over-time, but they provide an understanding of the range and degree of high risk practices that are occurring, and highlight the need to include these more at risk groups within surveillance and other bio-behavioural studies.

[5] NACS and NDOH, 2007.

Behavioural surveillance in 2006, behavioural research by IMR [6]conducted in 2005 and 2007 and behavioural research conducted in 2006 by SCiPNG,[7] have found that sexual behaviours create high risk for HIV transmission, through unprotected anal and vaginal sex between men and women and unprotected anal sex between men. Across these studies, the transmission of HIV is further heightened by the prevalence of early sexual debut; multiple premarital and extramarital sex partners, including some polygamy found in the BSS; the exchange or sale of sex from a young age; the paying for sex; inconsistent condom use; sexual violence including gang rape; and variability in practice and of diverse sexual networks between more at risk populations and general popualtion, while similarities in practice can be interpreted differently or have different meanings between cultures. Research results indicate that there is a need to address the relationship between violence and sex, while the variation in sexual practices between groups highlights the critical need to translate research results into behaviour change and HIV prevention programs.

The first round of **Behavioral Surveillance Surveys (BSS)** was conducted in 2006 through an initiative of the AusAID funded National HIV/ AIDS Support Project (NHASP). Female sex workers, youth in settlements, military personnel and men in private industries were surveyed in a number of high-risk settings in the National Capital District, Morobe and Western Highlands provinces to establish baseline data and a monitoring system to track trends in sexual behaviors in high risk settings.[8] Population groups included in the 2006 BSS were:

(i) **Adult male workers in private industries** from Lae Port and Ramu Sugar and truck drivers based in Mt Hagen, and the military from Taurama, Murray and Igam Barracks;

(ii) **Out of school youth** from Joyce Bay and Hanuabada settlements in Port Moresby; and

(iii) **Women who sell sex** either from Lae, Ramu and Mt. Hagen or along the Highlands Highway from Minj, Umi, and Yang Creek Markets.[9]

The following results of the BSS surveys have been disseminated through the Tingim Laip program to economic operators and others from these higher risk

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[6] Maibani-Mitchie, et al. 2007; Maibani-Mitchie and Yeka 2005

[7] SCiPNG 2007

[8] NACS and NHASP, 2007.

[9] NACS and NHASP, 2007

settings. Follow-up BSS are planned for round 3 of behavioural surveillance surveys in early 2009 to be done by the National Research Institute as part of the NDOH Surveillance system.

Adult male workers (1,358) were interviewed from a range of industries and occupations including: 246 truck drivers, 353 Ramu Sugar workers, 421 Lae port workers and 388 military personnel. A range of sexual behaviours with a higher risk of HIV transmission were reported, with important differences between the sampled groups. For example, the percentage of men paying women for sex in the last 12 months varied greatly between truck drivers (70%), military personnel (61%), port workers (33%) and Ramu Sugar workers (7%). While reported condom use was high during the majority of men's most recent commercial sex (62-91%); consistent condom use with sex workers during the last 12 months was less and varied from a low of 33% among truck drivers to 69% for Ramu Sugar workers.

Truck drivers were more likely to have non-commercial casual sex partners (71%) than port workers (41%), military personnel (37%) or Ramu Sugar workers (16%). Condom use was less common with casual partners than with paid partners. Condom use at last sex with regular partners was lowest with Ramu Sugar workers (10.8%), low with truck drivers (12.6%) and military officers (13.9%), but slightly higher with Lae Port Workers (24.9%). Consistent condom use was lower and ranged from 5.6% (military officers) to 6.5% (truck drivers), to 7.7% (Ramu sugar workers), with the highest consistent use of condoms just under ten per cent (9.3% - Lae Port Workers).

A range of sexual practices were reported by these men to have occurred between men, and between men and women. Oral sex was more common than anal sex (with a man or a woman) for all interviewed except for 59% of truck drivers who reported anal sex with women. There was variation in men reporting anal sex with another man: truck drivers and Ramu Sugar workers reported no male to male sex (0%), with a very small proportion of military personnel (1%), but more port workers (13%). As unprotected anal sex creates a higher risk for contracting HIV, particularly for the receptive partner; both men and women are at higher risk, particularly truck drivers and their female commercial, their casual and regular partners, and Lae Port workers and their male partners from this sexual practice.

Men working in private industries were also asked if they had ever had sexual intercourse (vaginal, anal, or oral) with a woman when she was unwilling. Almost half of the military personnel and close to 40% of truck drivers said that they had had forced sex with a woman who did not consent. A large proportion of Ramu Sugar workers (18.4%) and Lae Port workers (27.3%) also reported sex with a woman without her consent.

Young people under the age of thirty consist of 69.1% of the population. For this research, 1,701 **out of school youth**, aged 15-24 years (913 female and 788 male) were sampled from the communities of Joyce Bay and Hanuabada. Most young people interviewed were sexually active with over two-thirds of unmarried male (72.3%) and female (67.6%) youth reporting that they had already had sex. The median age of first sexual experience was 16 years for both female youth and male youth. Anal sex between married and unmarried female and male youth was very common, with almost 50% of male youth and 20% of female youth reported ever having had anal sex. Just over 12% of young men reported having had sex with another man.

Almost 50% of married female youth and two-thirds of unmarried female youth reported having exchanged sex for money or favours during the previous 12 months, and 28% of unmarried female youth had exchanged sex three or more times during the previous year. A large proportion of married (46%) and unmarried male youth (42%) had also engaged in transactional sex during the previous year; male youth were not asked if they had sold sex, only if they had bought sex, leaving a gap in our understanding of this practice. Married male youth were almost three times more likely than unmarried male youth to have bought sex three or more times in the past year. Reported condom use during transactional sex was significantly higher among unmarried male youth (70% last commercial sex) than unmarried female youth (29%). Condom use for married female and male youth during transactional sex was 40% and 49% respectively. While exchange of sex was high for both married and unmarried female youth; condom use was the lowest for unmarried female youth, who also reported more transactional sex and with more partners.

Among unmarried sexually active youth, 20% of female youth and 37% of male youth had more than one non-commercial sexual partner during the previous 12 months. Among married youth, 9% of female youth and 39% of male youth had more than one regular and non-regular sexual partner over the past 12 months.

Over forty percent of both married and unmarried female and male youth reported that they had been forced to have sex without their consent; 61.4% of married male youth and 49.3% of unmarried male youth had forced partners to have sex with them. Alcohol was linked to forced sex by married male youth. Female youth were not asked if they had coerced or exerted force with male youth to have sex with them.

Six hundred and thirty-four **women who sold sex** were surveyed; 415 from two non-highway-based sites (Lae and Mt Hagen) and 219 from four highway-based sites (Umi Market, Yang Creek Market, Ramu Market and Minj Markets). Just under half (40%) were 25 years old or younger in both samples. Sex workers reported having started to sell sex young (median age 16 for highway based and 17 for non-highway based), were married at a young age (17 years for both samples) and many got divorced not long after marriage.

Non-highway based women had a higher number of paying sexual partners in the previous week (median of 4) compared to highway-based women (median of 2). Approximately 76% of non-highway based and 66% of highway based women used a condom with their last client; while 43% of highway and 24% of non-highway based women who exchanged sex said that they consistently used a condom with their last paying client. Condom use was significantly lower between sex workers and their non-paying sex partners with 56% of non-highway based sex workers and 50% of highway based sex workers using condoms during their last sex with a non-paying client, while consistent condom use was much less (18% non-highway; 21% highway based).

Approximately 75% of women selling sex said that they knew that consistent condom use is an effective HIV prevention method: however, this knowledge did not translate into consistent practice. The most common reasons for not using condoms among non-highway and highway based women with their commercial and non-paying partners were that their partner objected, that they lacked access to condoms, they trusted their partner thought it was not necessary or were not comfortable to initiate.

The women interviewed reported that they had had a sexually transmitted infection in the past 12 months (32% of non-highway based and 42% of highway based) and the majority (81% and 88% respectively) sought treatment at a hospital or clinic. Close to 50% of non-highway based and 42% of highway-based women had been tested for HIV; approximately 80% of these women said that their test had been positive. Misconceptions about HIV transmission were common.

The women interviewed reported both physical abuse and sexual violence, with 3 out of 4 women having had experienced sexual coercion and had been forced to have sex when they were not willing (74% highway based and 73% non-highway based). A third (33%) reported that they had been raped from both samples. Close to half of women in both samples had experienced physical abuse and had been assaulted by a man (47% highway and 53% non-highway based).

The **IMR (Institute of Medical research)** conducted research with **female sex workers** in both Port Moresby and Goroka and with **men who have male to male sex** (MSM) in Port Moresby. Surveys were done in 2005 and 2007 to baseline and show change from the Poro Support Project interventions. This research was supported by FHI and USAID[10] Random sampling with respondent driven sampling was used and is recommended as a good practice for reaching more hidden populations. [11]

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[10] Maibani-Michie and Yeka, 2005; Yeka et al., 2006; Maibani-Michie et al, 2007

[11] Maibani-Michie and Yeka, 2005

Data results from the baseline in 2005 and the survey at the end of project (EOP) in 2007 allow for the analysis of **trend data**. [12] The data for female sex workers shows that the rapid transition from early sexual debut, to first marriage, to selling sex, maintains for both sites overtime. The proportion of female sex workers (FSW) that sold sex for money instead of exchanging it for goods or kind remained low in Goroka, but increased sharply from 45% to 74% in POM. The proportion of sex workers that experienced sexual violence (coercive sex or physical assaults) decreased between the baseline and the end of project (EOP) survey; however high in the both Goroka (58%) and POM (54%). The proportion of sex workers that had non-paying sexual partners increased substantially in POM from 70% to 90%, with a reported increase in condom use both at last sex and consistently with non-paying partners. Consistent condom use increased in POM from 53% to 88% and in Goroka from 20% to 35%. Consistent condom use over the past month with clients also increased form 63% to 88% in POM and 30% to 44% in Goroka. While self reported signs of STI decreased among FSW in POM and there was an increase in the proportion who sought treatment from 46% to 78%; there was a concerning increase in Goroka where self reported STI symptoms increased three-fold and the proportion seeking treatment decreased from 87% to 52%.

Both surveys with MSM in POM illustrated that MSM had diverse sexual networks with both commercial and non-commercial male and female partners. While the proportion of MSM who had a non-paying male sex partner decreased between surveys from 94% to 84%, with a median of 2-3 non-paying sex partners in the past 4 weeks; condom use at last sex (from 44% baseline to 86% EOP) and consistently (from 13% baseline to 68% EOP) increased. The proportion of MSM with non-paying female sex partners over the 4 weeks decreased between surveys from 71% to 63%, with an increase of condom use from 48% to 72% at last sex act and consistent condom use doubled from 23% to 58%. MSM with one time male paying clients decreased from 51% to 42%, with an increase in condom over the last 4 weeks both at last sex (from 62% to 91%) and consistently (from 33% to 77%). The proportion of MSM with regular paying male clients in the past 4 weeks decreased from 64% to 47% between surveys, with last time condom use in the past 4 weeks doubling (41% to 82%) and consistent condom use increasing greatly from 24% to 71%. About a quarter of MSM reported having paying female clients decreasing from 29% to 23% at EOP. Self reported signs of STI decreased between surveys and 33% of MSM reported visiting a VCT centre in the past year. The end of project report makes a series of conclusions and recommendations in relation to the data and the PSP behaviour change intervention; however as the data indicates targeted interventions with these most at risk populations has been effective in most areas.

[12] Maibani-Michie et al., 2007

In the next few years, a concerted effort would be needed to address the identified gaps in this area of research as well as to follow up on data collected up until this point. Furthermore, there is a need to gain greater understanding of the drivers of the epidemic and how such knowledge can be used to support the HIV and AIDS national response, and more specifically behaviour change interventions and strategies.

3. Overview of the national response to the HIV epidemic

3.1 Leadership, Partnership and Coordination

Acknowledging the risk of HIV/AIDS to the country, the Government established the National AIDS Council (NAC) and its Secretariat by Act of Parliament in December 1997. The NAC comprises representatives from government departments, the Council of Churches, the National Council of Women, the disciplined forces, the Chamber of Commerce and the NGOs, as well as PLHIV.

Two major changes to the National AIDS Council Act were amended in 2006 and the location of NAC and NACS shifted to the Prime Minister's Department and the composition of the Council to include persons of high profile in the community who are able to speak authoritatively on prevention, treatment and care, and from HIV umbrella organisations. These changes should also be reflected in the composition of PACS with the chairmanship to be that of Provincial Administrator. Five working advisory committees (behaviour change, medical expert advice, legal and ethical advice, research and sectoral response) operate at the national level. Twenty Provincial AIDS Committees, which have wide community representation, coordinate local HIV/AIDS awareness programmes, counselling care, testing and reporting. STI clinics have been established, training courses conducted for health workers and laboratory technicians, community-based IEC campaigns have been developed and grants provided to community-based organisations.

Other important milestones in the national response include the establishment of:

- The Provincial AIDS Councils (PAC) and their secretariats (PACS) and memoranda of understanding with provincial governments, key committees that coordinate the response to HIV and AIDS at provincial and district levels;
- The Special Parliamentary Committee on HIV/AIDS 2002-2007; and
- The NEC Directive – Decision No. 124/2004 – which moved the National AIDS Council to the Prime Minister's Department;
- A Minister responsible for HIV/AIDS was appointed to assist the Prime Minister in 2005. The actual Government of PNG has a Minister of Health and HIV
- The government endorsed HIV/AIDS as a key priority in the National Medium Term Development Strategy for 2006 – 2010.
- An independent and transparent mechanism for the review of the response – the *Independent Review Group* – has been established to assess performance and to fulfil the GTT's recommendations for accountability and oversight. This group will conduct a periodic *higher level assessment* of the national response to HIV in PNG, reviewing performance of planned activities against the objectives in the NSP

- In July 2003, Parliament approved the **HIV/AIDS Management and Prevention (HAMP) Act 2003,** establishing legal grounds by which to manage discrimination, stigmatisation and mandatory screening. The Act supports the recognition of human rights that is entrenched in the PNG Constitution and complements the powers of the PNG Ombudsman over discriminatory practices. It also reflected the UNAIDS/UNHCHR International Guidelines on HIV/AIDS and Human Rights and the ILO Code of Practice on HIV/AIDS and the World of Work. Important provisions of the HAMP Act are:

  - Prohibitions on discrimination and stigmatization of people with or suspected of having HIV/AIDS, their families, etc., and prohibitions on screening for most purposes;
  - Access must be given to all to means of protection, which includes condom provision and awareness materials. These are not subject to censorship or obscenity laws;
  - Virtually all testing must be done with informed consent, including provision of pre-test information and offer of post-test support; the only exceptions being medical emergencies or by court order in a case of wilful transmission;
  - Obligations of confidentiality regarding HIV status are imposed; and
  - Partner notification by care and counselling workers is enabled under certain circumstances but is not mandatory.

3.1.1 Leadership

In order to sustain the involvement of leadership in the fight against HIV and AIDS the UN through UNDP initiated a Leadership Development Forum in 2005. In addition, through the efforts of UNAIDS, PNG became a member of the Asian Pacific leadership Forum (APLF) in 2003.

The UNDP Leadership Development Program is designed to equip leaders with skills for leadership with the underlying notion that change can only come from within society. Leaders who attended workshops organized under this program were expected to identify innovative strategies within communities and to use community participation to prevent the spread of HIV and AIDS.

The UNAIDS APLF aims at seeking new leaders and using existing ones to become advocates for HIV and AIDS Awareness and Prevention. Workshops for APLF concentrate on sensitizing participants with information on the epidemic, prevention strategies and how to fight stigma and discrimination with emphasis on evidence informed advocacy.

The Medium Term Plan (1998-2002) did not adequately address issues of Leadership in the response to the HIV/AIDFS epidemic. The UNDP supported the Leadership Development Program (LDP) to address leadership issues at all levels focusing on the individual a an agent for change. A number of coaches

were trained to facilitate ongoing activities through the Breakthrough Initiatives (BI) for those who underwent the LDP trainings. The BI was supported by UNDP and UNAIDS under APLF for a limited period of time. The Chairman of the BI approval committee was Dr. Banare Bun, Previous MP and Ex-Chairman for the Parliamentary Special Committee on HIV/AIDS. Meanwhile UNAIDS supported the Asia Pacific Leadership Forum (APLF) to address Leadership at the national and Regional level.

The LSI concept was jointly developed by NACS and AusAID and supported by AusAID to address issues of Leadership at the Parliamentary and top level Managers at Bureaucratic levels, including CEOs of Statutory Government Bodies, Provincial Administrators and Departmental Heads. The programs were delivered under a contract arrangement with PATTAF in collaboration with NACS. The trainings provided under the LSI were through 2-3 days workshops which ended with personal commitments and activity plans for their organisations. Coaches trained under the LDP were utilised to provide one-on-one support to the top level manager after the workshops. This has resulted in many Departments and Statutory Organisations developing and implementing their HIV/AIDS policies. The activities under the LSI has come to a close by the end of 2007 but AusAID will continue to support programs and activities stipulated under the NACS' National Leadership Strategy (NLS) document.

3.1.2 Coordination of the National Response

There are a number of players involved in PNG's HIV and AIDS national response. Effective coordination is therefore essential to minimise duplication of efforts, maximise benefits of different interventions and achieve better outcomes. The NAC is the principal agent established by the Government to coordinate the country's response, and it's secretariat (NACS) is supported by a multi-stakeholder National Strategic Plan (NSP) Steering Group in the development and implementation of HIV and AIDS plans.

Other structures of coordination include: PNG Business Coalition against HIV and AIDS (BAHA) for the private sector response; Igat Hope, the National Network of PLHIV for PLHIV; and PNG Civil Society Coalition against HIV (PACSO) for Civil Society Organisations. The National Joint Coordinating Committee (NJCC) endorsed by Cabinet in 2004 to coordinate and drive the public sector response is not yet functional.

At the sub- national level, Provincial AIDS Committees are established with district links to coordinate provincial and community level responses. NACS has got an office in each province staffed with two technical officers (HIV Response Coordinator and Provincial Care and Counselling Coordinator) to support the work of Provincial AIDS Committees and stakeholders working on the response in the province.

Important initiatives have been put in place to operationalize the national coordination. A joint annual planning process which brings together all the actors around a single planning process to develop an annual implementation plan in line with the seven focus areas of the country's NSP is the single most important initiative in achieving a coordinated national response in the country. The annual NSP planning process is led by NACS and supported by development partners. Through this process one single consolidated plan encompassing activities of NGOs, government departments and private sector organisations is developed and submitted to Government and Donors for approval and funding. The NSP Steering Committee meets monthly to guide and support NACS in planning and coordinating implementation of the Annual Activity Plan.

The Development Partners' Forum which brings together representatives of all major donors and UN agencies on a monthly basis is the mechanism through which development partner's support is coordinated. This forum provides an opportunity for the Partners to harmonise and align their support with the NSP.

The larger NGOs involved in the response hold quarterly review meetings to review progress of implementation of their activities, discuss implementation barriers and share lessons from their programmatic interventions.

The PNG National Strategic Plan on HIV/AIDS 2006-2010 was developed through extensive consultation with all stakeholders. It aimed to meet the requirements of the new Bill, and generally reposition efforts to counter HIV/AIDS in PNG in order to better meet the challenges posed by the growing epidemic. The NSP identifies and provides strategic orientation for seven focal areas for five years. These focus areas are:

1) treatment, counselling, care and support;
2) education and prevention;
3) epidemiology and surveillance;
4) social and behavioural change research;
5) leadership, partnership and coordination;
6) family and community; and
7) monitoring and evaluation.

The National AIDS Council Secretariat adopts the participative multi-sectoral approach planning to formulate its consolidated plan annually. The process involves all stakeholder partners who were engaged in AIDS work and received funding support from either the National AIDS council or from the Donor Agency partners. Most of these agencies are the ones implementing the national response in the country.

The planning process is facilitated jointly between the NSP officers and Provincial Programs Divisional Officers. Meetings were convened with participation of civil and Private Sector organizations, public and statutory

organizations, provincial governments and the Provincial AIDS Committee's throughout the country.

Prior for all of these organizations coming for these planning workshop, they were advised to consult and gauge views from their organization or their stakeholder partners so that what is formulated in the plan represents a total view of the organization.

The National Strategic Plan planning cycle starts in April/May every year. The planning schedule is in line with the Government of Papua New Guinea planning schedule. By June/July copies of the plans from all the implementing partners would have reached NACS if exceeded K300,000. These plans are screened by the National Strategic Plan Screening Committees and any changes required from these plans are forwarded back to the concerned stakeholder to revise and send back to NACS NSP officers to formulate the consolidated costed implementation plan for HIV/AIDS in PNG for the year.

The NSP Steering committee then takes the consolidated plan to the Donor agencies to mobilize financial support and their commitment for funding this plan. After the Donor Agencies have made their commitments, the remaining financial gaps are then forwarded to the Government of PNG for funding. NACS and Treasury Department together submit the NACS HIV/AIDS plan to the Budget Priority Committee for their approval and endorsement. From here NACS HIV/AIDS plan is formulated into one consolidated budget for the Government of Papua New Guinea, which has to be passed by Parliament.

An ambitious **National Gender Policy (NGP) and Plan on HIV and AIDS** 2006-2010 was launched in December 2007 as a companion document to the NSP. PNG recognises the critical importance of gender in shaping the epidemic and the country's response to it. The NGP identifies eight key policy areas: gender inequality, gender mainstreaming, gender based violence, poverty, involving men, stigma discrimination and risk, burden of care and young people. The Gender Work Plan appears not to have been integrated in the 2008 Development Budget and thus it is not well integrated into the work plans for 2008.

The **PNG National HIV, AIDS and STI Surveillance Plan for 2007-2010** has been completed by the National Department of Health with substantial support from bilateral and multilateral partners and research institutions. It is expected this will lead to the strengthening of the system, increased understanding of the epidemic and improved estimates and projections. Major challenges to its realization include getting the necessary work force in place at NDoH and in the provinces. The availability of the necessary hardware and software at all levels ensuring communication and feedback will be essential for the plan to achieve its goals.

NACS has undergone a period of adjustment outsourcing most of its implementation functions to NDoH, civil society and faith-based organizations as it redirects its focus towards coordination. The following functions have been outsourced; care and counseling, education and training, advocacy and prevention through information, education and communication (IEC), peer education and monitoring and surveillance; outsourced to NHATU, NDoH, National Catholic AIDS Office (NCAO), Anglicare Stop AIDS, ADB Rural Enclaves Project, Igat Hope, Child Welfare Council. It is expected that PACs will follow NACS coordinating role, leaving implementation to local civil society community and faith based organizations in provinces and districts. Two important umbrella organizations have been formed to facilitate in the goal of mainstreaming HIV into the general population with the formation of the PNG Business Coalition against HIV and AIDS (BAHA) and PNG Alliance for Civil Society Organization (PACSO).

3.1.3 Networks of People living with HIV

The networks of PLHIV are increasingly strengthening their capacities and taking an active role in the national response. Beneficiating from the important support from the government and the development agencies, most organizations are still building structures and developing their neworks and capacity so that they can play an active role in the national response.

Over the reporting period of 2006 -07, Igat Hope was starting to set up it's organizational structure and annual work plan. A full time coordinator was employed by July 2006. 2007 kicked off on a positive note with the employment of 2 new staff; the program officer and the finance and admin officer which make up the secretariat of Igat Hope Inc. Securing an office space was another major step forward for the group.
As the national network of PLHIV in PNG; Igat Hope wants to play a proactive role by expressing views and getting involved in the activities and the coordinating committees at al levels of the national response to HIV.

Currently Igat Hope is planning for a number of activities to take place in 2008 and beyond. They have a plan to start a Public Speakers Bureau within Igat Hope by April 2008 after the speakers training which will be facilitated by NAPWA – Australia in April. Also, Igat Hope will be carrying out treatments advocacy and printing IEC material on treatment for its members starting January 2008 with a TOT training in treatments literacy and advocacy.
As Igat Hope PNG has plans to expand to other provinces in the coming months to include PLHIV individuals in the other provinces who have mobilized their peers and started to form support groups with the aim of educating others on HIV and addressing issues that affect them directly.

Some of these support groups are located in the following provinces and have achieved the following achievements:

- Alotau – In April 2006, the Igat Hope Alotau branch was officially launched and affiliated to Igat Hope PNG with the aim of: eliminating stigma and discrimination towards PLHIV and to educate the general public on issues of HIV and to be part of the decision making body in the province of Milne Bay.

- Mt Hagen: The PLHIV in Mt Hagen have got together and formed a support group called "The true warriors" who meet regularly at spaces provided to them by NGOs and FBOs to talk about their issues that affect them. In March 2007; StopAIDS Mt. Hagen trained 19 PLHIV in basic HIV information. Currently they are involved in carrying out activities in collaboration with the existing NGOs and FBOs in Mt. Hagen. These are: prevention and educations activities, positive living, care and support for their peers and the general public. There is also a women's program within their activities.

- Madang: The PLHIV group in Madang got together and formed a support group called The Good Samaritans which they are also carrying out a lot of education and awareness activities, positive living, care and support activities for themselves and their peers and also the general public. The good Samaritans was officially launched in June 2007 as an recognized NGO in Madang affiliated to Igat Hope PNG.

- Lae: The PLHIV in Lae have mobilized and formed a group naming themselves Morobe network of PLHIV. They have been faced with a lot of challenges as well. They have done education and prevention activities, care and support activities, positive living and also a number of their members have undergone trainings on peer education, HIV information and counseling.

All the above support groups still needs mentoring and support from Igat Hope in order to carry out their activities and Igat Hope currently is planning on how best they can involve these support groups in their activities as per their annual work plan. Igat Hope is planning to organize a national conference for PLHIV in PNG in mid 2008 to discuss the plans of other PLHIV groups. The hope a result of the workshop will identify areas of support needed for the planned initiatives and act as a national network.

Woman affected by HIV and AIDS in PNG (WABHA PNG) is a newly formed national network of women living with HIV in PNG. This group was formed as a result of women coming together to express their concerns over issues affecting their lives and the lives of other positive women in PNG. It was officially launched in November 2007 after a national workshop attended by positive women from Port Moresby and the other 4 provinces mentioned above. They have an organizational structure and a plan to work around issues of PMTCT, Gender violence, Stigma and Discrimination, OVC and Human rights. WABHA PNG now

plans to employ a coordinator and strengthen their core working group and to concentrate on the current existing groups before expanding out further to other provinces. The work in these 5 provinces will be the pilot program to see what could be done in other provinces.

- Although great efforts are being made to strengthen the Networks of PLHIV in country and their role in the national response, they face a number of challenges that Igat Hope summarized in the box above

CHALLENGES FACED BY IGAT HOPE INC.

1. Representation
   - Igat Hope has a representative and an alternate on the CCM. However, the CCM is usually high powered people who are heads of department which makes PLHIV feel reluctant to have a say as they don't feel compfortale to speak out. The handbook on CCM guidelines must be tabled or a workshop conducted to go over this handbook to familiarize new PLHIV joining the CCM and to create a conducive environment where PLHIV can participate effectively.
   - Igat Hope had a representative on the NAC in 2007 with full voting rights. But since the council is abolished and a new council will be set up under the new NACS Act, Igat Hope board will nominate a member to represent positive people.
   - There are 7 seven areas in the National Strategic Plan for HIV in PNG; however only one focus area which is the Research Advisory Committee has a PLHIV on the committee as a member. The other 6 focus areas don't have any representation of PLHIV on their respective committes
   - The NSP Steering Committee Started off with 3 PLHIV invited by NACS as representatives. After the NSP process was completed and up till now there has not been any more involvement of PLHIV in the NSP steering committee as reps of positive people.
2. Treatment is one area where Igat Hope members are not consulted or involved much in terms of their thoughts and inputs as people living with HIV or in setting up treatment guidelines and treatments rollout.
   Not much and adequate training is provided on treatments literacy and treatments advocacy to positive people which makes it even harder for them to talk about treatments to their peers and also to advocate on issues of treatments which they are often faced with.
3. Prevention is one of the biggest gaps faced by Igat Hope members. Though individual members have bits of information on prevention from sources here and there; not much is done in terms of broadening positive people's understanding on the prevention methods and strategies available and also as far as Igat Hope is concerned, there is absolutely nothing done on positive prevention.
4. There are challenges involved in Care and Support as a number of PLHIV work as volunteers in the Home Based Care and VCT programs.
   At times, they are expected to work beyond what they can do. Also the issue of having to compensate these PLHIVs fairly still needs to be addressed.
5. Members of Igat Hope do not participate in advocacy as much as no training has been provided to PLHIV. PLHIV themselves do not know how to effectively advocate about the issues that affect them in country to bring about positive change. Therefore, they do not act and the issues remain.

6. The greatest challenge is having PLHIV inputs in policy, guidelines and strategic development on HIV in PNG. Leadership of positive people in the HIV response is also not active. Partners need to work together to build Igat Hopes' capacity in these areas.
7. GIPA is central to an effective response, yet HIV positive people's involvement at all levels of the national response is exceedingly weak. Too often, the representation of positive people and their organization is tokenistic or non existent.

3.2 Treatment, Counselling, Care and Support

3.2.1 Community Care & Counselling Support - NACS

- **Policies and standards in place**
    - VCT policy for organisations intending to serve as a VCT site/Centre
    - Two/Three confirmation (rapid testing Algorithm) soon to be reviewed
    - "Know your status" plan the future campaign on the roll out soon through PNG Directory the Yellow pages
    - Home Based care Training is rolled out by NHATU
    - OVC Committee established to support the Child Welfare Council at the DCD

The **home based care** program is somewhat unique and tailored to specific setting across the country. As more people are infected and more so affected, individual trained and close to those infected and striving with least knowledge about the diseases but with heart to care for the loved ones are doing what they could do to help.

In certain Highlands's provinces like Southern Highlands, Enga and Western Highland provinces, a number of communities and institutional based care centres were listed so that people could seek shelter and support from one another.

Home and community based care serving provisions are often the least funded but they do a lot in the name of love. Some said: "*it a joy of satisfaction that burns within the heart that urged me to be there for them*". In the southern highlands, they have listing of those that have deceased by district. Thus deemed that reporting is slightly improving and soon, we could have proper listing of Orphans and vulnerable children in the society.

The positive support provided at all provincial and district level, many friends are congregating as team of friends to be part of the national and provincial AIDS and good health campaigners. From "**The group of friends**" in Western Highlands, "**The true warriors**" to those of the "**Good Samaritan**" at Madang the positive attitude continue to be growing.

3.2.2 *Scaling Up towards* **Universal Access**

PNG has begun to respond to the new global strategy of Scaling Up Towards Universal Access by holding a workshop attended by key stakeholders in 2006 to review the current targets of the NSP 2006-2010 and GFATM and to agree on new targets. Greater emphasis will be placed on scaling up prevention, treatment, care and support through the roll out of ART treatment, expansion of VCT sites and strengthening monitoring and surveillance. Scaling up for Universal Access is intended to strengthen the county's resolve to achieve the Millennium Development Goals and the National Strategic plan 2006-2010.

The care and treatment program is supported by both private and public health facilities. The treatment services have been established in health facilities run by government, churches, Non Governmental Organizations (NGOs), private sectors and private hospitals. The number of sites providing ART services has increased from two in 2004 to 38 sites by December 2007. Of these, six are in provincial hospitals that receiving a majority of patients.

Treatment

The number of patients (adults and children) accessing AIDS treatment has increased in similar ways. As of December 2007, there were 2767 people registered for ART services including 241 children. Of these, 2250 (185 children) are currently on treatment.

The 2007 HIV estimation and projection report indicates that 56175 people are estimated to be living with HIV. Of these, 11% (6348/56175) including 636 children needed ART by end of 2007. Of the PLHIV needing treatment by end of 2007, 35% (2250/6348) were on treatment by end of December 2007. The adult treatment coverage is 36% (2065/5712) and for children is 29 % (185/636) in the same period (Denominator is from 2007 HIV estimation report)

Heduru and Lae ART centers are the oldest clinics in the country with year one, two and three 12 months survival rates at 63%; 83% and 89% respectively. The overall 12 months survival rates in these first two clinics are 80%: The 24 months and 36 months survival rates are at 71% and 53% respectively. The rests of sites have not gone beyond 24 months since their establishment. The overall national ART 12 months survival rate is 61%

For a successful program, uninterrupted drug supply at service delivery points is crucial. The procurement supply management systems of ARV and opportunistic infections (OIs) drugs need to be strengthened. This is important to ensure quality of treatment outcome including improved drug adherence and minimizing drug resistance. All drugs for adults and some for children are procured through GF ATM support, while the Clinton Foundation supports most drugs for children. Ninety nine per cent of all patients are still on the first line treatment regimen (2235/2250) and only 15 patients are on second line

Scaling up ART services needs a comprehensive public health approach where services need to be linked and not in isolation. The program is closely linked to TB and Malaria programs. These programs are under the Disease Control Branch and they all have grants from the GFATM. Further, the TB program has selected 16 districts to implement TB/HIV collaborative activities. This will include HIV testing and counselling, referral services, monitoring, and evaluation.

The maternal and child health program is collaborating with HIV care and treatment to expand the ANC services including PMTCT and pediatric treatment. Health care workers are trained to integrate these services and to establish one stop shop for all services. The program is also linked to HIV testing and counseling (HTC), Sexually Transmitted Infections (STI), out patients, child and reproductive health services.

To facilitate scale up of ART services in countries, WHO developed a public health oriented HIV care and treatment training modules for developing counties. The Integrated Management of Adult and Adolescents Illness (IMAI) training module for resource constrained settings was adapted according to the PNG context.

A team of trainers from NDOH and development partners provides the course facilitation. As of December 2007, 363 health care workers were trained and HIV care teams have been created on each ART site and are working closely with other health care workers, to provide linkages and referral services to people living with HIV and AIDS. All trained health care workers are certified after passing both theoretical and practical training.

To ensure quality of services, a mentorship program supported by NDOH and partners has been introduced. A team of experienced national mentors provide mentorship to trained health care workers. This provides confidence to health care workers and ensures the quality of services provided. Further, supportive supervision is planned and provided by teams from NDOH and partners at central level on regular bases.

The laboratory support is paramount for HIV diagnosis and treatment. By end of 2005, the Central Public Health Laboratory (CPHL) was the only providing HIV testing confirmation. Given the country terrain, the HIV test results took three to six months for people to get their confirmed HIV results. This adversely impaired HIV testing and treatment. Most people who had their first HIV reactive test results get lost/died before getting their confirmed test results.

To support HIV treatment initiation and patient monitoring, six CD4 machines have been procured and installed in public provincial laboratories and 2 machines in church based hospitals. Technicians have been trained to run these CD4 machines. ART sites that do not have CD4 machines monitor patients' immune status by either referring the patient or sending the patient's blood

samples to laboratories with CD4 machines. The haematology and biochemistry analysers have been installed in provincial laboratories to support patients monitoring. In addition, laboratory reagents to support testing of different parameters are supported through Global fund ATM.

Testing for HIV

By mid 2006, four provincial laboratories were strengthened to confirm HIV results by December 2006, all 19 provincial laboratories could confirm HIV diagnosis. The provincial laboratory technicians have been trained to confirm HIV diagnosis using the nationally approved algorithm. To facilitate further HIV testing in both health and non-health settings, NDOH is leading a process of reviewing the HIV testing algorithm with the aim of introducing two thermal stable rapid tests to rapidly scale up HIV testing and treatment. This has facilitated easy availability of HIV results, enhancing HIV treatment including PMTC and PEP services.

In mid 2007, the NDOH introduced a provider Initiated HIV testing and counselling with the aim of scaling up HIV testing in the health sector. The number of people accessing HIV testing has increased since then, particularly in ANC and STI clients. The number of people tested through VCT services has increased from 3052 in 2006 to 26934 in 2007.

HIV testing is done in health and non-health facilities. Development and endorsement of the VCT national guidelines and training manuals was accomplished by NDOH. Previously, the VCT functions were run and coordinated by the NACS under National HIV/AIDS Support Project (NHASP). By December 2006, these functions were transferred to NDOH. Through partner support, the VCT technical adviser and National VCT coordinators were recruited to support implementation and scale up of services. The VCT accreditation criteria were developed and accreditation team established. As of December 2007, there are 62 VCT accredited sites that are providing services. To scale up services, the VCT training functions have been outsourced to the International Education Agency (IEA). This will strengthen and expand services availability and contribute to HIV prevention and Treatment.

Provider initiated HIV testing and counselling (PICT) was introduced in 2007. The NDOH provided directives to all health facilities and partners supporting HIV testing to expand this approach. Health care workers who are trained in the HIV management are trained in PICT approach as well. This intends to encourage health care workers to support patients with signs and symptoms related to HIV to undergo HIV testing. Patients from TB, STI clinics, inpatients, outpatients and ANC services are encouraged to test for HIV. This will increase the pool of clients who need treatment.

3.2.3 Prevention of Mother to Child Transmission of HIV

UNICEF and WHO have collaborated with national department of health to support the prevention of mother to child transmission. Integration of PMTCT services has been done either directly through the public health facilities, or through services provided by Catholic Health Services. In PNG, PMTCT services exist in health care facilities of 7 provinces out of the existing 20 provinces. These include the General Port Moresby Hospital in the National Capital District, and major hospitals in the following provinces: Western Highlands, Eastern Highlands, Chimbu, East Sepik, West New Britain, and Milne Bay. Since the commencement of the program in 2004, 20,000 pregnant women have accessed the PMTCT services, that is general information about HIV given during antenatal visit, group counselling, individual counselling with individualized risk reduction for some women, blood testing, ART dose during pregnancy or labour, and modified obstetric care. Of those, about 60% agreed to be tested. While 99 pregnant women received ART prophylaxis to prevent mother to child transmission of HIV in 2006, this number did not exceed 84 in 2007. This led to an increasing unmet need for PMTCT as the epidemic is growing, and the estimated number of pregnant women who are HIV+ reaches 3621 for 2007 while it was 2848 in 2006. The coverage of PMTCT program has fallen from 3.48% in 2006 to 2.32% in 2007.

This situation is a result from a transitional phase where the responsibility for PMTCT has been transferred from NACS to NDoH where there is absence of dedicated staff who will manage the PMTCT program although funds for those positions have been made available by UNICEF.

In 2006 NAC approved the PMTCT participant and trainer manual developed by NACS, NDoH and UNICEF. The printing of the first set of manuals was funded by the Global Fund.

A major constraint in reaching pregnant women is the limited availability of antenatal services throughout the country, especially in rural areas. Most women have their babies at home in settlements and villages. Generally, they are unable or unwilling to access antenatal clinics because of cost of services, transport difficulties or cultural inhibitions.

For those reached by services, ensuring exclusive breast feeding for a limited period has been not without a lot of problems. This is because of difficulties of monitoring and following up women post delivery, a lack of acceptable, affordable alternatives to breast feeding, and lack of information in easy, understandable language.

Long distances to health care facilities, presence of about 800 languages, and the rough, rugged terrain of many places which aren't connected by passable roads adds to the difficulties of follow up, particularly since 80% of women live in the rural areas.

3.3 Family and Community Support

The **Family Health International** initiative in **Community and Home-Based Palliative Care (CHBC)** is an example of good practices**.**

In 2007, to expand access to community home-based palliative care in PNG, the Family Health International (FHI), with the support of AusAID, initiated a CHBC program to help people living with HIV and their families to live longer and better lives. To guide the development of community home-based care services to best fit the needs of PLWH and their caregivers, an assessment was conducted by FHI, NACS, Friends Foundation Incorporated, Igat Hope and local health authorities. A convenience sampling methods was used and those interviewed included: people living with HIV (42), their caregivers (15), health workers (5) and key informants from national (17) and local (22) level organizations.

The assessment identified a range of physical, social, emotional and spiritual needs including:

- Pain was identified as prevalent and under treated, and distressing symptoms were commonly experienced.
- Hunger and poverty were serious problems.
- PLHIV had considerable emotional suffering, and experienced stigma and discrimination.
- There was a need for a range of supportive care for children from assistance with school fees, food, health care, and in identifying a future caregiver.
- Home was the preferred site for care when PLWH are unwell, family caregivers were stressed and unhappy, and while health care workers were willing to help they expressed that they require training and support.

In the assessment, CHBC support services were identified to be in great demand by both the PLWH (95%) and caregivers (93%) interviewed. Areas identified for support included: food and nutrition counseling, support for children, income generation support, transportation assistance, ART adherence counseling and care for pain and other symptoms.

The assessment findings frame the design of the community and home-based palliative care (CHBC) project initiated by FHI in partnership with a local non-government organization, the Friends Foundation Incorporated. The Friends Foundation is an experienced grass roots social work NGO that assists women living with HIV and children living with and affected by HIV.

Program development included consultative meetings with a range of stakeholders involved in CHBC and HIV care and support, the NACS, PACS, Heath Advisers, Provincial Heath and a Community Nursing Director. Twenty-three sites in rural and urban communities in the National Capital District (NCD) and the Central Province were identified. All sites received community

mobilization and sensitization meetings, with 420 people being consulted across the sites and over 5,000 people sensitized to the program.

Key team partners, such as the master trainers and community team members were identified through interviews, and health workers were selected through Departments of Health based on their clinic location and proximity to the identified sites for establishing the CHBC services. Health care workers, community and church leaders, PLWH and other community members then became interconnected on CHBC teams through meetings and training in community home-based and palliative care. Teams were trained to deliver services to those requiring community home-based based palliative care, including but not exclusive to people living with HIV, as it was believed that palliative care and support given for a wide range of illnesses could reduce potential for HIV related stigma.

The development of CHBC program also included putting a system in place and strengthening the capacity and mechanism for home based care. This included the development of a variety of forms and resource materials: including monthly reporting forms for adults and OVC, database registry forms, adult and paediatric visit and follow-up forms, referral cards, supervisory check-list, and a client record book written in by the CHBC team and helpful when people require further treatment from health workers. The current NACS national manual for home based care is being reviewed and revised based on the needs identified in the assessment, and in collaboration with key partners including PLHIV, government agencies, local NGOs and FBOs who are engaged in providing such services and treatment.

Palliative care supplies were purchased and distributed and systems created to track supplies. These supplies included personal hygiene kits and medical supplies, which are accessible over the counters and accessories, including CHBC kits (backpacks), which have been distributed to 23 sites. Those trained have been provided with supplies for treatment and assessment, and it is expected that providing care to PLWH and families in the community with the kit, reduces the burden on the hospital and health system while increasing.

CHBC teams have begun to provide pain and other symptom management, self care education, adherence counseling, emotional and spiritual support, care for affected children, end of life care, and referrals to needed services. While the implementation at a community level with people receiving palliative care, treatment, support and referrals has only began end of September 2007; this CHBC program has increased access for 497 people to reach services, including HIV and TB testing, ART and TB treatment, and treatment of opportunistic infection at health facilities. Through the newly established 23 CHBC sites, 409 people were receiving home-based palliative care by the end of 2007.

The **Catholic Church - National Health Services (CNHS)** illustrates good practice in giving community and family support from their **CHIMBU experience.**

The National Catholic Health Services is active member of network of implementing agencies that are supporting programs and interventions in HIV and AIDS in PNG. The church has embarked on series of community based preventive and care programs and activities at diocese level in number of provinces. The intervention programs targets infected and affected persons, particularly the women, youths and orphans. Below is an experience from the communities in Gembogl area of the Chimbu province, showing community response towards the fight against HIV and AIDS

More than 3000 students in 40 agency schools in the province were educated on HIV and AIDS having relevant teaching materials developed and taught as part of the curriculum for learning in schools. The approach has provided opportunity for the students to learn about HIV AIDS as part of their learning at the start of their education. Increasing number of Government schools in the area are interested in the scheme and plan is underway to extend this program as wide as possible if resources permit.

The drop in center started initially with the aim to operate as information center for care and counselling services for those infected and affected with HIV and AIDS and the community at large. From the initial 6 centers, the number has increases to 21 centers by end of the year (December 2007). The centers have extended scope of its activities from simple care and counselling to cater for clients of rape, violence, drug, family planning, behavioural problem and simply offering access to general HIV and AIDS information. These care or drop-in centers are providing direct counselling services at the community grass roots level.

Seeing the plights of the children orphaned by the AIDS epidemic the community through the support of church's network at the diocese level, have erected the orphan center called '***Gembogl Orphans Resource Center***'. The center was officially opened on the 14th December 2007 and well over two thousands people (including Government dignitaries) witnessed the opening. A mini hydro was constructed to provide electricity to the center. Five of the drop in centers will access information and other services provided by the Gembogl Orphan Center.

In 2007, the CNHS supported over 20 trainings being conducted community/ village based HIV and AIDS training at different sites in the province. More than 200 people participated and volunteered as peer trainers to extend the activity into their respective communities. The members of church and the community at large are becoming conscientious about the HIV and AIDS issues. People themselves took on interest to take the training into other areas. The Basic HIV/ AIDS training is a success. It is cheap and easy to coordinate at Grass root level and more importantly people now know accurate information on HIV epidemic,

which help to change the attitudes and perception of the community, particularly on the issues of stigma and discrimination against the PLWHA .

Most projects and activities implemented by the Catholic Church- National Health Services that are undertaken in Chimbu under the CNHS, are relevant and community based with the participation by community members on a voluntary basis. The members of the communities are supportive and responding to fight against the HIV in their communities. It is unknown how long can their interest and support be sustained. Appropriate funding and technical support have to be channelled on a continued basis to ensure these programs are sustained to produce the maximum benefits aspired in the community.

3.4 Education and Prevention

Innovative programs to combat HIV/AIDS have been established. A high risk setting strategy was established in 2004 to target high risk groups including sex workers, MSM, members of the defence and the disciplinary forces, truck drivers and dockside workers. Other innovative programs, implemented by ADB and BAHA, engage the private sector, including large rural-based enterprises, in prevention, testing, treatment, care and support.

3.4.1 Prevention with more at risk populations (MARPS):

The High Risk Settings Strategy and Tingim Laip

The High Risk Settings Strategy (HRSS) was designed by the NACS and the National HIV/AIDS Support Project (NHASP) in 2004 and was renamed to Tingim Laip in January 2007 implemented by the Burnet Institute under AusAID's new program of support. Tingim Laip is a large community based HIV prevention project in 36 sites and 11 provinces that implements behaviour change interventions with more at risk populations in sites where HIV is known or more likely to occur. These sites include the markets and entertainment sports along the Highlands Highway, ports, military barracks, nightclubs, factories, villages around mines, sugar and palm industries, and urban settlements. Strategies focus on youth, men and women who live or congregate at or around sites where sex is exchanged and sold.

The goal of Tingim Laip (TL) is 'to facilitate and sustain behaviour change to minimize HIV/AIDS and STI transmission and increase awareness in high risk settings and communities in PNG'. Tingim Laip is grounded on four pillars that include 1) ensuring accessibility and availability of condoms (male and female); 2) referrals to user friendly STI services; 3) referrals to user friendly VCT services; and 4) care and support for PLHIV.

Strategies for behaviour change communications range and include the engagement with the community and targeted groups through the distribution of billboards, caps and shirts with messages and logos, and the distribution of IEC and male and female condoms. Behavioral change communication training, life skills classes and venues for selling products from the use of these skills have been created. Peer education, the targeting industry workforce with sensitization and HIV information and condom distribution, and the involvement of PLHIV are important facets of their BCC strategy. Referrals for STI treatment and VCCT, involving youth meaningfully to develop their skills at all level of program development and implementation, and the creation of communication groups with youth. Addressing issues of gender-based violence are being integrated into behaviour change intervention strategies. Success has been made from where there has been community resistance to condoms and condom distribution, a 'condom culture' emerging in some areas. There has also been the incorporation on drug and alcohol related harm minimization initiatives into TL activities.

Tingim Laip have had a range of achievements including the harnessing the energy and commitment of many people including volunteers, and the mobilisation of community HIV responses. A site assessment tool has been developed, training in key area, youth engagement, the emergence of a condom culture, the creation of strong and effective partnerships and the introduction of drugs and alcohol into programs. Challenges have been created by the disruptive supply in condoms and continuing stigma and discrimination. Lessons learnt include the need for a stronger monitoring and evaluation framework and strategies to improve communication with their sites in rural areas and how to increase a more enabling environment for STI and VCT referrals. Tingim Laip works in partnership with FHI, IEA, Burnet Institute, World Vision, Provincial AIDS Councils (PAC) and Save the Children. [13]

FHI – BCC materials for MARPS

BCC materials developed by FHI for more at risk populations fill a void in materials with MARPS. These include a personal risk assessment quiz; a flipchart (The Love Story) used as a tool discuss issues such as safe sex, PPTCT, female and male condoms, STI, stigma, HIV transmission, and counselling; and a series of 12 cards for sex workers and MSM that give information and connect them to clinics. Hope Worldwide PNG, the Red Cross and World Vision are also using these materials in their programs with more at risk populations. FHI has supported the Nine Mile and Porot Sapot Clinic.

There has been collaboration between Family Health International and Tingim Laip in the area of BCC capacity building, IEC material distribution, the TL Youth

[13] Tingim Laip, 2007

HIV and AIDS Music Competition and have provided technical expertise and support specific for youth onsite for young people.

Porot Sapot

Save the Children PNG (SCiPNG) has a program goal to reduce the impact of HIV among young people and other most vulnerable groups. The Porot Sapat Project aims to reduce the risk factors and impact of HIV amongst FSW and MSM. This is done through a range of strategies including peer outreach, condom, lubricant and IEC distribution; promotion of health services; sensitization of police and other gatekeepers; and through advocacy and partnership building. Porot Sapot staff and volunteers work in NCD, Goroka, Kainantu, and Lae. More that 130 sex workers and MSM have been trained as peer educators since 2003 and play an important role in referrals for STI and VCT, dissemination of information and condoms. In NCD the Poro Sapot Project runs a Drop-In Centre for sex workers where they provide information and a safe space. A clinic for sex workers and MSM opened in 2005 at the same site, which provides STI and VCT services. The research data previously discussed conducted by IMR in 2005 and 2007 indicates areas where Porot Sapot has had impact in increasing safer sexual behaviors with MARPS.[14]

PNG Friends Frangipani

PNG Friends Frangipani is a national network of sex workers formed by both male and female sex workers in PNG. They officially started the network in a meeting held in April 2006 in Goroka. They formed a national network of sex workers in 2006; set up their organizational structure; created a constitution and has been registered as an NGO with PNG IPA; has working relationships with international sex workers organisations. Friends Frangipani have just opened an office space with 2 male and female coordinators.

Friends frangipani work to improve the rights of sex workers in PNG by: advocating for human rights for sex workers in PNG; making services friendlier for FSW and MSW; through peer support to new and existing members; working to addressing the health concerns of its members in the areas of HIV, STI, contraception and pregnancy; by creating and designing IEC material for peer sex workers; and by getting involved in local, national and international meetings to advocate on existing legislation that impacts the lives of sex workers.

Population Services International

In February 2007 Population Services International (PSI) was awarded two contracts with ADB. Under the first contract, PSI will implement behaviour

[14] SCiPNG, 2007

change interventions in select rural development enclaves. Those interventions will focus on most at risk populations. Under the second contract, PSI is responsible for launching a condom social marketing program with the aim of contributing to the reduction of HIV transmission. Key program components include nation wide social marketing of male condoms, female condoms and lubricants as well as targeted communication campaigns with most at risk populations to encourage correct and consistent condom use.

3.4.2 Prevention among young people

There are range of partners that work with prevention programs for both in and out school young people such as; Save the Children (Youth Outreach Project), UNFPA, UNICEF, the Department of Education; FHI, Tingim Laip, Anglicare, World Vision, Hope Worldwide PNG, the Red Cross and Oxfam International.

UNFPA funded prevention programs for young people in schools for the development of the reproductive and sexual health curriculum for primary schools (2002-2004). A Teachers Training Manual, Facilitators Guidelines and Resource books on Sexual Health and Reproduction have been developed (2002), as well as a Syllabus on Personal Development and another on Population Education. The curriculum includes basic facts about HIV and AIDS and Life Skills Education. UNFPA supports a Peer Education project training and empowering young people about HIV to carry out awareness and share open discussions about sexuality and HIV and AIDS with their peers in a number of tertiary institutions.

The **Department of Education** completed its HIV and AIDS Policy in 2005. One of the key components of the Policy was the development of an appropriate HIV and AIDS Life Skills Education (LSE) teaching materials for schools in PNG, a component missing in the curriculum developed by UNFPA. In 2006, the UN Theme Group working through **UNAIDS** was given the responsibility to develop LSE materials for schools in PNG. Resources and workbooks for upper primary level teachers and students have been completed, and teachers were trained in the provinces where the curriculum was piloted during the last quarter of 2007. The materials have been evaluated and assessed in the three pilot provinces of Bougainville, Eastern Highlands and Madang, involving some 74 teachers from 64 upper primary schools. The teachers found the curriculum materials useful but many teachers still feel reluctant to teach topics on condom use and prevention of HIV and STIs. Some teachers suggested that condom use should be taught by health workers or NGOs working in the area of HIV. The LSE activity has been assured funding from GFATM and is being coordinated by UNAIDS. After a piloting phase, the manuals are being printed in preparation for the scaling up to cover all schools in PNG. A challenge comes from parents and some religious groups who are adamant that young people should not be exposed to explicit information on condom use and issues relating to adolescent sexual practices, and condemn the teaching of HIV Life Skills education.

Supported by AusAIDS, **Anglicare-Stop AIDS and Hope World wide (PNG)** carry out education programs for schools in the capital city of Port Moresby. The Hope World Wide program has covered over 44 primary schools targeting children aged 13-15 years. Anglicare implements a similar programs among young people aged from 16-19. **UNICEF,** in collaboration with the Department of Education and Milne Bay PAC have developed a school-based HIV program that targets teachers and parents of young people in and out of school. Teaching materials have been developed for use by teachers which include role plays making it easier for teachers to talk about sexuality and HIV and AIDS. Printed class materials are also distributed to parents by the students. Teachers initiate discussions with parents usually through the parents and citizens meetings cum discussions centering on how best to assist young people to protect them from HIV. This program has been piloted in six provinces and it has greatly assisted parents in openly talking about the epidemic.

Programs to reach out of school youth have been supported by the EU, AusAID and UNICEF through PAC offices around the country, and by Anglicare Stop-AIDS and Hope World Wide using a peer education strategy providing basic information about HIV. Peer Educators have been trained in a number of provinces with particular attention to urban settlements. Leaflets and condoms have been distributed by peer educators to settlements and communities across the country. Beginning in August 2005, NHASP installed 3,270 condom dispensers throughout the 20 provinces. These dispensers are looked after by the peer educators.

To strengthen community responses, in 2007 **UNICEF** supported community mapping and theatre against AIDS, and AIDS competence activiites. They have supported the COMATAA training of 23 young people in Sepik as facilitators to work with schools. Twenty-five young people in Anglip South Waghi have also been trained in community theatre and are currently mobilizing their community. Five young people were trained in mass media, and a talk back show is aired on FM 100 every Sunday from 5-6 pm to talk about youth issues and young people are encouraged to call in and discus issues and ask questions about certain issues. In partnership with NACS and the National Youth Commission, UNICEF supported a three week TOT training in psychosocial life skills for 26 young people. These young people left the training with action plans of how and when to facilitate life skills training for out of school young people in their respective provinces. UNICEF supported in funding three youth friendly centers in three Districts in Maprick, Korowai, Minj

Social Mapping studies done by NACS show that young sexually active people with multiple partners interviewed in all 20 provinces who know about condoms, do not use condoms or do not use them consistently.[15]

The **Tingim laip (TL) Program in partnership with FHI** ran a Youth Music competition between August and September 2007, in four sites, the application forms were given to interested youth groups through the Tingin Laip program officers in the tingin laip project locations. A total 130 young people performed in 26 bands and delivered HIV and AIDS awareness through lyrics and messages for a crowd of almost 2,700 people. The positive atmosphere with the 4 sites created opportunity for FHI to use the breaks to engage the crowd in quick Quizzes and questions on HIV and AIDS prevention, care and treatment, prizes were given to the winners.

In preparation for the TL youth music competition meetings were conducted with site committee members and the Tingim Laip site from Joyce Bay and Taurama to discuss logistics, challenges and plan the event. The theme of the music completion was also decided in those meetings as: “Music, our song! Our message! Your consideration! Stay safe from HIV and AIDS”. TL youth music competition received support with live recording from CHM while the next of Kin production provided the musical equipments and sound engineering for the event. At the end of the event, a group from Joyce bay was finally announced winners of the TL youth Music competition.[16]

Porot Sappot Project (PSP) has reported a success in the trial of a new approach in reaching out specifically to young female sex workers and have introduced them to the PSP. Monthly meetings organised by PSP, whereby the Outreach Volunteers invite their peers (young female sex workers) and the following month the peers invite their peers and this continues, with this approach the number of young female sex workers attending the meetings and introduced to PSP has subsequently increased since last July. PSP reports that activities restricted to young FSW have been effective and the need to engage young women as volunteers and staff. PSP also report that one of the challenges faced is the lack of STI services to match the quantity of referrals per month. [17]

The **Youth Outreach Project (YOP) of Save the Children**, is a peer-mediated sexual health improvement and HIV prevention project which works with young people (aged 15 – 25 years) who are out-of-school and unemployed. The project operates through increasing safe sex knowledge; enhancing life skills; improving

[15] NACS and NHASP 2005

[16] Tingim Laip 2007

[17] SCiPNG, 2007

access to male and female condoms and youth-targeted behaviour change communication materials; working with service providers to improve access to sexual health services; and working with older adults and community leaders to create an enabling environment for improved youth sexual health.

Tremendous progress has been made towards the official launching of the Youth Friendly Centre in Madang and clearly defined work plans with definite timelines have been established towards this goal. Networking with local, provincial and national partners has continued, resulting in strategies for delivery of youth-friendly sexual health services in Madang.

The Youth Outreach Project in the four project sites does the following activities:

- Conduct Youth Advisory Committee meeting with the Peer Outreach Volunteers (POVs) (who are young people),
- Conduct Peer Outreach activities through various programs during the day and in the evenings,
- Provide incentive for Peer Outreach Volunteers (POVs) such as Caps , shirts,
- POV Continue accompanying peers when referring for STI services.

A concern raised by YOP is that young people are still having difficulties accessing STI clinic services. While YOP also face problems in maintaining the the POVs as their number is continuously dropping out.

The **Oxfam Youth Program** works directly with young people and local partner organisations to develop young people as leaders of today and develop and implement programs that support them in that role. In the prevention of HIV among young people, Oxfam is currently supporting four young people – two in Eastern Highlands, one in East New Britain, and one in Wewak who are developing plans and ideas to implement HIV prevention, care and support projects in their communities. There are also ten (10) other young people who are also supported by Oxfam in other provinces around PNG with their project initiatives to incorporate HIV as an interlinked issue in their projects. This support for young people is a three year program (2007-2010) and is directly linked to the Oxfam International Youth Partnership Program.

3.4.3 Orphans and Vulnerable Children

In 2005, it was recognized that orphans and vulnerable children in PNG did not receive special medical support, school related assistance, emotional or psychological support, including counseling, and other material or social support, such as clothing, extra food, childcare and legal support from the national government. UNICEF supported the Government to conduct a number of situation analyses to contribute to stronger empirical decision making.

A report on commercial sexual exploitation of children noted that, "Protecting children infected or affected by HIV/AIDS will be one of PNG's biggest welfare and anti-poverty challenges in the coming decade," and noted that children at risk of commercial sexual exploitation shared many of the risks facing children made vulnerable through HIV and AIDS.[18] This report, along with national HIV social mapping, identified increased risks and vulnerabilities for children through avenues such as informal adoption, high-risk sexual activity, commercial sexual exploitation of children, endemic violence and abuse for children including child sexual abuse, as well as poverty, barriers to education, and discriminatory cultural practices such as bride price and polygamy. The absence of specialist programs or organizations equipped to support children affected by HIV and AIDS to claim their right to protection was a significant gap in service delivery identified by the Commercial Sexual Exploitation of Children Situational Analysis.

In recognition of the need for further information on orphans and vulnerable children, the Department for Community Development Child Welfare Council and UNICEF conducted a national situation analysis on families and children affected by HIV/AIDS and other vulnerable children in Papua New Guinea.[19] This situation analysis identified that children in Papua New Guinea are rendered vulnerable by pervasive gender inequality and violence against women and children that 'condemns many children to lives of violence, ignorance and ill-health'[20]. Modern changes to bride price system increasingly commodities children; while poverty and urbanization place enormous pressure on communities, evident in the breakdown of the wantok system that traditionally provided social cohesion and community based protection for vulnerable members of a community. In particular, the practice of informal adoption was highlighted, stating that, "Less than 1 per cent of children in Papua New Guinea live in institutions or on the streets. Most children live with families – either biological or adopted."[21] This was qualified by the recognition that orphans and other children living away from their parents were particularly vulnerable to abuse, neglect and exploitation.

The situation analysis identified that children affected by HIV or AIDS face the loss of loved ones, the trauma of caring for dying family members, risk of HIV infection from providing such care, low family capacity for care of child, loss of schooling and access to health services, poverty (which pushes children into work, including sex work), and increased vulnerability to abuse and neglect in the

[18] HELP Resources 2005, pg20

[19] UNICEF PNG 2006

[3] UNICEF PNG 2006:ii

[4] UNICEF PNG 2006

absence of caregivers. The analysis further cautions that as AIDS-related deaths increase in adult populations, increasing numbers of children will be orphaned by the epidemic, increasing their vulnerability to abuse and exploitation. In the 2007 Estimation Report, it was estimated that there has been increasing trends in the numbers of orphans living with HIV; in 2003 it was estimated that 1549 orphans were living with HIV; in 2005, the estimated number increased to 2704, and in 2007 to 3704 [22].

The situation analysis on children and families affected by HIV and AIDS, and other vulnerable children outlines recommendations to respond to the escalating impact of HIV and AIDS on children and families. The following activities have taken place with UNICEF support:

- The establishment of the Orphans and Vulnerable Children National Action Committee, which is a working committee of the Papua New Guinea Child Welfare Council, a statutory body that reports directly to the Minister for Community Development. This committee includes representatives from Department for Community Development, National AIDS Council Secretariat, HOPE Worldwide (PNG) Inc., National Research Institute, Family and Sexual Violence Action Committee, UNICEF, Department of Education, Papua New Guinea Sports Foundation, Save the Children Fund, Papua New Guinea Council of Churches, Department of Health, Royal Papua New Guinea Constabulary, and Department for Justice and Attorney General.
- Development of a Four-Year National Strategy for the Protection, Care and Support of Orphans and Other Vulnerable Children in Papua New Guinea, which was developed by the OVC National Action Committee. The Strategy draws from local knowledge and international experience to deliver 39 actions for children over four years at a cost of 18 million kina. Key objectives identified for the Strategy include improved social protection; legal protection and justice; extended community-care in the community; and human services coordination.
- A stronger, rights-based legislation, the Lukautim Pikinini Act (Child Protection), was passed in April 2007 to enable all children to demand the right to protection from statutory authorities. It also limits the use of institutional care for orphans and vulnerable children. Regulations are currently being finalised and gazettal is pending. Updated child protection training is being developed to ensure that 6 – 10 provinces have the capacity to implement this legislation by the end of 2008.
- UNICEF provided support in 2007 to develop a training manual to strengthen the capacity of faith based organizations to identify and

[22] NDOH and NACS 2007

respond to issues facing orphans and vulnerable children in their communities.

- A Universal Basic Education Plan is currently being finalized for submission to the Papua New Guinea National Executive Committee in the first quarter of 2008, ensuring access to primary education for all children.
- Supported by 6 provincial technical advisors, the Village Courts Secretariat has conducted child protection training for 100 per cent of Village Court Magistrates in a total of 12 village courts in the five districts, and an equal number of women and youth leaders. This training has supported Magistrates and the community leaders to identify a range of community-based initiatives to strengthen the protective environment for children across these districts, including putting up signs that advise communities that serious offences will be referred to higher courts and conducting awareness campaigns in market places.
- The National Action Plan Against Commercial Sexual Exploitation is now awaiting Parliamentary review, and combined with the Orphans and Vulnerable Children Strategy will be used as a base for the National Children and Family Policy that will be developed in 2008.

The United Nations 2008 – 2012 Country Program commits support to the protection of orphans and vulnerable children, with an intermediate outcome that by 2012, vulnerable children and young people will experience improved access to quality basic social services, including welfare and justice services, particularly in rural and isolated areas.

3.4.4 Gender- based violence

Gender-based violence is not confined to its physical aspects; there is sexual, verbal and non verbal, emotional, psychological forms of violence that are pervasive in PNG. Ethnic and tribal violence is very often sexualized. This takes place in a gender discriminatory social climate. Research by the Medical Research Institute in Goroka in 1994 found that 55% of women interviewed had been forced into sex against their will.[23]

Sexual violence comes in different forms; rape and marital rape, gang rape, sexual abuse of women and girls, incest, sexual exploitation of women, girls and boys are common occurrences in the country. The Gender Policy has targeted strategies that will begin to deal with some of these issues. It is hoped that the existence of the NGP as a separate policy does not deter an integrated approach which all stakeholders in the fight against HIV take on and not leave its implementation to those in the '*gender desk'*.

[23] Research cited by UNICEF 2006

Pioneering research on domestic violence was undertaken by the Law Reform Commission under Susan Toft in the mid 1980s, and completed by Christine Bradley in the early 1990s. Recommendations from the Final Report on Domestic Violence with its 54 recommendations remained shelved until revisited in 2000 by another study commissioned by the Consultative and Implementation Commission (CIMC). The findings of the second study conducted by Christine Bradley found that nothing had changed since the 1980s and in many instances family and gender-based violence has intensified. [24]

The multi-sectoral Family and Sexual Violence Action Committee (FSVAC) is a committee of the CIMC set up in the wake of the Institute of National Affairs (INA) workshop which has led to an intersectoral integrated approach to the rampant family and sexual violence in the communities. The FSVAC was tasked to implement the recommendations from the Bradley & Kesno Report. Violence is both a development issue and a crucial human rights issue. FSVAC recognises two aspects of the problem:

a) It is mainly a family issue appearing in forms of wife beating, marital rape, physical abuse of children by parents and relatives, sexual abuse of children, incest, sexual harassment of the babysitter and domestic workers and physical assault as a result of polygamy and forced prostitution of wives and children.

b) Women and children are particularly vulnerable to sexual violence which occurs outside of the family. This includes rape and gang rape in towns and areas of tribal fighting. Women and girls are frequently harassed sexually, even raped by persons in authority such as employers and teachers, and by those they go to for help in crisis – police, defence force, and rescue workers in times of disaster and conflict zones. The sexual abuse of boys and girls has become increasingly common.[25]

Another new initiative in the 2007 National Response was the development of a National Surveillance Plan for 2007-2010, completed by the National Department of Health with substantial support from bilateral and multilateral partners and research institutions. It is expected this will lead to an increased understanding of the epidemic and improved estimates and projections.

Major challenges to its realization include getting the necessary manpower in place at NDoH and the provinces. The availability of the necessary hardware and software at all levels ensuring communication and feedback will be essentially for

[24] See Bradley and Kesno 2001.

[25] Bradley and Kesno 2001

the plan to achieve its ambitious goals. The management of the process will also tax the current overstretched manpower.

The Red Cross and World Vision started a lunchtime forum in October 2007 called the Alliance Against Gender Based Violence Committee. Its purpose is to increase opportunities for a range of organizations to get together and become more informed about the issues involved and the work happening in the area of domestic and sexual violence.

3.4.5 Prevention Programs at the Work Place

The private sector response has been ably led by the PNG Business Coalition Against HIV and AIDS (BAHA). BAHA was formed in January 2007 as a non-profit organization, to assist the private sector develop workplace policies, and provide training and information service for its clientele. Over the last twelve months, BAHA has been able to approve Work Place Policies for 40 private sector companies including the largest and most diverse employers such as Steamships Trading Company and the Rimbunan Hijau Group of companies who employ an aggregate of more than 7,000 Papua New Guineans. BAHA plans to reach out to industry groups and smaller companies in regional areas. In 2007 BAHA ran two Work Place training workshops in Lae and Port Moresby for 50 representatives of employers and HIV related service groups.

The policy development team at BAHA are currently working with another 70 companies located across the country to formulate their Work Place Policies. The policies cater for the needs of employees, their families and local communities on HIV and Tuberculosis.

BAHA has used variety of strategies to create awareness in the private sector including the publication of a monthly newsletter sent to over 10,000 email addresses covering topics such as the impact of HIV on business, TB and the STOP TB campaign in PNG and how business can participate in DOTS, ART, ARV and other related service information.

BAHA has developed the country's most comprehensive and popular web- based resource where information on the most recent research pertinent to PNG conducted by research institutions and donors can be accessed; approved work place policies, health treatment guidelines and other health professional resources. The website also hosts the most comprehensive HIV service directory listing names and addresses of VCT sites, ART providers, crisis counseling, and contacts for PACs.

It plans to organize regular business leaders HIV workshops. The first was held in Mt Hagen in November 2007. Leaders of businesses, Chambers of Commerce, government representatives and HIV service providers met to discuss the impact of HIV on their business and were introduced to service

providers in the area. BAHA plans to hold six more such business centre forums in 2008.

BAHA has produced an interactive DVD incorporating PNG doctors, HIV positive spokespersons and service information. The DVD is given free to BAHA work place training participants and covers eight module of learning. It prints and distributes IEC materials such as posters on TB for PNG work places, HIV and its impact on business. It sponsored an award called HIV in Education widely advertised nationally has attracted 43 entries. Fifteen teachers have won cash awards for their work in delivering the new HIV curriculum.

On World AIDS Day BAHA organized to have a huge red ribbon suspended and illuminated from the Deloitte Tower, the tallest building in the South Pacific in the central business district of Port Moresby. It was able to mobilize 97 business from around the country to formally register as participants in the WEAR RED to work on 29 November.

The public sector with Work Place Policies include the Departments of Education, Defense, Treasury, Personnel Management, Community Development, Department of Health, the NACS and the National Research Institute . A number of these departments have gone on to develop yearly work plans. At least eleven Employers surveyed have anti-discrimination policies in place while two private companies have their own clinics providing VCT, STI treatment and HIV related drugs to treat opportunistic infections.

3.4.5 Law and Justice sector's response to HIV

Papua New Guinea – Australia Law and Justice Program, is a joint governments' development initiative in the Law and Justice Sector, managed by Cardno Acil PTY Ltd. Australia is providing around $200 million from 2003 to 2009 to increase the responsiveness of the justice system and the national, provincial and community levels.

The Law and Justice Sector Program support PNG's National Law and Justice Policy and Plan of Action, the sector strategic framework and its MTDS 2005-2010.

The program adopts a sector-wide approach to law and justice in PNG, recognizing that a weakness in one agency will impact on others. Agencies such as police, courts and jails must coordinate with each other to deliver effective results. It provides a flexible mechanism to support PNG law and justice priorities at the national and provincial levels of government and through civil society. The approach builds on successful interventions from recent projects and focuses on building agency and individual capacity in planning, management and operations.

HIV Mainstreaming and AIDS work

Law and Justice sector, in accordance with MTDS, the NSP 2006-2010, and the National Gender Strategy, has Cross Cutting Issues (CCI) including gender, family and sexual violence, human rights and HIV and AIDS reflected in its White Paper, the Sector Strategic Framework and the Sector Gender Strategy. Agencies of the sector also have CCI reflected in their Corporate and Annual Plans.

In terms of political support, the sector has Cross Cutting Issues Activity Management Team (CCI AMT) which provides leadership for agencies and which report and receive directives from LJS Working Group and the National Coordination Mechanism (NCM). Each CCI has its own development budget including HIV and AIDS.

In terms of Areas of Work, LJS is gradually moving away from AIDS work to HIV and AIDS mainstreaming, so that in the sector's core business, which is to create a just, safe and secure society for all, every one is conscious and mindful of HIV and AIDS. In other words, in all the work of the sector, it is important to insure that any action does not contribute to the escalation of HIV in country.

The following activities are ongoing in the sector:

- HIV and AIDS education and awareness programs at workplace for its employees
- Condom distribution at workplaces
- Reprinting of IEC material and distribution in the agencies and the community at large,
- World AIDS Day participation including staging of floats as a sector or CS and the Royal PNG constabulary's (RPNGC) involvement in public awareness.

- Development of workplace HIV and AIDS policies. All agencies of the sector, including Legal Training Institute have developed their policies and the sector will be launching the policy in the first quarter of 2008
- Conducted base study in 2007 to ascertain the impact of gender and HIV related training and awareness programs over the years in the sector. Social survey completed in 2007 and data is being entered in preparation for data analysis and reporting. It is anticipated that information from the study will enable the sector and its agencies to establish data base system on gender and HIV, and make informed decisions in the corporate planning and budgeting.
- Training of village Court Magistrates, Peace Officers and Mediators on gender, family and sexual violence, HIV and AIDS and the HAMP Act.
- Training of Magistrates, Court clerks and Court Registrars on HAMP Act in the Magistral service.

- Incorporation of gender and HIV and AIDS implications in the Project Formulation Documents for the annual budget
- Incorporation of HIV and AIDS into Contract Documents for companies seeking contracts with agencies of the sector for any facilities development. The provision in the contract provides for contractor to provide awareness on HIV and AIDS for its workers and the surrounding communities of the project site and distributing condoms to its employees.
- Incorporation of gender, family and sexual violence and HIV messages into the tenant's Handbook under the Sector's Housing Program.
- Incorporation of the provision for AIDS work and HIV and AIDS mainstreaming in the project proposal guidelines for NGOs and CBOs. When submitting project proposals, NGOs and CBOs working on Crime Prevention and Restorative Justice are required to include HIV in their proposals

3.4.6 HIV prevention at the community Level

PNG rural dwellers account for 85% of PNG's population. Most of the HIV intervention has taken place in urban areas. UNICEF has piloted the Community Mapping and Theatre Against AIDS program in four provinces. UNAIDS has embarked on a Community Mobilization Strategy to empower community members identify people in their communities who are more at risk of acquiring HIV and to document their case histories which would include tradition, culture and practices that contribute to the spread of HIV and to suggest ways of responding to them. Under this initiative condoms are stored by selected young people to be made available upon request. This program has been expanded to other provinces.

Anglicare conducts awareness using films and video shows in settlements around Port Moresby and have extended their theatre performances into rural Central and Oro provinces.

Condom distribution

Condoms are procured by the National Department of Health with a funding support from AUSAID, GFATM and the ADB funded Rural Development Enclaves Project in coordination with the National AIDS Council (NACS). NACS uses a holistic network in distributing the condoms through a systemic channel of many public and private sector agencies, FBOs, NGOs, VCTs and CBOs that form the network of the National Response to HIV/AIDS throughout the country based on their demands.

Large institutions request condoms directly from NACS and supply them to their local units for distribution. While the Provincial AIDS Committees (PACS) receive condom supply from the NACS and supply them to all the organizations based in the provinces, districts, Local Level Governments (LLGs) and community levels.

Agencies having direct access to end users also distribute condom directly without the use of condom dispensers and condom vending machines.

Local level agencies put condoms into "Condom dispenser machines" for the end users. At Port Moresby, condoms are also distributed using the "Condom vending machine - (Condom ATM)".

PSI is a new partner in condom distribution. PSI will socially market male condoms, female condoms and lubricants. In 2007, a new brand was developed for male condoms and lubricants. PSI has ordered 3.5 mln male condoms and 3.5 mln lubricants that are expected to arrive in the country in March-April 2008. An official launch of the products will take place immediately afterwards.

NACS position paper on male condoms

Discussions have been held between NACS and NDoH resulting to the latter taking the responsibility for the importation of male and female condoms on behalf of NACS. However, no funds have been allocated for importation of condoms in 2008 either by NDOH, NACS or Sanap Wantaim.

The current situation relating to male condoms is that NACS will have access to about approximately 10 million condoms within the first 2 -3 months of 2008. There are about 4 million currently in stock (NACS has approximately 2 million in POM and a further 2 million in the Area Medical Store in Lae), and an additional 6 million received from Sanap Wantaim through their ISP and JTAI.

Although NACS had distributed approximately 7 million condoms in 2007, it is noted that NACS did not have adequate stocks and had rationed issues to ensure all stakeholders received some stocks. The initial estimate for NACS for 2008 based on best available information is that 25 million condoms will be needed annually, making the total national requirement (including NDOH) at around 55 million condoms. NACS is working with stakeholders to arrive at a more definitive estimate and indications are that both NDOH and NACS may need more than 55 million annually if we were to achieve the objective of 100% availability for condoms.

It needs to be noted that the awareness campaigns carried out by NACS and other stakeholders are showing results and the demand for condoms, specially in the Highlands, have been showing increased levels and NACS and stakeholders have not been able to meet this demand.

Based on NACS initial estimates, and current availability, NACS can foreshadow a shortfall of about 20 million condoms for 2008 for NACS, with the possibility of not having enough condoms to distribute from April/May 2008.

Obtaining new supplies will take anything from 3 months to 9 or more months, depending on who is importing and what procedures are being followed. For

example, JTAI maybe able to obtain supplies within 3 months, while the GoPNG process could potentially take 9 months if one were to go by past experience of the Medical Supplies Branch (MSB). However, as the MSB has a valid period contract in place for condoms, it may be possible for them to obtain supplies earlier.

The issue as NACS views it is about funding for condoms and whether NDoH will secure condoms for NACS as part of an overall national condom need or whether NDOH will act as the importing agent for NACS.

In regard to funding, clarification is needed whether NDoH will include NACS funding needs for condoms (approximately 5 million Kina for 25 million condoms at today's prices) in its recurrent budget for medical supplies and whether we could have an assurance that this money will be quarantined to ensure NACS requirements are met. This clarity is needed as currently neither NACS nor Sanap Wantaim have made any provisions for condom imports in their 2008 budgets.

NACS preferred position for 2008 is for NACS (with assistance from Sanap Wantaim if required) to identify a budget allocation of 5 million Kina and for NDOH Medical Supply Branch to act as the import agent for NACS by utilizing its period contract. As the Medical Supply Branch has a policy of payment upon delivery, NACS could ensure funds are quarantined within NACS or placed in the NDOH HSIP account to effect payment when supplies are delivered.

NACS are yet to arrive at an estimate for female condoms, it is anticipated that an estimation of NACS requirements could be given soon. In the meanwhile, it is to be noted that Sanap Wantaim, through JTAI, have imported 30,000 female condoms and they are currently available for distribution.

Two other matters of relevance should be noted. The need for re-packaged condoms to fill dispensers that have been distributed throughout the country and the possibility of Sanap Wantaim, through JTAI, agreeing to import a further 50 million male condoms and 3 million female condoms in 2008. with regard to the former, the procurement department of NACS is preparing a national inventory of dispensers and calculating likely needs of re-packaged condoms. As no inventory or previous estimations have been made, it will not be an easy task to arrive at precise information in the very near future. It is anticipated that best available information will be provided within 3 – 4 weeks. For the latter, JTAI has informed NACS that they have made a request to Sanap Wantaim and are awaiting a formal response to their request for importation of condoms. If this approval is granted, national condoms requirements based on available estimates for 2008 will be met. However, a longer-term sustainable policy decision is still needed in respect of funding and how condoms are to be imported to meet the HIV/AIDS response.

It is also pertinent to note here that the Procurement and Logistics Department of NACS are in the process of developing a distribution plan and a national distribution matrix to identify how condoms move from central storage centers to actual users, and determine responsibilities for various aspects of the distribution chain. In addition to that the distribution plan takes into account the constraints faced, and how some of these may be overcome by developing better partnerships with all partners associated with the national response to HIV.

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4. Major challenges and remedial actions

The national response to the HIV and AIDS epidemic in PNG has become more complex with significant growth in the number of players, funding and implementing activities within and across sectors. Coordination of these activities and adequate oversight and accountability, have largely been absent. Where they exist, they have tended to remain exercises undertaken and reported only to the donor.

The Independent Review has been critical of the lack of strategic leadership by the National AIDS Council (NAC) and the capacity of its secretariat to take on the role of coordinating the national response. NAC has failed to provide the necessary leadership to influence practices leading to a rapidly expanding epidemic including unsafe sexual behaviour, and alcohol and gender-based violence.[26]

An annual planning cycle involving all stakeholders would promote greater country leadership and ownership of national strategies and their implementation. This plan should also include funded activities to support the implementation of the NSP. This would be in line with the Three Ones Principle. The plan must be aligned to the NSP and its seven areas and objectives with detailed implementation plans with targets set. Targets must reflect the strategic significance of certain groups and stakeholders. Currently there a number of plans available by NACS and NDoH, those do not indicate sources of funding nor achievable targets with the exception of NACS Development Budget.

While there has been an expansion of outlets delivering treatment and care, the numbers receiving treatment at these sites are small. With a total of 46,275 estimated to be HIV positive, only 1,647 people have started on ART, 106 of who are children. Reports of shortages of drugs, transport difficulties continue because currently all ART is facility-based. Adherence rates are also low. The prevention and management of related infections in TB and STI's as well as Malaria need to be linked. More advocacies should be carried out by civil society organisations on messages that link HIV to STI and TB. More programs needed on nutritional information and assistance, nutritional supplements for those undergoing ARV treatment and those unable to access treatment.

Paediatric care and treatment, PMTCT and rural based services are lagging in scale and coverage. Lack of sufficient health systems continue to be the bottlenecks to scaling up efforts.

[26] Aggelton et al, 2007.

Current programmes in all focus areas do not address sufficiently well the cultural realities of their target populations. This is critical as the epidemic penetrates the rural areas of the country. Prevention efforts must address the socio-cultural realities driving the spread of the epidemic. Research must provide information on risk behaviour, sexual networking, mobility and migrations and commercial/transactional sexual activities and the impact of this risky behaviour on their wives/husbands or regular sex partners. Research into the cultural factors influencing HIV transmission and the social responses to it is lacking.

A Gender policy has been launched but unfortunately, there is a common misunderstanding in PNG that gender refers to women and girls. Few programmes address gender roles and relations, gender power configurations, masculinity, male aggression and gender-based violence, sexual coercion and rape, and trans-generation sex. These are linked to cultural practices of polygamy, bride price, big man political and economic structures and practices and a culture of paybacks and compensations.

Good quality social and behaviour change research is urgently required. However, initiatives have been recentrly put in place to develop an inventory of local researchers with their research capacity identified. In addition, plans have been made by AusAID to further assess capacity of all research and academic institutions in order to develop specific plans for support. The nationa Research Institute is currently training researchers and in addition, the Institute of medical Research with the support of AusAID is currently training social research cadettes to conduct HIV related research. Priority research areas and research capacity of local institutions was the focus of the National Research Agenda workshop in November 2007. however, with these initiatives in place, there is a need for greater financial support in order to build the long term capacity of PNG to conduct rigorous social and behaviour research studies.

The Agriculture Research and Development Support Facility (ARDSF) was recently established with the support of AusAID to provide assistance to national agriculture research facilities across the country to conduct small studies in the area of poverty, HIV, gender and agriculture. However, despite this initiative, there are still current gaps in understanding the socio-economic dimensions of the epidemic on the household, the mental health of people living with HIV and AIDS and their needs for coping mechanisms. Although attention to research is now beginning, it is crucial that it is systematic good social science research, which has been inconspicuously absent from the country's national response thus far.

Some promising HIV prevention programmes and interventions are ongoing they have not been evaluated for impact. The impact of faith-based and private sector programmes in changing HIV related attitudes and risk behaviour needs evaluation. The contribution of various church-based groups to HIV prevention work has been impressive. But their position on the use of condoms or 'just

turning a blind eye' to condom distribution and not moving beyond awareness to addressing behaviour

change by promoting abstinence and being faithful have little relevance to a large number of omen ho have no control over the behaviour of their partners.

NACS should continue to support, strengthen and empower PLHA in each province to run an empowered network. Their participation at all levels of intervention should be strengthened and not be used as token representatives on steering committees, boards and councils as is the case at present.

An M&E system has been established but the management capacity is still lacking. The management capacity of NACS provides a major challenge due to high turn over of staff where new staff have to be retrained to maintain a high level of efficiency. Capacity building is the greatest challenge for the country, of all stakeholders, both in government and civil society organisations including PLHIV and those within the health sector in order to maximise their participation in the fight against HIV.

The setting up of the M& E Unit has progressed towards being near functional with skeleton staff recruited and trained. Some training has also been conducted for M&E coordinators in provinces (PACs) although this continues to present challenges relating to the availability of staff to be responsible for M&E in the provinces. Surveillance systems in the country have been improved for the current reporting period making it possible for the country to report on almost two-thirds of the national indicators although data gathered comes from specific sites rather than a national aggregate.

Effective **coordination** of national the response is contingent on the ability of the national coordinating authority to provide effective leadership and direction to the response. PNG's response has grown phenomenally with significant increase in the number of players hence presenting significant challenges for coordination. Over the last two years, the NACS with support of Development Partners has undertaken major changes in its structure and roles responsibilities in order to cope with the imperatives of its mandate. Progress is being made but at a very slow pace. The NACS Capacity Mapping conducted in June 2006 and a recent report by the Independent Review Group highlighted the need for some changes within the organisational structure of NACS. Some of the areas highlighted include:

- Delivery of the NSP to be consistent with NACS coordination role
- Stronger management processes and systems
- Sound and safe financial systems
- Strengthened IT systems, and
- Other areas such as more efficient systems of procurement and management,

These findings are consistent with concerns that have been variously raised by stakeholders' working on HIV and AIDS about NACS inability to provide clear direction and support for the response. At the provincial level, most of the PACS lack the capacity to support stakeholders in planning and implementation of provincial response. There is limited opportunity for sharing information, lessons and experiences between partners and for scaling up successful practices.

There are ongoing efforts to strengthen NACS and PACS' coordination capacity as part of the broader strategy to strengthen overall national coordination. Through the AusAID funded Sanap Wantaim programme, technical assistance is being provided to NACS in the areas of organisational development, planning, financial management, human resource management, Behavioural Research and Surveillance, gender mainstreaming and Monitoring and Evaluation and Communication. Specific assistance is also being provided to NACS with the restructuring of its current structure to align it with its coordination mandate. Additional technical assistance is provided by UNAIDS, UNDP and ADB in the area of monitoring and Evaluation. The Government has also scaled up its funding to NACS activities under the Development Budget from about PNG Kina 3 million in 2006 to PGK 18 million in 2008 FY. This is expected to provide the much needed financial resources to address capacity constraints with NACS and the national response.

With respect to the provincial response, new guidelines have been developed for the Provincial AIDS Committees and will be rolled out to all the provinces in 2008. Funding commitment from the Government to the PACS has also been stepped up with effect from 2007 FY.

With regard to scaling **up towards universal Access**, major challenges remain, particularly in developing and implementing prevention and care programs that reach remote, rural communities throughout PNG in culturally effective ways. These challenges affect efforts to prevent the spread of epidemic, encourage people to access VCCT, scale up PMTCT to rural communities where most babies are born at home, minimize stigma and discrimination, scale up ARV treatment for those who will test positive to HIV and provide them care and support.

- Though the program has taken off; there is still limited commitment from authorities at different levels. This ranges from limited support for the development of infrastructure and human resources. The few health care workers who provide services lack motivation and hence burnout is very common.
- Stigma and discrimination remains high among communities and health care workers. This has resulted to the limitation of the number of people accessing the HIV testing, counselling, care and treatment

- There is no rural delivery system and there is minimal linkage to community support groups. This approach is still in a pilot stage in one province (Goroka) with support from the Clinton foundation[27].
- There are a number of challenges affecting the adequate adherence to treatment, these are: stigma and discrimination, transport cost, staff attitudes, long waiting time at clinic, employers not giving time to patients when they come to collect their medications.
- Families and PLHIV face enormous challenges when it comes to food security. Given the poverty level and the limited resources for families, Family members find no way but to leave their jobs to care for their sick relatives, and to sell their belongings to provide support to them. This leaves limited food available for PLHIV and the family members.
- The limited availability of social services in PNG including material, legal and spiritual leaves most patients unsupported.
- Gender violence and gang rape are common social problems in PNG. These affect the program by limiting women accessing HIV testing and counselling, and adds to the spread of the epidemic.

Challenges were encountered in the gathering of data, involved the very real problems of law and order in PNG when a laptop belonging to NACS with data collected was stolen from a parked car in Port Moresby. Another involved the lack of commitment by government officers in answering questionnaires and survey forms for the National Composite Policy Index.

[27] Aggleton P. et al, 2007

5. Support from the country's development partners

The national response encompasses a multi-partner and multi-sectoral approach to the HIV epidemic. Partners in the national response, include, people living with HIV, faith based organizations, civil society organizations, national and international NGOs, the government and the private sector and economic enclaves. Development and donor partners are also key players in the national response.

Prior to 2004 the budgetary allocations from the government were sporadic. Government funding for HIV programs has seen significant increases since 2006. As most of the government funds are absorbed by salaries and administrative costs, funding for programs has come from donor partners.

The Australian Government through AusAID has been the major Government funding agency for HIV and AIDS prevention treatment and care programs in PNG through its NHASP project until 2006, which was replaced by the Sanap Wantaim PNG-Australia HIV and AIDS Program (2006-2010). Other major donors include ADB, USAID, the UN system and NZAID. Other international donors include the Word Bank, British High Commission and the European Union.

In 2005, PNG successfully applied for a GFATM grant of US$ 30 million over five years for HIV. The implementation report of Phase I of the Global Fund HIV Program 2005-2007 has been accepted and PNG has been given the go ahead to proceed into the second phase draw down from the GFATM grant facility. Funding from GFATM will enhance considerably the country's scaling up targets.

The AusAID Sanap Wantaim Programme has assisted in funding to all of the major NGOs and most of the CBOs involved in the National Response as well as and technical assistance in the form of advisors based at NACS and NRI. Sanap Wantaim has also involved in supporting high priority activities such as NSP Activity Planning and budget cycle, the National Leadership Strategy (NS), NACS provincial consultations and review of PAC operational manual, small grants and HIV activities during the PNG National Elections mid year, National Research Agenda workshop and the Research Advisory Committee based at NACS.. Emergency funding was set aside to assist at NACS request funding short falls within NACS for key planning and operational activities, including provincial planning. the program funds priority activities approved through the annual NSP planning process covering all the 7 focus areas. In 2007, activities of 9 major NGOs in the country were funded by the programme.

The Development Partners' Forum which brings together representatives of all major donors and UN agencies on a monthly basis is the mechanism through which development partner's support is coordinated. This forum provides an opportunity for the Partners to harmonise and align their support with the NSP. in those meetings, donors partners share information about their contribution to the

national response, and coordinate jointly funded activities, such as the independent review of the NSP implemented by an Independent Review Group.

In a retreat organized in August 2007, donors committed contribution of a total amount reaching US$43 million to the 2008 NSP implementation plan. These commitments are summarized below:

Summary of funds committed to the 2008 NSP Implementation Plan.

Focus Areas	UN	GFATM	Clinton Foundation	ADB	AUSAID	USAID	World Bank
Treatment Councelling and Support	547,000	3,200,000	2,300,000	1,692,500	9,968,000	-	-
Education and Prevention	855,000	746,000	-	3,158,000	6,230,000	1,600,000	-
Epidemiology and surveillance	90,000	-	-	720,000	-	-	100,000
Social and Behavioural Research	140,000	60,000		30,000	2,047,000	-	-
Leadership, Partnership and coordination	240,000	-	-	105,000	4,450,000	-	-
Family and communitry support	820,000	-	-	-	1,780,000	-	-
Monitoring and Evaluation	275,000	373,000	-	165,000	1,335,000	-	-
TOTAL	**2,967,000**	**4,379,000**	**2,300,000**	**5,870,500**	**25,810,000**	**1,600,000**	**100,000**

Challenges facing the national response to HIV are many. Though funding is available to support the national response, there is a pressing need to build national capacity at all levels to manage and implement programs.

One of the first priorities that needs appropriate attention from Donors is to help PNG managers know better the nature and the drivers of the epidemic. A new surveillance plan has been developed, support is needed to make the surveillance team at NDoH fully operational and to implement the surveillance plan. In another hand, PNG is planning to implement its first national population based bio-behavioural survey in 2008-2009 that requests consistent technical and financial support.

Certainly, one of the main pressing areas is the establishment of an effective logistics system that will make provision and scaling up of prevention, testing, treatment and care activities possible.

The IRG has also recommended improvement and development of the financial management capacity of the NACS through recruitment of qualified and trained staff and setting up of appropriate financial systems.

With regard to M&E, NACS would need technical and financial support from the donors and funding agencies to give continuity of the Joint M&E Program till the end of current NSP 2006-2010. Support will also be needed for: National and Provincial capacity building including the trainings, equipments, database networking roll out of CRIS; to facilitate National and provincial M&E coordination; to implement the recommendations of the national M&E assessment and strengthening workshop; to develop M&E guidelines and training manuals; build capacity of the District AIDS Committees (DACS); to develop capacity for M&E staffs within NACS and in the provinces through continued and on the job training; continuous availability of international technical assistance on M&E; and to expose national M&E and staff to successful experiences from other countries in implementing a comprehensive M&E system

6. Monitoring and evaluation environment

Recognising that the HIV reporting system suffers from serious weaknesses, the PNG Government, together with its international development partners, has mobilised a large amount of resources to strengthen the national surveillance system by implementing the First National Surveillance Plan, 2007-2010, which in turn will allow for more effective allocation of resources and strategies for HIV prevention, treatment, care and support.

Until early this decade, there were few sources of data about the epidemic in PNG. Even now, much remains unknown about people with HIV or AIDS at the time of their diagnosis or their treatment needs.[28] By the end of 2006, for example, no information was recorded for over half (53%) of people who had tested HIV positive that year as to whether they had an HIV infection or an AIDS defining illness at the time of their diagnosis. Of the people for which this information was collected, just over a third (36%) presented with an AIDS defining illness, suggesting that many HIV infections still go undetected. Of all the reported HIV infections, age was not recorded for 33% and sex not recorded for 6% of the people diagnosed, making it difficult to follow the trend of HIV infection in the general population and among specific age groups..

6.1 Coordination of the M&E System

The Government of Papua New Guinea has adopted the principles of the “Three Ones” and placed high priority for setting up a vibrant M&E system at NACS with and in the provinces and districts. The National AIDS Council has created a Policy Planning Monitoring and Evaluation Unit to materialize that the One M&E framework works in the country. NACS is also getting considerable financial and technical assistance from donors and funding agencies to set up a functional M&E system for HIV and develop the capacity for M&E at national and provincial levels.

Including the establishment of M&E unit, development of M&E framework with clear goals and objectives, designing national indicators, preparing and implementing overall M&E plan, developing & implementing program monitoring indicators and guidelines (PMIG), developing impact evaluation plan, and support capacity development in provinces..

NACS has also built its structural, and human capacity for setting up a “National HIV & AIDS Data Center at NACS”, and to implement a system to harmonize data collection on the national response throughout the country.

[28] NACS and NDOH, 2007

Long-term impact evaluation program of the national response has been designed in collaboration the Office of Development Effectiveness (ODE) of AUSAID. This effort will make use of different types of data coming from surveillance, research, surveys and programme monitoring to determine the impact of the national response to HIV, and of specific interventions on the risk behaviour of Papua New guineas and on the levels of HIV infections among general population and targeted groups.

The NACS and its partners created a steering committee to coordinate and oversee the implementation of the project activities targeting capacity development on M&E at NACS and Provinces and implementation of a system for programme monitoring supported by a the joint M&E project. The committee discusses and validates M&E work plans, ensures availability of appropriate funding, and coordinates and oversees its implementation.

Regarding surveillance, A Surveillance Working Group (SWG)has been established to provide technical advise and oversee the development and the implementation of the surveillance plan. The SWG is chaired by the Director of Disease Control of NDoH and is comprised of representatives from NDOH, NACS, National Research Institute, WHO, UNAIDS, and ADB.

In another hand, the National Research Advisory Committee (RAC) has been reactivated with membership from all research and academic institutions within Papua New Guinea, NGOs, CBOs, Donor Organizations, National Department of Health as well as representation of People Living with HIV and AIDS. The RAC assesses and approves research proposals, coordinates and monitors research implementation, and validate research results before its dissemination. The RAC receives technical support and funding for research activities from AusAID.

The actual challenge, is to establish a high level National Coordination Committee for M&E that insures the link between those three committees and coordinates their respective efforts inline with the principle of the three ones. Although there was notable efforts to bring the NACS M&E and the NDoH surveillance around the same table to coordinate activities, Issues in relation to leadership made that there is limited contact between the three existing coordination mechanisms, leading to duplication of efforts, and implementation of activities in conflicting manner.

6.2 Programme monitoring

Two years back, M&E Unit was created at NACS supported by the UN agencies (UNAIDS, UNDP, UNFPA, UNICEF, WHO) through a Joint M&E Program, which is an excellent approach. Now the Joint Program is also supported by other agencies such as AUSAID, GF and ADB. This is one of the most successful examples of funding coordination amongst various agencies.

Starting from one national and one international M&E staffs, NACS's M&E Unit have now grown to five national staffs, two of which are M&E officers, and two are International experts.

The **National Strategic Plan**, its '**M&E Framework**' and a '**Program Monitoring Indicators and Guidelines**' (PMIG) are prepared with clear description of data flow and feedback channels. Data collection tools regarding non health programme monitoring were developed following a participatory approach and recently rolled out in the provinces. This reporting system is at it's early stage of being implemented, and a limited number of provinces managed to collect information from the different stakeholders and send aggregated data to NACS.

National and international trainings were provided to M&E staffs of NACS under the capacity building activity of the Joint M&E Program. M&E trainings were also provided to a variety of national and provincial stakeholders.

In order to improve and facilitate utilisation and management of HIV data at country level, a National HIV & AIDS "Data Center" is in the process of establishment at the Monitoring and Evaluation Unit of the National AIDS Council.

An M&E needs assessment and strengthening workshop was conducted at national level in August 2007 with support from the Global Fund. This led to identification of key priorities to improve the M&E system and helped formulate number of recommendations with this regard. A number of those activities are actually being implemented. As a follow up of this exercise, Provincial M&E capacity assessment has been undertaken in 15 out of the20 provinces by the end of 2007, and plans are being made to review all HIV data reporting forms to harmonise data collection and improve quality of data.

The Joint M&E Program , an example of a success story.

National AIDS Council established in 1998, has been in operation for the last ten years with several units to look after various focus areas. However, Monitoring and Evaluation was lacking until late 2005 due to the lack of an institutionalized that will take charge of M&E activities as well as the lack of capacity of NACS's staffs on monitoring and evaluation of HIV and AIDS. NACS, donor and funding agencies have realized the need of M&E system establishment at NACS.

Fortunately, UN agencies stood together to assist NACS to establish M&E Unit within its formal organizational structure. NACS was also convinced to create the Unit and staff positions to look after M&E. Therefore, NACS in collaboration with the UN agencies developed a "UN Joint M&E Program on HIV and AIDS". The program was launched from the last quarter of 2005.

Main objectives of the Joint Program are to:

- Enable NACS to establish M&E Unit, build capacity of M&E Officers and other staffs of the National AIDS Council
- Provide technical and financial support to NACS for building M&E capacity of health sector and non-health multi-sectoral stakeholders at national and provincial levels.
- Facilitate to develop M&E system, assist in designing and implementation of data collection using programmatic data collection tools, cero surveillance tools and social and behavioral surveys methods.
- Facilitate NACS to make a vibrant ME system with HIV & AIDS data base system established to guide the users of data for devising their project interventions based on the facts and figures.

Initially the Joint M&E program was fully funded by the UN agencies i.e. UNAIDS, UNDP, UNICEF, UNFPA and WHO in 2005 in the name of UN Joint Program. In 2006, the National AIDS Council also allocated funds to the program from its own sources. In 2007, the program was expanded to attract more donor and funding agencies to join hand together for the common cause. The program title was changed from UN Joint M&E Program to the "Joint M&E Program". As of now, there are nine agencies putting their funds together for M&E system establishment and capacity building. As a result the Joint M&E Program has a well-coordinated multi-donor / funding sources like: UNAIDS, UNDP, UNICEF, UNFPA, WHO, GFATM, ADB, AUSAID and the NACS itself.

Since there was no capacity at NACS to look after M&E and manage the funds, the contributors of the Joint M&E Program agreed to create a Joint account to be administered by UNDP. The program is governed by the Steering Committee comprised of NACS, donors, funders, and key stakeholders with the Director of the NACS as an ex-officio Chairperson. The current - 1st phase of the program is ending by March 2008.

Considering the need of continued and coordinated support for M&E, the Joint Program Steering Committee has decided to extend the program for its 2nd phase beyond 31st of March 2008 until 31st of December 2010. The Program will be evaluated, revised and redesigned for its 2nd phase with wider objectives to support overall M&E capacity building, improve national coordination, and strengthen the national M&E system including surveillance and research. The fund management modality would be directly by the NACS.

6.3 Epidemiology and Surveillance

Although the **HIV surveillance system** has improved since 2002, the reporting system for HIV is still weak. A large proportion of records about HIV infections lack critical data about the age or sex of the person, the province of origin, or the apparent mode of transmission, and until recently, there has been a lack of bio-

behavioural data in more at risk and the general population within the surveillance system.

The surveillance system is in a transition phase with the transfer of responsibility on surveillance from NACS to NDOH. This implies establishment of a new surveillance unit, recruitment of new staff, and development of a new surveillance plan.

Previous consensus reports, and the *2007 Estimation Report on the HIV Epidemic in PNG* (NAC 2005; NDOH and NACS, 2007; MOH et al., 2000) identified that there were gaps in surveillance data, the areas of surveillance that required strengthening, and issued recommendations to address these gaps and challenges. Recommendations ranged from:

- Mobilization of a sufficient budget to support the improvement of the surveillance system;
- Strengthening of central and provincial coordination mechanisms and partnerships;
- Increased resources, technical support and supervision to provincial laboratories and data collectors;
- Review of the current routine case reporting system to improve data flow and technical presentation of the data generated;
- Improvement of technical and financial resources to the PMTCT program and provide systematic data on HIV prevalence and the behavioural risks of pregnant women;
- Review of protocols, methods and data collection tools in behavioural and sero-surveillance, and revise to reflect international best practice;
- Increase focus on most at risk populations in behavioural, sentinel and bio-behavioural surveillance and track trends in risk behaviours, STI and HIV prevalence;
- Identification of sites and targets for behavioural and sentinel sero-surveillance prioritized through analysis of existing data and criteria for selection;
- Implementation of bio-behavioural surveys among the general population and with key populations at higher risk to understand the dynamics and characteristics of the epidemic;
- Improving the data flow and the presentation of the quarterly surveillance routine case reporting data;
- Dissemination of surveillance data in a timely manner to all stakeholders and groups targeted (NDOH and NACS, 2007).

A National Surveillance Plan for 2007-2010 has recently been completed by the National Department of Health with substantial support from bilateral and

multilateral partners and research institutions to strengthen and support the surveillance system.[29] Together, with the availability of better quality trend data coverage over a longer period and wider geographical area, it is expected that implementation of this plan will improve surveillance data quantity and quality. Quality will be improved with increased support, training and supervision, and from a diversity of types of data planned to be collected, including routine surveillance and ANC, bio-behavioural sentinel surveillance at PPTCT and STI clinics, with bio-behavioural studies with most at risk population and the national population.

The planned increased range of data within the surveillance system will increase an understanding of the degree of HIV infections, where areas with higher prevalence are and how they are changing overtime. It will lead to an enhanced understanding of what socio-behavioural and sexual practices and contexts are linked to these and driving the HIV epidemic. Increased socio-behavioural and other epidemiological research and strengthened surveillance data will also improve estimates and projections to provide further understanding of the dynamics and drivers of the HIV epidemic in PNG.

6.4 Social and Behavior Change Research

Although the knowledge about the characteristics of the epidemic in PNG has increased in the recent years, there is still much yet to know. This is especially since the epidemic is showing a much higher prevalence in the rural areas, and has increasingly become more feminized in 2006.[30] This necessitates a more focused attention to the cultural aspects (to include influence of Christianity as it informs perceptions of people) of each of the seven focused areas of the NSP.

Existing programs have not addressed socio-cultural realities sufficiently, and there has been a lack of focused attention to the translation of socio-cultural research into behavior change communication. Scaling up to meet the increasing demands of the epidemic in terms of epidemiological knowledge, treatment and counseling and care is still a huge challenge in PNG given the run down or non existence of health centers throughout the country, a lack of coverage for ART although increasing, the continuous problems facing supply of condoms and drugs to treat STI and opportunistic infections , and capacity building challenges.

The **National Research Agenda for HIV and AIDS in PNG** is an example of Good Practice considering what had been done to date in terms of HIV related

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[29] NDOH and NACS, 2007

[30] NACS and NDoH, 2006. HIV/AIDS Quarterly Report, December, 2006.

research in Papua New Guinea; in 2007, it appeared important to the National AIDS Council Secretariat to have a clear guide for research for the purpose of coordinating research that has been conducted to date, identifying future plans for Monitoring and Evaluation, Surveillance and Research, and covering research gaps and priorities with a view to establishing a cohesive research strategy.

As a result, the National AIDS Council Secretariat supported by a core-working group comprising of AusAID, National Research Institute, University of Papua New Guinea, Asian Development Bank, UNAIDS, and National Department of Health organised a 3-day National Research Agenda workshop in October 2007 in order to achieve some of the above aims, by bringing together relevant stakeholders to:

1) Review HIV related research that had been conducted in Papua New Guinea in the past 8-9 years;
2) Identify what has not been done i.e. gaps in knowledge; gaps in discipline (social and behavioural, epidemiological, clinical) and to discuss research that is planned, and
3) Facilitate group discussions and develop recommendations for a) research studies, b) priorities within the research identified as well as c) research capacity development

The National Research Agenda aim is to: Provide a strategy for the conduct of HIV related research for the next 3-5 years with respect to prioritized areas, research capacity development, processes for research dissemination and information sharing. In addition it seeks to engender international collaboration and networks and encouraging engagements with other sectors.

The National Research Agenda was derived through a consultative process. The content and direction of the National Research Agenda was a result of discussions and recommendations that were developed as a result of the National Research Agenda workshop. Participating in the workshop were a range of stakeholders including researchers (both from overseas and within PNG), representatives from all major academics and research institutes in Papua New Guinea, health care professionals and service providers working in the sector of HIV and AIDS, as well as representatives of key community groups such as Friends Frangipani (Papua New Guinea’s Sex Worker’s Association) and Igat Hope (NGO for People Living with HIV and AIDS). Presentations and discussions took place in 4 groups, each considering work within a specified area of particular interest in the context of social and behavioural, monitoring and evaluation, and surveillance and epidemiology research in PNG. These groups were: Society, Culture, Law & Order and Awareness; Living with HIV and AIDS; Women, Violence and Groups at Higher Risk; Children and Youth

During the 3 days each group reviewed and considered research to date within the field. With the help of team leaders and rapporteurs each group had led

discussions regarding the quality and appropriateness of these studies presented; this was followed by members of each group identifying research gaps remaining specific to their group topic. Finally, members of the groups documented key priority areas for research based on the gaps identified. On the third day, identified gaps from each group were presented in a plenary session to all participants with opportunities for questions and comments. This session was also recorded by rapporteurs. With discussions and review from the National Research Agenda Working Group members, the following outlines the outcome of the process from the workshop, with a consolidation of the key recommendations that were made.

Currently the final draft of the National Research Agenda is in writing, with the plan to launch the Agenda nationally and internationally during the first quarter of 2008.

Research Advisory Committee

In May 2007, The Research Advisory Committee (RAC) of the National AIDS Council was re-established based on the recommendation of the HIV and AIDS Management Act. The new membership consists of representation from all research and academic institutions within Papua New Guinea, NGOs, CBOs and Donor Organizations, National Department of Health as well as representation of People Living with HIV and AIDS.

The main activities of the committee includes assessing and approving research proposals and final reports through a peer review process, in addition to provides recommendation on dissemination to the National AIDS Council (NAC). The RAC also engage in monitoring and evaluating funded activities to ensure quality and consistency with proposed activities and submit a report using the guidelines for provincial monitoring. With the aim of achieving their core activities the committee meets quarterly but also meets for special meetings during the year

For the purpose of supporting a coordinated effort of partnership, reporting and dissemination, it was deemed necessary by the National AIDS Council Secretariat that all researchers who plan to conduct HIV and AIDS related research in Papua New Guinea to submit a proposal to the Research Advisory Committee, even if funds for the project are not required.

Research proposals related to HIV and AIDS or Sexually Transmitted Diseases are eligible for grant funding (which the committee co-ordinates), and approval is subject to the assessment of the application by the Research Advisory Committee and also subject to the availability of funds which are donated through the National Government and AusAID. In addition to the proposed structure and content of the study, proposals are examined for ethics and critical research elements which are included in the assessment criteria.

In order to ensure good practice the committee has also developed National Research Guidelines as a tool for those who wish to submit a proposal to the committee. In addition, criteria assessment forms (based on international tools) are used by members of the committee in order to guide the assessment of research proposals and final reports. In 2008, the committee hopes to engage international experts as peer reviewers to also contribute to assessment of proposals and final reports

The '**Strengthening HIV Social Research Capacity in Papua New Guinea**' project is an AusAID-funded joint Papua New Guinea Institute for Medical Research and National Centre of HIV Social Research, University of New South Wales project. The project is designed to position social research as a central component of the evidentiary base to found effective, sustainable responses to the HIV epidemic. The project aims to generate healthy public policy by strengthening the linkages between the government, NGOs, FBOs and researchers.

The project objectives are to: a) strengthen HIV-related social research by training a group of skilled HIV social researchers through a two-year cadetship program; and
b) increase understanding of the benefits of HIV-related social research among health workers, policy-makers, NGOs, political leaders, community leaders and members

Based at PNG IMR ten research cadets with undergraduate degrees are involved in undertaking in-depth, concentrated HIV social research training program over a sustained period. The program has been designed with the following major goals:

- To provide the research cadets with a rigorous conceptual grounding in major forms of HIV social research;
- To train the Research Cadets through classroom learning and real world research tasks (learning by doing);
- To provide research training in a variety of qualitative and quantitative research methods and approaches;
- To encourage independent research, team work and collegiality;
- To sharpen the analytical skills of Research Cadets;
- To develop the writing skills of Research Cadets and to apply them practically in the form of articles for peer-reviewed journals and conference presentations;
- To allow PNGIMR staff to develop teaching skills by encouraging them to participate in the training program.

The Training Program has consisted of:1) Classroom-based modules including: qualitative research, including focus group interviewing, informal conversation, and in-depth interviewing ; quantitative research, including survey research and

SPSS; monitoring and evaluation; field-note writing, diary-keeping, and participant-observation; use of archival and secondary source materials (health records, ethnology, newspapers); and data collection practice runs. 2) Data collection and analysis on real-world research projects, such as: In-house research projects; IMR research projects; External research projects approved by NCHSR and IMR; and 3) Other skills, including preparation of: Research grant applications; Manuscripts to be submitted for publication in professional journals; Human Subjects Ethics Committee applications; and Conference paper-style presentations.

6.5 Challenges faced in the implementation of a comprehensive M&E system

One of the main challenges facing the implementation of a comprehensive M&E system in Papua New Guinea is the lack of specialized M&E capacity to manage and implement M&E related activities and set up the system at the provinces, and at the national level.

Until very recently, all components of the M&E capacity were lacking at all levels, by this, we mean infrastructure, systems and knowledge. The continuous technical and financial support provided by donors to programme monitoring through the Joint M&E Project and to surveillance helped establish the some basic foundations for M&E at NACS and NDoH, However a lot still needs to be done.

The national staff that can be considered as having acceptable knowledge and understanding of M&E at central level are completely overwhelmed with the number of pressing priorities to make the M&E system work. All efforts to build capacity of national staff through training are inhibited by the high turnover of staff resulting from high demand of qualified staff from international organizations.

At provincial level, there is no staff dedicated to M&E, the basic M&E trainings provided to provincial government and stakeholders in a number provinces cannot ensure effective functioning of an M&E system at provincial level. Efforts to create Provincial Monitoring and Evaluation and Surveillance Teams still need to be followed by consistent training and support to make those teams function properly and collect and analyze provincial data to improve coordination and inform decision making at provincial level.

In terms of infrastructure, as there is no central data base on HIV data, efforts are being made to establish a national data centre at NACS, and a surveillance database at the Department of Health. Establishment of these databases will be a key milestone in setting up a monitoring and evaluation system, helping for a

an improved access and management of data, and ensuring at the same time the necessary confidentiality and security of data.

All components of the M&E system for HIV are being reformed or newly established in PNG. While the National Health Information System is being revised to include reporting on HIV data, the responsibility on surveillance has been transferred from NACS to NDoH and new surveillance plan has been developed with revised protocols for data collection and case reporting. At the same time, a new reporting system for programme monitoring is being put in place to collect data on the national response in non-health settings. This situation makes access to and availability of data extremely challenging, where most of it is collected through parallel systems. With the absence of good quality and timely data, decision making becomes blind and possibly ineffective.

Another challenge is the need for improved coordination at the most senior level that links and harmonizes efforts in programme monitoring, surveillance and research. To date, there are specific coordination mechanisms in each of the specific areas, but there is no overall coordination mechanism that links the three of them. With this regard, the recently held M&E assessment and strengthening workshop recommended the creation of a national M&E coordination committee, and NACS is making the necessary preparations to establish that committee.

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ANNEX 1: UNGASS indicators

UNGASS 08 - Summary Report - Papua New Guinea

Code	Indicator	Status	Value
Government HIV and AIDS Policies			
1	AIDS Spending	Completed	0.0000
National Programme Indicators			
3	Blood Safety	Completed	100.00%
4	HIV Treatment: Antiretroviral Therapy - 2006	Completed	23.20%
4	HIV Treatment: Antiretroviral Therapy - 2007	Completed	35.44%
5	Prevention of Mother-to-Child Transmission - 2006	Completed	3.48%
5	Prevention of Mother-to-Child Transmission - 2007	Completed	2.32%
6	Co-Management of Tuberculosis and HIV Treatment	Completed	34.90%
7	HIV Testing in the General Population	Completed	No data available
8	HIV Testing in Most-at-Risk Populations - Sex Workers	Completed	47.34%
8	HIV Testing in Most-at-Risk Populations - Men Who have Sex with Men	Completed	41.67%
8	HIV Testing in Most-at-Risk Populations - Injecting Drug Users	Completed	No data available
9	Most-at-risk Populations: Prevention Programmes - Sex Workers	Completed	22.26%
9	Most-at-risk Populations: Prevention Programmes - Men Who have Sex with Men	Completed	10.33%
9	Most-at-risk Populations: Prevention Programmes - Injecting Drug Users	Completed	No data available
10	Support for Children Affected by HIV and AIDS	Completed	No data available
11	Life Skills-based HIV Education in Schools	Completed	25.00%
11	Life Skills-based HIV Education in Schools	Completed	0.00%
Knowledge and Behaviour Indicators			
12	Orphans: School Attendance - Part B	Completed	87.10%
12	Orphans: School Attendance - Part A	Completed	75.00%
13	Young People: Knowledge about HIV Prevention	Completed	No data available
14	Most-at-risk Populations: Knowledge about HIV Prevention - Sex Workers	Completed	40.69%
14	Most-at-risk Populations: Knowledge about HIV Prevention - Men Who have Sex with Men	Completed	70.67%
14	Most-at-risk Populations: Knowledge about HIV Prevention -	Completed	No data

	Injecting Drug Users		available
15	Sex Before the Age of 15	Completed	4.20%
16	Higher-risk Sex	Completed	7.50%
17	Condom Use During Higher-risk Sex	Completed	42.50%
18	Sex Workers: Condom Use	Completed	93.71%
19	Men Who Have Sex with Men: Condom Use	Completed	88.49%
20	Injecting Drug Users: Condom Use	Completed	No data available
21	Injecting Drug Users: Safe Injecting Practices	Completed	No data available
Impact Indicators			
22	Reduction in HIV Prevalence	Completed	No data available
23	Most-at-risk Populations: Reduction in HIV Prevalence - Sex Workers	Completed	No data available
23	Most-at-risk Populations: Reduction in HIV Prevalence - Men Who have Sex with Men	Completed	No data available
23	Most-at-risk Populations: Reduction in HIV Prevalence - Injecting Drug Users	Completed	No data available
24	HIV Treatment: Survival After 12 Months on Antiretroviral Therapy	Completed	60.78%

Indicator 1. Domestic and international AIDS spending by categories and financing sources

In the absence of a proper Nations AIDS Spending Assessment (NASA), it was extremely challenging to collect information regarding what was actually spend on the national response to HIV. Efforts made in from October to December provided a very incomplete set of data that makes analysis and commenting impossible.

Indicator 2. National Composite Policy Index.

Narrative

It must be noted NCPI trend data analysis and comparison for years 2005 to 2007 is not possible. This report is the first to include NCPI. The brief provided in this report is an overview on situational update in respect to policy development and institutionalization of relevant policies that guide the national response for prevention and control of HIV and AIDS in Papua New Guinea.

1. **National Strategic Plan.**

Papua New Guinea has made remarkable efforts in areas of HIV and AIDS national policy development since the first incidence of reported case in 1987. In 1997 the Government unanimously passed the National AIDS Council Act and the establishment of its Secretariat (NACS).

The Secretariat is the mandated central authority coordinating the entire multi-sectoral national response to fight against HIV AIDS in the country. Subsequently a Mid Term Plan on HIV/AIDS was formulated to provide the overall strategic framework for HIV and AIDS prevention and control programmes in the country.

The MTP was reviewed in 2004 and a new National Strategy Plan (NSP) was developed and endorsed by Parliament in 2006. It sets the framework of multi-sectoral approaches; included active involvement of key sectors in the Government, donor partners, private sector, NGOs and civil society groups. The strategic program interventions that are outlined under the 7 focus areas of the NSP are consistent with the Governments Medium Term Development Strategy (2005-2010) priority on addressing HIV and AIDS epidemic in the country.

The donor partners and key NGOs are harmonizing their strategic financial and technical input along the NSP and MTDS to support NACS in the multi-sectoral national response to the HIV and AIDS epidemic.

Looking at the efforts made towards the strategy planning in the HIV and AIDS program in 2007, the country has done well and thus provided ratings of 6 out of 10.

2. **Political Support**

After the enactment of NAC Act in 1997, the incumbent Government set up the Bi-partisan Permanent Parliamentary Committee on HIV/AIDS to provide leadership at the political level. This move is seen as a key milestone commitment from the Government in responding to the HIV and AIDS epidemic in the country. Under the NACS Act, NACS has a mandatory commitment to make Annual Report through the Minister responsible for HIV and AIDS to the National Parliament.

Since 1997, NACS, as an organization is governed by the National AIDS Council consisting of 21 members representing different sectors of the societies that also include representative from PLHIV and civil society organizations. In 2005 the Government has appointed a separate Minister for HIV and AIDS to provide decisive political leadership at the corridors of decision making and resources mobilization.

The Governor -General and the Prime Minister take lead in making national leadership support commitment in many keynote forums and conferences on the issue of HIV and AIDS and its impact on the country's development and community well being.

The funding support from the Government has increased considerably since the establishment of NACS. Since 2005 Budget allocation on HIV/AIDS has increased from K1 million to about K23 million in 2008. Hence, the overall political support for the programmes in HIV and AIDS is the country in 2007 is was considered positive with the rating of 6 out of 10 in 2007

Despite all the political and leadership efforts commitment from the Government and the development partners, the actual ground work is yet to improve including; changing sexual habits, behaviour and attitudes of the general populace, practising safer sex are still continued to remain as the main challenge for the Government and its development partners to deliberate on.

3. Human Rights

It was noted from the current NCPI survey that the NAC Act was broad and did not address the practical issues of stigmatization and discriminations faced by those infected and affected segment of the population.

A comprehensive review of existing human rights laws, acts, regulations and policies was undertaken in 2002 as basis for the formulation of HIV and AIDS Management and Prevention Act (HAMP Act) that was subsequently passed by the Parliament in 2003

Appropriate information and training tool kit on the HAMP Act was provided to government organizations, NGOs, CBOs and FBOs as a guide in the implementation of the Act.

Some encouraging signs that have emerged in recent years indicate that HAMP Act is gradually making in roads. An increasing number of people with HIV (PLWHIV) have come out and openly declaring their HIV status and doing awareness work.

One of the key developments is the emerging number of the organizations such as Igat Hope, an NGO that are being formed specifically by and for people living

with HIV and AIDS (PLWH) to coordinate prevention messages and to promote and protect the rights issues for the people affected by HIV and AIDS.

In line with HAMP Act guidelines, a number of major private sector corporations and Government institutions have developed their HIV workplace policies as a policy instrument to inform and safeguard their workers from discrimination, stigma and abuses related to HIV in the work environment.

The country launched its first National Gender Policy in 2006. The policy contains a list of gender specific provisions that aligns closely with the parent HAMP Act. This policy enhances roles of women in development, community and family life without bias, discrimination and stigmatization.

The views from some sections of the community stands that the HAMP Act tends to be too general and rigid to some extent. There is no specific mention of MSM and sex workers as criminal offence in the Act. Although there has been attempt to decriminalise the activities of this groups, this has not been successful. Hence the activities of these groups are seen as crime under the country's laws, which drive them underground where they remain anonymous and inaccessible to any protection, care and counselling services.

Apparently there is no established national monitoring system to record and document HIV related human rights violation and no known cases of abuses being registered. Also no recorded cases of denial of opportunities to education and employment because of HIV/AIDS and as a result it has been contested in the national court. Even if the abuses are happening, these are rarely reported due to obvious lack of functional system of recording and monitoring abuses at the national level.

However, the country is well endowed with human rights monitoring and enforcement mechanisms, such as the Police, social welfare system, local human rights violence activist groups and the different levels of judicial systems. The actual enforcement of the relevant provisions in the HAMP Act, in the cases of HIV and AIDS related abuses, is generally lacking. One possible reason is the general lack of understanding the technicality of the HAMP Act.

Overall most stakeholders feel that the appropriate policies, laws and regulations to promote and protect human rights in relation to HIV and AIDS are currently in place (6 out of 10), but enforcement efforts are is still a long way off (3 out of 10)

4. Prevention

The HIV Prevention awareness is well promoted by both the Government and its partners. School based HIV Prevention efforts are stepped up through the development of relevant curriculum for different level of education. This initiative was launched in 2007 and the actual teaching of the curriculum in the classrooms will begin in 2008.

The formation of an NGO known as Business Coalition Against HIV and AIDS (BAHA) was launched in 2007, to coordinate HIV Prevention activities in the private sector. The key messages such as reducing number of sexual partners, abstaining from sex, being faithful to one partner etc are themes promoted extensively by all sectors of the community.

The formulation of 100% Condom Accessibility policy has been endorsed and currently in force. PLWH have formed an NGO known as IGAT HOPE, through which they regularly present HIV Prevention messages. NGOs such as Save the Children have developed projects (Poro Sapot Project) which cater for the needs (protection and confidentiality from stigmatization etc) of the specialised groups such MSM and the Female Sex workers.

Relevant activities on blood safety and universal precautions in health care settings are implemented in most of the districts through health facility based services. HIV Testing and counselling is well supported by a number of NGOs and Faith-based organizations (FBOs) such as Catholic National Health Services and Anglicare Stop-AIDS.

Civil Society Organizations have formed a group known as PNG Alliance of Civil Society Organizations (PACSO) to coordinate HIV and AIDS Prevention activities (under one banner) through their networks.

Several large scale corporations from both the public and private sectors have now in place their HIV workplace policies in line with the guidelines and recommendations stated in the HAMP Act.

Increased strategic mechanisms for treatment, care and support at the community level are established through the extensive network of the NGOs and FBOs

Overall, the efforts in implementation of HIV prevention has improved in recent years, but there is still a lot more to do especially targeting populations in rural areas and those at higher risk. with the ratings of 5 out of 10. these challenges are recognized both by civil Society organizations and the government officials.

5. Civil Society Involvement.

There has been substantive efforts to involve civil society in the national response during the last few years. Major Civil society organizations report that they are sufficiently involved in the development of key strategies and policies, including the development of the National Strategic Plan and the National Gender Policy. In terms of the national response, civil society organizations play a major role in implementing activities and in reaching population throughout the country with prevention activities, and provide care and support to those who are in need. A Number of civil society groups have registered under PACSO, to draw funding and technical support for their various programs on HIV and AIDS

to support the national response. PACSO is a full member of the National Aids Council. CSOs receive funding support from NACS and from donors.

However, Civil society organizations feel that they play a passive role when it comes to the planning and framing of budget or in beneficiating from the national budget for prevention, treatment, care and support. The rankings with this regard have been below average for the reason that most financial assistance received by donors comes from donors, and that they are only asked to submit proposals for funding and that their involvement in the planning and budgeting process is not sufficient.

With the HAMP Act endorsed, the PLHIV have been increasingly involved to contribute towards the framing and development of a number of significant HIV related Policies and Strategies. However, the main network of PLHIV, Igat Hope, complains that this involvement is not enough, and that they are facing big challenges to be more active, and have their say in the various committees where they are members.

Overall the ratings in terms of civil society;

- Contributions to strengthening political leaders commitment: **6**
- Representation in planning and framing of budget process for the NSP: **4**
- Involvement in areas of HIV prevention, treatment care and support in NSP: **4**
- Involvement in areas of HIV prevention, treatment care and support in the national budget **2**
- Participation in a national review of NSP **6**
- Representation in HIV-related efforts inclusive of its diversity **4**

6. Treatment, care and Support

In 2003, Papua New Guinea reached a 'generalised' category in HIV and AIDS epidemic. This was signal telling the Government and the partners that the HIV and AIDS in the country is not confined to any specific group, people or place but every where. Since then Papua New Guinea Government with the assistance from its donor and NGO partners have embarked on number of major treatment, care and intervention programs. Anti-retroviral therapy was extensively promoted in through all health facility based services and NGO/Church health centres. ART is now provided free and available in most districts. Like wise for paediatric AIDS treatment, although this mostly available in provincial hospitals. Support was provided to NGO and civil society organizations to provide treatment home-based care counselling services.

Test kits were extensively promoted and there are now over 65 VCTs sites in all parts of the country with the number continue to increase in response to the number of people demanding for such services like blood testing and counselling. The care for orphans are non- existent, although there are few places such as Gembogl area of Simbu province, where a care centre for the

orphans was recently established with the help of the Catholic National Health services.

While the signs may look encouraging, there are more that need to be done in the area of the treatment care and support, while the various systems are being built up.

Hence, the overall ratings for the efforts in the implementation of HIV treatment, care and support in 2007 is 5 out of 10

7. Monitoring and Evaluation.

From the MTP review carried in 2004-2005, it was revealed that the lack of central data flow system was identified as main obstacle in monitoring and assessing the spread and impact of HIV and AID in Papua New Guinea. In 2005, Monitoring and Evaluation Unit was established and capacitated with relevant staff to function within the NACS policy division. The unit is staffed by 5 permanent staff including UNDP M&E Advisor. The current M&E Framework was built from the “three one” principles and a priority focus area in the NSP document launched in 2006. The framework sets out the strategic program for M & E to be undertaken in the current NSP period (2006-2010). The Plan is still in its progressive stage with more financial support and as recently as 2007, it was provided with separate budget line within the NACS budget framework.

The list of M&E activities in the plan include establishment of national data centre (now in progress) which will cater for collection, analysis and management of data from the surveillance, program monitoring and the bio-behavioural researches. Relevant indicators are developed to monitor the national responses and the various interventions that are being implemented. Sharing of information will be done in collaboration with the Surveillance Unit of NACS, M& E and NDOH. As part of this initiative, the donor partners and NGOs are brought into focus to harmonize their programs, share and exchange information and data from their respective HIV/AIDS programs and activities. Basic M& E training package has been put together and used to train people in the provinces to collect data from the provinces, through the existing Provincial AIDS Committee (PAC) mechanism. Under this initiative over 400 people were trained on M&E in 2007.

The unit is staffed by 5 permanent staff including UNDP M&E Advisor. The current M&E Framework was built in as part of the NSP document launched in 2006. The framework sets out the program goals and activities to undertaken in the current NSP period (2006-2010). The Plan is still in progress stage and as recently as 2007, M&E was provided with separate budget line within the NACS budget framework.

The list of M&E activities in the plan include establishment of national data centre (now in progress) which will cater for collection, analysis and management of

data from the surveillance and the research institutes such as Institute of Medical Research (IMR) and National Research Institute (NRI).

Relevant indicators needed for the assessment and monitoring of prevalence of AIDS at the national level are being identified in collaboration with the Surveillance Unit of NACS and NDOH. As part of this initiative, the donor partners and NGOs are brought into focus to share and exchange information and data from their respective HIV/AIDS programs and activities.

Training package has been put together and used to train people in the provinces to collect data through the existing Provincial AIDS Committee (PAC) mechanism. Under this initiative over 400 people were trained on M&E in 2007. Program M&E data collection tool was launched 20th September 2007. Data collection training is ongoing.

Joint M&E Project Steering Committee (comprising of key stakeholders including donors, NGOs and CBOs) has been established and meets monthly to provide necessary technical guidance to ensure M&E meets its objectives as stated in the NSP. However, although civil society organizations, including networks of PLHI have been invited to stand as members of the M&E steering committee, they were unable to attend the meetings and participate in the decisions made.

the lack of technical capacity to realise the goals and objectives of M&E under the current NSP pose the main challenge for the Monitoring and Evaluation in Papua New Guinea.

The mechanism for the sharing and exchanging M&E results with and from UN and bi-lateral partners and other institutions is not fully established (ratings 3 out of 5).

Likewise, the overall efforts in M&E efforts in AIDS program is still in the development phase (5 out of 10) and more is yet to be done in this area.

Indicators 3 to 24: See attached output from CRIS.

3 - Blood Safety

Indicator relevance	Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool	Program Monitoring/Review - Other (please specify): Blood Bank Database
Data collection period	1/1/2007 - 12/31/2007
Comments	*During the course of 2008, there was 14,000 blood units collected, and they were all screened for HIV using the national protocols with a quality assured manner. The percentage of blood units screened for HIV is 100%* *Information for this indicator was collected from the provincial blood bank databases. As there is no national database that gathers data at national level, information was collected from provincial databases and aggregated by the team of statisticians from NDoH with help of WHO.*

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of donated blood units screened for HIV in a quality-assured manner	All	100.00 %	
Numerator : Number of donated blood units screened for HIV in blood centres/blood screening laboratories that have both: (1) followed documented standard operating procedures and (2) participated in an external quality assurance scheme	All	14000	
Denominator : Total number of blood units donated	All	14000	

CRIS Report - All Indicators Papua New Guinea

4 - HIV Treatment: Antiretroviral Therapy - 2006

Indicator relevance	Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool	Patient Record/Register Systems -
Data collection period	1/1/2006 - 12/31/2006
Comments	*As of December 20067, 1098 people including 35 children were currently on treatment. The 2007 HIV estimation and projection report indicates that 46,257 people are estimated to be living with HIV by the end of 2006. Of these, 10.22% (4732/46257) including 493 children needed ART by end of 2006. Of the PLHIV needing treatment by end of 2006, 23% (1098/4732) were on treatment by end of December 2006. The treatment coverage for children did not exceed 7% (35/493) in the same period. The denominator was driven from the last estimation and projection exercise using EPP and Spectrum on 2006 ANC data (2007 estimation report). Data for this indicator is collected from the monitoring of the treatment programme. Provincial databases have been compiled and aggregated to produce the data reported. The reporting period covers all the calendar year. In the absence of a functional reporting system, data was not readily available when needed for the reporting on UNGASS. A team of statisticians from NDoH visited the various provinces and ART centres late December 2007 and January2008 to collected the needed information and copy the provincial databases. The data reported cover the full calendar year 2007*

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	All Adults & Children	23.20 %	
	Males	21.72 %	
	Females	24.64 %	
	<15	7.10 %	
	15+	25.08 %	
Numerator : Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period	All Adults & Children	1098	
	Males	505	
	Females	593	
	15+	1063	
	<15	35	
Denominator : Estimated number of adults and children with advanced HIV infection	All Adults & Children	4732	
	Males	2325	
	Females	2407	
	<15	493	
	15+	4238	

4 - HIV Treatment: Antiretroviral Therapy - 2007

Indicator relevance	Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool	Patient Record/Register Systems -
Data collection period	1/1/2007 - 12/31/2007
Comments	*As of December 2007, 2250 people including 185 children were currently on treatment.* *The 2007 HIV estimation and projection report indicates that 56175 people are estimated to be living with HIV. Of these, 11% (6348/56175) including 636 children needed ART by end of 2007. Of the PLHIV needing treatment by end of 2007, 35% (2250/6348) were on treatment by end of December 2007. The adult treatment coverage is 36% (2065/5712) and for children is 29 % (185/636) in the same period. The denominator was driven from the last estimation and projection exercise using EPP and Spectrum on 2006 ANC data (2007 estimation report).* *all these indicators represent an important increase comparing for 2007 especially for coverage of treatment needs for children as a reults of efforts to scaling up treatment care and counciling throughout the various provinces in country.* *Data for this indicator is collected from the monitoring of the treatment programme. Provincial databases have been compiled and aggregated to produce the data reported. The reporting period covers all the calendar year. In the absence of a functional reporting system, data was not readily available when needed for the reporting on UNGASS. A team of statisticians from NDoH visited the various provinces and ART centres late December 2007 and January2008 to collected the needed information and copy the provincial databases. The data reported cover the full calendar year 2007*

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	All Adults & Children	35.44 %	
	Males	39.40 %	
	Females	32.64 %	
	<15	29.09 %	
	15+	36.15 %	
Numerator : Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period	All Adults & Children	2250	
	Males	1037	
	Females	1213	
	15+	2065	
	<15	185	
Denominator : Estimated number of adults and children with advanced HIV infection	All Adults & Children	6348	
	Males	2632	
	Females	3716	
	15+	5712	
	<15	636	

5 - Prevention of Mother-to-Child Transmission - 2006

Indicator relevance Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool Patient Record/Register Systems -
Data collection period 1/1/2006 - 12/31/2006
Comments *This data was collected form the registers at the ANC clinics that provide PMTCT services. Due to lack of a functional routine information system that would make data available at national level, only partical data was originally availble, for this reason a team of statisticians from NDoH visited the different centers at provinces to collect data for this indicator. Unfortunately, other details such as age of pregnant women is missing, this we are unable to have a disaggregated anaylsis bu age groups.*
Since the commencement of the program in 2004, 20,000 pregnant women have accessed the PMTCT services, that is general information about HIV given during antenatal visit, group counselling, individual counselling with individualized risk reduction for some women, blood testing, ART dose during pregnancy or labour, and modified obstetric care. Of those, about 60% agreed to be tested. While 99 pregnant women received ART prophylaxis to prevent mother to child transmission of HIV in 2006, this number did not exceed 84 in 2007. This led to an increasing unmet need for PMTCT as the epidemic is growing, and the estimated number of pregnant women who are HIV+ reaches 3621 for 2007 while it was 2848 in 2006. The coverage of PMTCT program has fallen from 3.48% in 2006 to 2.32% in 2007.

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	All	3.48 %	
Numerator : Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	All	99	
Denominator : Estimated number of HIV-infected pregnant women in the last 12 months	All	2848	

5 - Prevention of Mother-to-Child Transmission - 2007

Indicator relevance Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool Patient Record/Register Systems -
Data collection period 1/1/2007 - 1/31/2007
Comments *This data was collected form the registers at the ANC clinics that provide PMTCT services. Due to lack of a functional routine information system that would make data available at national level, only partical data was originally availble, for this reason a team of statisticians from NDoH visited the different centers at provinces to collect data for this indicator. Unfortunately, other details such as age of pregnant women is missing, this we are unable to have a disaggregated anaylsis bu age groups.*
Since the commencement of the program in 2004, 20,000 pregnant women have accessed the PMTCT services, that is general information about HIV given during antenatal visit, group counselling, individual counselling with individualized risk reduction for some women, blood testing, ART dose during pregnancy or labour, and modified obstetric care. Of those, about 60% agreed to be tested. While 99 pregnant women received ART prophylaxis to prevent mother to child transmission of HIV in 2006, this number did not exceed 84 in 2007. This led to an increasing unmet need for PMTCT as the epidemic is growing, and the estimated number of pregnant women who are HIV+ reaches 3621 for 2007 while it was 2848 in 2006. The coverage of PMTCT program has fallen from 3.48% in 2006 to 2.32% in 2007.

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	All	2.32 %	
Numerator : Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission	All	84	
Denominator : Estimated number of HIV-infected pregnant women in the last 12 months	All	3621	

6 - Co-Management of Tuberculosis and HIV Treatment

Indicator relevance Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool Antiretroviral Therapy Patient Registers -
Data collection period 1/1/2007 - 12/31/2007
Comments -

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	All Cases	34.90 %	
	Males	40.53 %	
	Females	33.86 %	
Numerator : Number of adults with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines) within the reporting year	All Cases	320	
	Males	169	
	Females	151	
Denominator : Estimated number of incident TB cases in people living with HIV	All Cases	917	
	Males	417	
	Females	446	

7 - HIV Testing in the General Population

Indicator relevance Indicator Relevant to Our Country - No Data Available
Type and Name of Data Measurement Tool -
Data collection period
Comments *This question was not included in the DHS survey implemented in country in 2006*

8 - HIV Testing in Most-at-Risk Populations - Sex Workers

Indicator relevance Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool Behavioral Surveillance Survey - Family Health International (FHI) Methodology
Data collection period 10/2/2006 - 11/30/2006
Comments *The proportions given for this indicator are based on an end of project evaluation where 82% also said that they knew where to go to have an HIV test.*
In another survey during the first round of BSS conducted in 2006 with rural highway and non-highway based sex workers, six hundred and thirty-four women who sold sex were surveyed. Of these close to 50% of non-highway based and 42% of highway-based women said that they had been tested for HIV. Significantly, approximately 80% of these women said that their test had been positive (NACS and NHASP, 2007).

Indicator	Value	*
Sample Size of Survey Respondents:	320	

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	All Sex Workers	47.34 %	
	Males	Missing	
	Females	47.34 %	
	<25	41.86 %	
	25+	51.05 %	
Numerator : Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results	All Sex Workers	151	
	Males	Missing	
	Females	151	
	<25	54	
	25+	97	
Denominator : Number of most-at-risk population included in the sample	All Sex Workers	319	
	Males	Missing	
	Females	319	
	<25	129	
	25+	190	

8 - HIV Testing in Most-at-Risk Populations - Men Who have Sex with Men

Indicator relevance Indicator Relevant to Our Country - Data Entered

Type and Name of Data Measurement Tool Behavioral Surveillance Survey - Family Health International (FHI) Methodology

Data collection period 10/2/2006 - 11/30/2006

Comments *The data reported for this indicator comes from an end of project evaluation targeting female FSWs and MSMs in Port Moresby. The baseline study (2005) and the end of project study showed that knowledge and use of confidential VCT services reported by MSMs remain low in both rounds.*
Of respondants who accessed any VCT servises during the previous 12 months, less than half accessed VCT servises multiple time, and all of them received their results.

Indicator	Value	*
Sample Size of Survey Respondents:	306	

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results	All Men Who Have Sex With Men	41.67 %	
	<25	39.15 %	
	25+	45.95 %	
Numerator : Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results	All Men Who Have Sex With Men	125	
	<25	74	
	25+	51	
Denominator : Number of most-at-risk population included in the sample	All Men Who Have Sex With Men	300	
	<25	189	
	25+	111	

8 - HIV Testing in Most-at-Risk Populations - Injecting Drug Users

Indicator relevance	Indicator Relevant to Our Country - No Data Available
Type and Name of Data Measurement Tool	-
Data collection period	
Comments	-

9 - Most-at-risk Populations: Prevention Programmes - Sex Workers

Indicator relevance	Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool	Behavioral Surveillance Survey - Family Health International (FHI) Methodology
Data collection period	10/2/2006 - 11/30/2006
Comments	*The data reported for this indicator comes from an end of project evaluation targeting female sex workers in Port Moresby.*

Indicator	Value	*
Sample Size of Survey Respondents:	320	

Indicator	Disaggregation	Value	*
Indicator Value : "Yes" to all questions	All Sex Workers	31.46 %	200
	Males	Missing	201
	Females	31.46 %	
	<25	31.43 %	
	25+	31.48 %	
Numerator : Number of respondents who replied yes to all questions	All Sex Workers	84	
	Males	Missing	
	Females	84	
	<25	33	
	25+	51	
Denominator : Total number of respondents surveyed	All Sex Workers	267	
	Males	Missing	
	Females	267	
	<25	105	
	25+	162	

Indicator	Disaggregation	Value	*
Indicator Value : "Yes" to question 2, in the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)	All Sex Workers	32.81 %	
	Males	Missing	
	Females	32.81 %	
	<25	30.77 %	
	25+	34.21 %	
Numerator : Respondents who replied "Yes" to question 2	All Sex Workers	105	
	Males	Missing	
	Females	105	
	<25	40	
	25+	65	
Denominator : Total number of respondents surveyed	All Sex Workers	320	
	Males	Missing	
	Females	320	
	<25	130	
	25+	190	

Indicator	Disaggregation	Value	*
Indicator Value : "Yes" to question 1, do you know where you can go if you wish to receive an HIV test?	All Sex Workers	68.44 %	
	Males	Missing	
	Females	68.44 %	
	<25	66.15 %	
	25+	70.00 %	
Numerator : Respondents who replied "yes" to question 1	All Sex Workers	219	
	Males	Missing	
	Females	219	
	<25	86	
	25+	133	
Denominator : Total number of respondents surveyed	All Sex Workers	320	
	Males	Missing	
	Females	320	
	<25	130	
	25+	190	

200 55 missing values

201 *The survey was only implemented on Female Sex workers.*

9 - Most-at-risk Populations: Prevention Programmes - Men Who have Sex with Men

Indicator relevance	Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool	Behavioral Surveillance Survey - Family Health International (FHI) Methodology
Data collection period	10/2/2006 - 11/30/2006
Comments	*The data reported for this indicator comes from an end of project evaluation targeting female sex workers in Port Moresby.*

Indicator	Value	*
Sample Size of Survey Respondents:	300	

Indicator	Disaggregation	Value	*
Indicator Value : "Yes" to all questions	All Men Who have Sex with Men	10.33 %	
	<25	13.23 %	
	25+	5.41 %	
Numerator : Number of respondents who replied yes to all questions	All Men Who have Sex with Men	31	
	<25	25	
	25+	6	
Denominator : Total number of respondents surveyed	All Men Who have Sex with Men	300	
	<25	189	
	25+	111	

Indicator	Disaggregation	Value	*
Indicator Value : "Yes" to question 2, in the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)	All Men Who have Sex with Men	11.67 %	
	<25	14.29 %	
	25+	7.21 %	
Numerator : Respondents who replied "Yes" to question 2	All Men Who have Sex with Men	35	
	<25	27	
	25+	8	
Denominator : Total number of respondents surveyed	All Men Who have Sex with Men	300	
	<25	189	
	25+	111	

Indicator	Disaggregation	Value	*
Indicator Value : "Yes" to question 1, do you know where you can go if you wish to receive an HIV test?	All Men Who have Sex with Men	78.00 %	
	<25	78.31 %	
	25+	77.48 %	
Numerator : Respondents who replied "yes" to question 1	All Men Who have Sex with Men	234	
	<25	148	
	25+	86	
Denominator : Total number of respondents surveyed	All Men Who have Sex with Men	300	
	<25	189	
	25+	111	

9 - Most-at-risk Populations: Prevention Programmes - Injecting Drug Users

Indicator relevance	Indicator Relevant to Our Country - No Data Available
Type and Name of Data Measurement Tool	-
Data collection period	
Comments	*There are no surveys or research done on PNG target Injecting Drug Users. However there are anoectodal stories referring to use of Injecting drugs across the Indonesian border.*

10 - Support for Children Affected by HIV and AIDS

Indicator relevance	Indicator Relevant to Our Country - No Data Available
Type and Name of Data Measurement Tool	-
Data collection period	
Comments	-

11 - Life Skills-based HIV Education in Schools

Indicator relevance	Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool	- Other (please specify, no acronyms): Report from the piloting of LSE in schools in selected provinces
Data collection period	1/1/2007 - 12/31/2007
Comments	*The implementation of Life skills Education in schools is in a pilot stage in Papua New Guinea. The life skills manuals have been developped and tested in October - November 2007 in a number of schools in 4 provinces. Information provided for this indicator is related to the number of schools where LSE has been piloted as a proportion of the total number of schools in the covered districts.*

Indicator	Value	*
Number of Schools in Country:	3456	

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of schools that provided life skills-based HIV education in the last academic year	All Schools	25.00 %	
	Primary	25.00 %	
	Secondary	0.00 %	
Numerator : Number of schools that provided life skills-based HIV education in the last academic year	All Schools	64	
	Secondary	0	
	Primary	64	
Denominator : Number of schools surveyed	All Schools	256	
	Primary	256	
	Secondary	0	

12 - Orphans: School Attendance

Indicator relevance	Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool	Population Based Survey - Demographic and Health Survey (DHS)
Data collection period	10/1/2006 - 3/31/2007
Comments	*This data is taken from the Demographic and Health Survey implemented in country in 2007.* *The values entered are not weighted as the analysis of data for this survey is in its early stages, and weighted data could not be produced.*

Indicator	Value	*
Sample Size of Survey Respondents:	10000	

Indicator	Disaggregation	Value	*
Indicator Value : Part A - Current school attendance rate of orphans aged 10-14	All	75.00 %	
	Males	70.00 %	
	Females	81.30 %	
Numerator : Number of children who have lost both parents and who attend school	All	27	
	Males	14	
	Females	13	
Denominator : Number of children who have lost both parents	All	36	
	Males	20	
	Females	16	

Indicator	Disaggregation	Value	*
Indicator Value : Part B - Current school attendance rate of children aged 10-14 both of whose parents are alive and who live with at least one parent	All	87.10 %	
	Males	85.70 %	
	Females	88.70 %	
Numerator : Number of children both of whose parents are alive, who are living with at least one parent and who attend school	All	4269	
	Males	2293	
	Females	1976	
Denominator : Number of children both of whose parents are alive who are living with at least one parent	All	4904	
	Males	2676	
	Females	2228	

13 - Young People: Knowledge about HIV Prevention

Indicator relevance	Indicator Relevant to Our Country - No Data Available
Type and Name of Data Measurement Tool	-
Data collection period	
Comments	*This question was not included in the DHS in the format accordin to the definition in the Indicator construction guidelines. there was one open question regarding the knowledge of prevention methods, where respondents had to spontaneously mention those methods and the interviewer marks them without prompting. Results from those questions are as follows: (note, results are not weighted). among all the open answers, the % of young people aged 15-24 who mentioned for Use of condom and having only one partner as ways of prevention from HIV were as follows: Use of condom Total: 47.6% , Male 56.56%, and female 39.39% for Having only one suxual partner : total: 52.28%, male 56.14%, and female: 48.7%*

14 - Most-at-risk Populations: Knowledge about HIV Prevention - Sex Workers

Indicator relevance	Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool	Behavioral Surveillance Survey - Family Health International (FHI) Methodology
Data collection period	10/2/2006 - 11/30/2006
Comments	*In the first round of BSS with young people conducted in 2006, 1,701 out of school youth, aged 15-24 years (913 female and 788 male) were sampled from urban communities in the National Capital Districts (NACS and NHASP, 2007). Of these young people some were married and unmarried. Very few believed that a health looking person could have HIV: 9.1% married female youth; 14.1% unmarried female youth; 8.5% married male youth; and 21.2% of unmarried male youth. A larger percent of youth, particularly female youth, believed that HIV could be transmitted through sharing a meal: 30.5% married female youth; 40.3% unmarried female youth; 13.9% married male youth; and 21.5% of unmarried male youth. Many more female youth than male youth believed that HIV could be transmitted through mosquito bites: 44.4% married female youth; 53.2% unmarried female youth; 15.2% married male youth; and 28.7% of unmarried male youth. Almost 40% (38.4%) of unmarried female youth and 23.2 married female youth were unaware that consistent condom use was a method of HIV prevention. Knowledge of condom use as a HIV prevention method was higher for both male married (3%) and unmarried 8.9%.*

Indicator	Value	*
Sample Size of Survey Respondents:	320	

Indicator	Disaggregation	Value	*
Indicator Value : Correct answer to question 4, can a person get HIV from mosquito bites? (or country specific question)	All Sex Workers	64.38 %	
	Males	Missing	
	Females	64.38 %	
	<25	56.92 %	
	25+	69.47 %	
Numerator : Number of respondents who gave correct answer to question 4	All Sex Workers	206	
	Males	Missing	
	Females	206	
	<25	74	
	25+	132	
Denominator : Number of respondents who gave answers, including "don't know", to question 4	All Sex Workers	320	
	Males	Missing	
	Females	320	
	<25	130	
	25+	190	

Indicator	Disaggregation	Value	*
Indicator Value : Correct answer to question 3, can a healthy-looking person have HIV?	All Sex Workers	87.19 %	
	Males	Missing	
	Females	87.19 %	
	<25	86.15 %	
	25+	87.89 %	
Numerator : Number of respondents who gave correct answer to question 3	All Sex Workers	279	
	Males	Missing	
	Females	279	
	<25	112	
	25+	167	
Denominator : Number of respondents who gave answers, including "don't know", to question 3	All Sex Workers	320	
	Males	Missing	
	Females	320	
	<25	130	
	25+	190	

Indicator	Disaggregation	Value	*
Indicator Value : Correct answer to all five questions	All Sex Workers	35.31 %	
	Males	Missing	
	Females	35.31 %	
	<25	39.23 %	
	25+	32.63 %	
Numerator : Number of respondents who gave the correct answers to all questions	All Sex Workers	113	
	Males	Missing	
	Females	113	
	<25	51	
	25+	62	
Denominator : Number of respondents who gave answers, including "don't know", to all questions	All Sex Workers	320	
	Males	Missing	
	Females	320	
	<25	130	
	25+	190	

Indicator	Disaggregation	Value	*
Indicator Value : Correct answer to question 5, an a person get HIV by sharing food with someone who is infected? (or country specific question)	All Sex Workers	78.44 %	
	Males	Missing	
	Females	78.44 %	
	<25	85.38 %	
	25+	73.68 %	
Numerator : Number of respondents who gave correct answer to question 5	All Sex Workers	251	
	Males	Missing	
	Females	251	
	<25	111	
	25+	140	
Denominator : Number of respondents who gave answers, including "don't know", to question 5	All Sex Workers	320	
	Males	Missing	
	Females	320	
	<25	130	
	25+	190	

Indicator	Disaggregation	Value	*
Indicator Value : Correct answer to question 1, can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	All Sex Workers	69.38 %	
	Males	Missing	
	Females	69.38 %	
	<25	72.31 %	
	25+	67.37 %	
Numerator : Number of respondents who gave correct answer to question 1	All Sex Workers	222	
	Males	Missing	
	Females	222	
	<25	94	
	25+	128	
Denominator : Number of respondents who gave answers, including "don't know", to question 1	All Sex Workers	320	
	Males	Missing	
	Females	320	
	<25	130	
	25+	190	

Indicator	Disaggregation	Value	*
Indicator Value : Correct answer to question 2, can a person reduce the risk of getting HIV by using a condom every time they have sex?	All Sex Workers	73.13 %	
	Males	Missing	
	Females	73.13 %	
	<25	76.92 %	
	25+	70.53 %	
Numerator : Number of respondents who gave correct answer to question 2	All Sex Workers	234	
	Males	Missing	
	Females	234	
	<25	100	
	25+	134	
Denominator : Number of respondents who gave answers, including "don't know", to question 2	All Sex Workers	320	
	Males	Missing	
	Females	320	
	<25	130	
	25+	190	

14 - Most-at-risk Populations: Knowledge about HIV Prevention - Men Who have Sex w

Indicator relevance Indicator Relevant to Our Country - Data Entered

Type and Name of Data Measurement Tool Behavioral Surveillance Survey - Family Health International (FHI) Methodology

Data collection period 2/1/2007 - 3/30/2007

Comments *In the first round of BSS with young people conducted in 2006, 1,701 out of school youth, aged 15-24 years (913 female and 788 male) were sampled from urban communities in the National Capital Districts (NACS and NHASP, 2007). Of these young people some were married and unmarried. Very few believed that a health looking person could have HIV: 9.1% married female youth; 14.1% unmarried female youth; 8.5% married male youth; and 21.2% of unmarried male youth. A larger percent of youth, particularly female youth, believed that HIV could be transmitted through sharing a meal: 30.5% married female youth; 40.3% unmarried female youth; 13.9% married male youth; and 21.5% of unmarried male youth. Many more female youth than male youth believed that HIV could be transmitted through mosquito bites: 44.4% married female youth; 53.2% unmarried female youth; 15.2% married male youth; and 28.7% of unmarried male youth. Almost 40% (38.4%) of unmarried female youth and 23.2 married female youth were unaware that consistent condom use was a method of HIV prevention. Knowledge of condom use as a HIV prevention method was higher for both male married (3%) and unmarried 8.9%.*

Indicator	Value	*
Sample Size of Survey Respondents:	300	

Indicator	Disaggregation	Value	*
Indicator Value : Correct answer to question 4, can a person get HIV from mosquito bites? (or country specific question)	All Men Who have Sex with Men	88.33 %	
	<25	89.42 %	
	25+	86.49 %	
Numerator : Number of respondents who gave correct answer to question 4	All Men Who have Sex with Men	265	
	<25	169	
	25+	96	
Denominator : Number of respondents who gave answers, including "don't know", to question 4	All Men Who have Sex with Men	300	
	<25	189	
	25+	111	

Indicator	Disaggregation	Value	*
Indicator Value : Correct answer to question 3, can a healthy-looking person have HIV?	All Men Who have Sex with Men	96.33 %	
	<25	95.77 %	
	25+	97.30 %	
Numerator : Number of respondents who gave correct answer to question 3	All Men Who have Sex with Men	289	
	<25	181	
	25+	108	
Denominator : Number of respondents who gave answers, including "don't know", to question 3	All Men Who have Sex with Men	300	
	<25	189	
	25+	111	

Indicator	Disaggregation	Value	*
Indicator Value : Correct answer to all five questions	All Men Who have Sex with Men	70.67 %	
	<25	72.49 %	
	25+	67.57 %	
Numerator : Number of respondents who gave the correct answers to all questions	All Men Who have Sex with Men	212	
	<25	137	
	25+	75	
Denominator : Number of respondents who gave answers, including "don't know", to all questions	All Men Who have Sex with Men	300	
	<25	189	
	25+	111	

Indicator	Disaggregation	Value	*
Indicator Value : Correct answer to question 5, an a person get HIV by sharing food with someone who is infected? (or country specific question)	All Men Who have Sex with Men	80.67 %	
	<25	85.19 %	
	25+	72.97 %	
Numerator : Number of respondents who gave correct answer to question 5	All Men Who have Sex with Men	242	
	<25	161	
	25+	81	
Denominator : Number of respondents who gave answers, including "don't know", to question 5	All Men Who have Sex with Men	300	
	<25	189	
	25+	111	

Indicator	Disaggregation	Value	*
Indicator Value : Correct answer to question 1, can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	All Men Who have Sex with Men	94.67 %	
	<25	94.71 %	
	25+	94.59 %	
Numerator : Number of respondents who gave correct answer to question 1	All Men Who have Sex with Men	284	
	<25	179	
	25+	105	
Denominator : Number of respondents who gave answers, including "don't know", to question 1	All Men Who have Sex with Men	300	
	<25	189	
	25+	111	

Indicator	Disaggregation	Value	*
Indicator Value : Correct answer to question 2, can a person reduce the risk of getting HIV by using a condom every time they have sex?	All Men Who have Sex with Men	97.67 %	
	<25	97.88 %	
	25+	97.30 %	
Numerator : Number of respondents who gave correct answer to question 2	All Men Who have Sex with Men	293	
	<25	185	
	25+	108	
Denominator : Number of respondents who gave answers, including "don't know", to question 2	All Men Who have Sex with Men	300	
	<25	189	
	25+	111	

14 - Most-at-risk Populations: Knowledge about HIV Prevention - Injecting Drug Users

Indicator relevance	Indicator Relevant to Our Country - No Data Available
Type and Name of Data Measurement Tool	-
Data collection period	
Comments	-

15 - Sex Before the Age of 15

Indicator relevance	Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool	Population Based Survey - Demographic and Health Survey (DHS)
Data collection period	10/1/2006 - 3/30/2007
Comments	*The data reported here comes from the DHS survey implemented in Papua New Guinea in 2006.* *As an additional source of information, In the first round of BSS with young people conducted in 2006, 1,701 out of school youth, aged 15-24 years (913 female and 788 male) were sampled from urban communities in the National Capital Districts (NACS and NHASP, 2007). All married male and female youth had had sex and 67.6% of female unmarried youth and 72.3% of unmarried male youth had had sex. The median age of first sex for both married and unmarried youth was 16 years old (NHACS and NHASP, 2007).*

Indicator	Value	*
Sample Size of Survey Respondents:	20712	

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	All 15-24	4.20 %	
	Males	4.00 %	
	Females	4.30 %	
	15-19	3.80 %	
	20-24	4.50 %	
Numerator : Number of respondents (aged 15-24 years) who report the age at which they first had sexual intercourse as under 15 years	All 15-24	311	
	Males	144	
	Females	167	
	15-19	143	
	20-24	168	
Denominator : Number of all respondents aged 15-24 years	All 15-24	7475	
	Males	3583	
	Females	3892	
	15-19	3729	
	20-24	3746	

16 - Higher-risk Sex

Indicator relevance — Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool — Population Based Survey - Demographic and Health Survey (DHS)
Data collection period — 10/1/2006 - 3/31/2007
Comments — -

Indicator	Value	*
Sample Size of Survey Respondents:	20712	

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	All 15-49	7.50 %	
	Males	13.20 %	
	Females	2.00 %	
	15-19	5.90 %	
	20-24	11.30 %	
	25-49	6.90 %	
Numerator : Number of respondents/population aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	All 15-49	1536	
	Males	1331	
	Females	205	
	15-19	219	
	20-24	422	
	25-49	894	
Denominator : Number of all respondents aged 15-49	All 15-49	20424	
	Males	10075	
	Females	10349	
	15-19	3729	
	20-24	3746	
	25-49	12949	

17 - Condom Use During Higher-risk Sex

Indicator relevance Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool Population Based Survey - Demographic and Health Survey (DHS)
Data collection period 10/1/2006 - 3/30/2007
Comments -

Indicator	Value	*
Sample Size of Survey Respondents:	20712	

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of women and men aged 15-49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	All 15-49	42.50 %	
	Males	45.00 %	
	Females	26.40 %	
	15-19	49.50 %	
	20-24	48.70 %	
	25-49	38.10 %	
Numerator : Number of respondents/population (aged 1549) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex	All 15-49	686	
	Males	629	
	Females	57	
	15-19	110	
	20-24	209	
	25-49	367	
Denominator : Number of respondents/population (1549) who reported having had more than one sexual partner in the last 12 months	All 15-49	1615	
	Males	1399	
	Females	216	
	15-19	222	
	20-24	429	
	25-49	964	

18 - Sex Workers: Condom Use

Indicator relevance	Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool	Behavioral Surveillance Survey - Family Health International (FHI) Methodology
Data collection period	10/1/2006 - 11/30/2006
Comments	*The data given for this indicator is based on an end of project evaluation.* *In another survey during the first round of BSS conducted in 2006 with rural highway and non-highway based sex workers, six hundred and thirty-four women who sold sex were surveyed. In this survey condom use at last sex with a client among both non-highway-based (76%) and highway-based women (66%) was relatively common. However, fewer than 50% (43.4%) of non-highway based and only one in four (24.3%) highway-based women used a condom consistently with clients in the past 6 months. Roughly four out of five women in each group did not consistently use a condom with a non- paying partner (non-highway based 18.4% and highway based 20.7%). (NACS and NHASP, 2007)*

Indicator	Value	*
Sample Size of Survey Respondents:	320	

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of female and male sex workers reporting the use of a condom with their most recent client	All Sex Workers	93.71 %	
	Males	Missing	
	Females	93.71 %	
	<25	94.57 %	
	25+	93.12 %	
Numerator : Number of respondents who reported that a condom was used with their last client in the last 12 months	All Sex Workers	298	
	Males	Missing	
	Females	298	
	<25	122	
	25+	176	
Denominator : Number of respondents who reported having commercial sex in the last 12 months	All Sex Workers	318	
	Males	Missing	
	Females	318	
	<25	129	
	25+	189	

19 - Men Who Have Sex with Men: Condom Use

Indicator relevance	Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool	Behavioral Surveillance Survey - Family Health International (FHI) Methodology
Data collection period	2/1/2007 - 3/31/2007
Comments	*The data reported for this indicator does not match the definition of this indicator. This study did not ask the specific question regarding the use of condom in the last anal sex with male partner. however there were several questions regarding the use of condom in the last sex with each type of partner. the four categories considered are:* *Non commercial partners including female* *One-time client* *regular client* *where the respendant paid for sex.* *For the purpose of this reporting, we are considering the values regarding the use of condom in the last anal sex with a one time client, as we do not know which one of all those partners was the last for the respondant.* *In terms of results, the level of use of condoms in the last sex with all those types of partners remains high within the range of 80% as follows:* *Non commercial partners including female : 87.2%* *One-time client: 88.5%* *regular client: 80.4%* *where the respendant paid for sex: 84.1%*

Indicator	Value	*
Sample Size of Survey Respondents:	300	

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	All Men Who Have Sex With Men	88.49 %	
	<25	88.89 %	
	25+	87.76 %	
Numerator : Number of respondents who reported that a condom was used the last time they had anal sex	All Men Who Have Sex With Men	123	
	<25	80	
	25+	43	
Denominator : Number of respondents who reported having had anal sex with a male partner in the last six months	All Men Who Have Sex With Men	139	
	<25	90	
	25+	49	

20 - Injecting Drug Users: Condom Use

Indicator relevance	Indicator Relevant to Our Country - No Data Available
Type and Name of Data Measurement Tool	-
Data collection period	
Comments	-

21 - Injecting Drug Users: Safe Injecting Practices

Indicator relevance	Indicator Relevant to Our Country - No Data Available
Type and Name of Data Measurement Tool	-
Data collection period	
Comments	-

CRIS Report - All Indicators Papua New Guinea

22 - Reduction in HIV Prevalence

Indicator relevance	Indicator Relevant to Our Country - No Data Available
Type and Name of Data Measurement Tool	-
Data collection period	
Comments	-

23 - Most-at-risk Populations: Reducation in HIV Prevalence - Sex Workers

Indicator relevance	Indicator Relevant to Our Country - No Data Available
Type and Name of Data Measurement Tool	-
Data collection period	
Comments	-

CRIS Report - All Indicators Papua New Guinea

23 - Most-at-risk Populations: Reducation in HIV Prevalence - Men Who have Sex with

Indicator relevance	Indicator Relevant to Our Country - No Data Available
Type and Name of Data Measurement Tool	-
Data collection period	
Comments	-

23 - Most-at-risk Populations: Reducation in HIV Prevalence - Injecting Drug Users

Indicator relevance	Indicator Relevant to Our Country - No Data Available
Type and Name of Data Measurement Tool	-
Data collection period	
Comments	-

24 - HIV Treatment: Survival After 12 Months on Antiretroviral Therapy

Indicator relevance	Indicator Relevant to Our Country - Data Entered
Type and Name of Data Measurement Tool	Patient Record/Register Systems -
Data collection period	1/1/2007 - 12/31/2007
Comments	-

Indicator	Disaggregation	Value	*
Indicator Value : Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	All	60.78 %	
	Males	67.49 %	
	Females	55.50 %	
	15+	67.33 %	
	<15	9.96 %	
Numerator : Number of adults and children who are still alive and on ART at 12 months after initiating treatment	All	1283	
	Males	627	
	Females	656	
	15+	1259	
	<15	24	
Denominator : Total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.	All	2111	
	Males	929	
	Females	1182	
	15+	1870	
	<15	241	

ANNEX 2: Consultation and Preparation Process

The National Response to HIV and AIDS in PNG was formally launched in 1997 when the National AIDS Council with its Secretariat (NACS) was established. To date the response has grown into a “multi sector intervention” where so many players are involved.

There are many funding sources including development partners (donors) and the PNG Government. There are so many implementing agencies for HIV intervention programs.

However, to date there is no comprehensive HIV and AIDS Monitoring & Evaluation Plan. NACS M&E unit was established in 2006 and is now building M&E capacity. At this time when UNGASS report for 2007 is being prepared, NDOH and NACS has only a plan for an HIV and AIDS data base to be centrally located.

HIV and AIDS data and information is being collected but spread and kept up so many stakeholders who generate them, Most of the time, the data is not regularly submitted to the central level (NACS and NDOH) at a regular basis, it remains kept at the facility level and needs special effort to be gathered. For NACS as the coordinating body for HIV and AIDS to assist the government meet reporting obligation to the UN General Assembly, data collection is a daunting task.

This section of the report attempts to briefly explain the process involve to gather the required HIV and AIDS data and information for the report. The section also very briefly describes the difficulties experienced in this data collection process.

1. Formation of UNGASS Core Group

In late September 2007, the M&E steering committee of NACS formed an UNGASS Core Group chaired by a representative from NACS and constituted by members from a wide range of institutions given their roles with regard to the national response and specifically in data collection and M&E work. This group had members form NDOH-Surveillance, National research institute, network of PLHIV, civil Society, UNAIDS and WHO among others.

The UNGASS working group has been responsible for planning, programming and directing the various activities to be undertaken through the whole process to complete the UNGASS report on time.

As a primary task, the Core Group organized a national stakeholders workshop to discuss with partners from government and civil society about the UNGASS requirements, the process for finalizing the report, and encourage an active

contribution from civil society organizations. This meeting led to the development of a workplan for finalizing the various components of the report..

2. 1st Stake Holder Meeting

The first stakeholders meeting were held on 25th October 2007 at Holiday Inn. This was a national meeting attended by representatives from all the provinces and all the partners and government that NACS believed have generated and managed HIV and AIDS data.

The meeting deliberated among other issues the importance of the report, the need to support the process and agree to be available when called on to attend meetings to verify data and make other inputs for the UNGASS Report.

3. Selection and Engagement of Consultants

The Core group identified certain tasks to be outsourced to national consultants to undertake**.** These tasks included**;**

a) Consultations and collection of data for **National Composite Policy Index Part B among civil society organizations and donors.**
b) Narrative Report Writing.

Two private consultants and one civil servant were engaged in November and December to undertake their tasks as per TORs developed by the Core Group.

4. Collection of Data for Other Indicators

The Core Group also identified and engaged Senior Program Managers with NACS and NDOH to liaise with research organisation like National Research Institute, PNG Institute of Medical Research and National statistics office to provide data regarding the various surveys on risk behaviour and knowledge of HIV among Most at Risk Populations and the DHS. The Department of Health led the data collection for the other indicators in line with the efforts to report on Universal Access. The working group had regular meetings with statisticians and M&E officers from NACS and NDoH to discuss the collected data and assess its quality. And recommend ways to improve it.

5. National Stakeholders Meeting on Draft report and NCPI

A National stakeholders meeting was called again on 6th December 2007. In this meeting, stakeholders discussed various views and data resulting from individual consultations on the National Composite Policy Index that was gathered and presented before them. The participants had working groups to reach consensus on the final answers and rankings to the NCPI questions where inconsistent views were observed. This led to the final NCPI matrix attached to this report.

6. Finalization of Draft Report with UNGASS Working Group.

While consultations were made maintained with a wide range of stakeholders to provide their contributions to the report, the core working group organized a workshop for data vetting and consolidation of the narrative report.

7. Final Stakeholders Meeting on UNGASS Report

On 21st December 2008, the final UNGASS Report is held. This was the opportunity for all stakeholders to review the pre-final report and provide inputs or comments for the finalization of the report and validate the data collected.

8. Input Data to CRIS System

With Assistance from an external consultant provided by UNAIDS, the M&E team held a workshop on 22-23 January on data entry into CRIS-UNGASS module for its submission in the appropriate deadline and format according to the guidelines.

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent Yes

b) NAP

c) Others (please specify)

With inputs from

Ministries:

	Yes	No
Education	Yes	
Health	Yes	
Labour		No
Foreign Affairs		No
Others (please specify)	Yes	

Law and Justice Sector, Department of National Planning and Monitoring, National Research Institute, PNG Institute of Medical Research, Department of Education, Department of Community Development, Department of Transport.

Civil society organizations	Yes
People living with HIV	Yes
Private sector	Yes
United Nations organizations	Yes
Bilaterals	Yes

International NGOs Yes

Others No

(please specify)

Was the report discussed in a large forum? Yes

Are the survey results stored centrally? No

PNG IMR maintain data from surveys on MARPS, while NSO maintains and manages the DHS Database

Are data available for public consultation? No

Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: __Mr Romanus Pakure, Acting director of the National AIDS Council secretariat___

Date: 31 December 2008

Signature: __Romanus Pakure

Address: _P.O Box 1345, Boroko. National Capital district.

Papua New Guinea_

Email: Romanus_pakure@nacs.org.pg

Telephone:+675 323 6161

ANNEX 3: National Composite Policy Index 2007

COUNTRY: Papua New Guinea

Name of the National AIDS Committee Officer in charge:

Romanus Pakure, Acting director

Signed: Romanus Pakure

Postal address: P.O Box 1345, Boroko. NCD

Papua New Guinea

Tel: (+675) 323 6161

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E-mail: Romanus_pakure@nacs.org.pg

Date of submission: 31 January 2008

National Composite Policy Index Questionnaire

PART A

[To be administered to government officials].

1. Strategic Plan

1. Has the country developed a national multi-sectoral strategy/action framework to combat AIDS?

(Multi-sectoral strategies should include, but not limited to those developed by Ministries such as the ones listed under 2.1)

Yes	Period Covered(*write in*) **2006-2010**		

IF NO or N/A, briefly explain

IF YES, complete questions 1.1 through 1.10, otherwise, go to question 2.

1.1 How long has the country had a multisectoral strategy/action framework?

Number of Years: **5 years**

1.2 What sectors are included in the multisectoral strategy/action framework with a specific HIV budget for
their activities?

Sector included	Strategy/Action Framework	Earmarked Budget
Health	**Yes**	**Yes**
Education	**Yes**	**Yes**
Labour	**Yes**	**No**
Transportation	**Yes**	**No**
Military/Police	**Yes**	**No**
Women	**Yes**	**No**
Young people	**Yes**	**No**
Other* *(write in)*	**Yes**	**No**

* Any of the following: Agriculture, Finance, Human Resource, Justice and Energy, Planning, Public Works, Tourism, Trade and Industry

IF NO earmarked budget, how is the money allocated? **When specific needs arises, for instance if an agency sees a need to develop the workplace policies, the concerned agency would look within the its budget to re program to cater for such needs or seek assistance from the development partners through the NACS as a central coordinating agency..**

1.3 Does the multisectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations		
a. Women and girls	**a. Yes**	
b. Young women / young men	**b. Yes**	
c. Specific vulnerable sub-populations[31]	**c. Yes**	
d. Orphans and vulnerable children	**d. Yes**	
Settings		
e. Workplace	**e. Yes**	
f. Schools	**f. Yes**	
g. Prisons	**g. Yes**	
Cross-cutting issues		
h. HIV, AIDS and poverty	**h. Yes**	
i. Human rights protection	**i. Yes**	
j. PLHIV	**j. Yes**	
k. Addressing stigma and discrimination	**k. Yes**	
l. Gender empowerment and/or gender equity	**l. Yes**	

1.4 Were target populations identified through a process of a need assessment or needs analysis?

Yes	

Though the Social Mapping exercise (carried out nation wide in 2005) that profiled perception and behavioural pattern of youths (both in and Out-of school system), Sex workers and mobile population at the community and district level.

I F YES, when was this needs assessment/analysis conducted? Year: **2005.**

IF NO, how were target populations identified?

[31] Sub-populations that have been locally identified as being at higher risk of HIV transmission (injecting drug users, men having sex with men, sex workers and their clients, cross-border migrants, internally displaced people, refugees, prisoners etc.(

1.5 What are the target populations in the country? *(write in)Compiled*

- **Mobile populations**
- **Young people (15-25 years) in the reproductive age**
- **Women and children**
- **Sex workers and MSM**

1.6 Does the multisectoral strategy/action framework include an operational plan?

	No

NSP is a broad guiding document that does not really specify the operational plan.

1.7 Does the multisectoral strategy/action framework or operational plan include:

a. Formal Program goals?	**Yes**	
b. Clear targets and /or milestones?	**Yes**	
c. Detailed budget of costs per programmatic area?	**Yes**	
d. Indications of funding sources?	**Yes**	
e. Monitoring and Evaluation framework?	**Yes**	

1.8 Has the country ensured 'full involvement and participation 'of civil society[32] in development of the multisectoral strategy/action plan?

Active involvement		

IF active involvement, briefly explain how this was done. **All civil society organizations established an umbrella organization known as PACSO (PNG Alliance of Civil Society Organizations) to represent and involve them in strategy and policy development matters**

IF NO or MODERATE involvement, briefly explain.

1.9 Has the multisectoral strategy/action framework been endorsed by most external development partners (bi- laterals and multi-laterals)?

Yes	

1.10 Have External Development Partners (bi-laterals and multilaterals) aligned and harmonised their HIV and AIDS programmes to the multisectoral strategy/action framework?

[32] Civil society include among others, network of people living with HIV, women's organizations, young people's organizations, faith based organizations, AIDS service organizations, community based organizations organizations of key affected SW, IDU, migrants, refugees,/displaced populations, prisoners),workers organizations, human rights organizations, etc. For the purpose of NCPI, the private sector is considered separately

	Yes, some partners	

IF SOME or NO, briefly explain

For the Health sector, this is done through SWAP mechanism. This is not the case for other sectors.

2. Has the country integrated HIV and AIDS into its general development plans such as: a) National
Development Plans, b) Common Country Assessments/United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach

Yes (its linking more than integration)		

2.1 ***IF YES,*** in which development plans is policy support for HIV and AIDS integrated?

a. National Development Plans	**Yes**	
b. common country assessments/ United Nations Development assistance Framework	**Yes**	
c. Poverty Reduction Strategy Papers	**Yes**	
d. Sector wide Approach	**Yes**	
e. Others		**No**

2.2 ***IF YES,*** in which policy area below are included in these development plans?

√ Check for policy/strategy included

Policy Area	Development Plans				
	a)	b)	c)	d)	e)
HIV Prevention	√	√	√	√	
Treatment for opportunistic infections				√	
Antiretroviral therapy				√	
Care and support (including social security or other schemes				√	
AIDS impact alleviation	√	√	√	√	
Reduction of gender inequalities as they relate to HIV prevention/ treatment, care and/ or support		√	√	√	
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and/ or support	√		√	√	
Reduction of stigma and discrimination			√	√	
Women's economic empowerment	√	√	√		

Other *(write in)* **Orphans and Vulnerable Children**		√	√		

3. Has the country evaluated the impact of HIV anad AIDS on its socio-economic development for
   planning purposes?

Yes		

HEMI Study that was undertaken in 2002-2005

3.1 IF YES, to what extent has it informed resource allocation decisions?

0	1	2	**3**	4	5

4. Does the country have a strategy/ action framework for addressing HIV and AIDS issues among its
   national uniformed services such as military, police and peace keepers, prison staff etc?

Yes	

IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?

Behavioural change communication	**Yes**	
Condom provision	**Yes**	
HIV testing and counselling	**Yes**	
STI services	**Yes**	
Treatment	**Yes**	
Care and support	**Yes**	
Other *(write in)* **Home based care and support**	**Yes**	

What is the approach taken to HIV testing and counselling? Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain

Both the VCT and STI treatment are pre-requisites for tests

5. Has the country followed up on commitments towards universal access made during the High-
   Level AIDS Review in June 2006?

Yes	

5.1 Has the National Strategy Plan/operational plan and national AIDS budget been revised accordingly?

Yes	

5.2 Have the estimates of the size the main target population sub-groups been updated?

Yes	

5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

	Estimates only	

5.4 Is HIV and AIDS programme coverage being monitored?

Yes	

a) IF YES, is coverage monitored by sex (male, female)

Yes	

b) IF YES, is coverage monitored by population sub- groups?

Yes	

IF YES, which sub-populations?

Mostly the young people, sex workers coming through STI clinics/ VCT sites

c) ***IF YES,*** is coverage monitored by geographical area?

Yes	

IF YES, at which level (provincial, district, other)?

Mostly at the provincial / district level across the country

5.5 Has the country developed a plan to strengthen the health system, including infrastructure, human resources and capacities, logistical system to deliver drugs?

Yes	

Included in the National Health Plan (2004-2014)

Overall how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005.

2007	Poor									Good
	0	1	2	3	4	**5**	**6**	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10

Comment on progress made since 2005

No comparison since this is the first Country Progress Reports

II. Political Support

Strong political support and include government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budget to support the AIDS programmes and effective use of government and civil society organizations and process to support effective AIDS programmes

1. Do high officials speak publicly and favourably about AIDS efforts in major domestic for at least twice a year?

President/ Head of government	**Yes**	
Other high officials	**Yes**	
Other high officials in regions/or districts	**Yes**	

2. Does the country have officially recognised national multisectoral AIDS management/ coordination body? (National AIDS Council or equivalent)?

Yes	

IF NO briefly explain

IF YES, *when* was it created? Year **1997**

2.2 ***IF YES*** who is the Chair
[write in name and title/function?]
Dr. Clement Malau
Secretary -Department of Health

IF YES does it;

have terms of reference?	**Yes**	
have active government leadership and participation?	**Yes**	
have defined membership? have civil society representatives? IF YES, what percentage? *(write in)* include people living with HIV? include the private sector	**Yes** **Yes** **30%** **Yes** **Yes**	
have an action plan?	**Yes**	
have a functional secretariat?	**Yes**	
meets at least quarterly? review actions on p[olicy decisions regularly actively promote policy decisions? promote opportunity for civil society to influence decision making strengthen donor coordination to avoids parallel funding and duplication of efforts in programming	**Yes** **Yes** **Yes** **Yes** **Yes** **Yes**	

3 Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes?

Yes	

3.1 ***IF YES*** does it include;

Terms of reference?	**Yes**	
Defined membership?	**Yes**	
Action Plan?	**Yes**	
Functional Secretariat?	**Yes**	
Regular meetings	**Yes**	
	Frequency of Meetings: **Quarterly**	

IF YES, what are the main achievements?

Establishments of :

- **Mid Term Plan (MTP)**
- **National Strategic Plan (NSP)**
- **Development of Monitoring and Evaluation Framework**
- **Joint Budget Planning Framework (Gov, CBOs, NGOs, FBO etcs)**
- **HIV and AIDS Management and Prevention Act**
- **National Network for Positive People**
- **Provincial AIDS secretariats in all provinces**

IF YES, what are the main challenges for the work of the body?

Some of the challenges:

- **Drug procurement and distribution to districts and community health facilities and care centres**
- **Remote and inaccessible areas are hard to reach with appropriate intervention programmes**
- **Acceptance of infected and affected segment population by community at large (Stigmatization and discrimination is high)**
- **Care and support for the PLWHA**
- **Lack of qualified staff (capacity) for effective coordination and management of the national response.**
- **Implementation of the National Strategy Plan**
- **Implementation/ enforcement of HIV and AIDS Management and Prevention Act and other relevant Policies**
- **Implementation of National Monitoring and Evaluation Framework**
- **Effective networking for database yet to be established**

2 What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year?
Percentage: **50% (estimate)**

3 What kind of support does NAC (or equivalent) provide to implementing partners of the national programmes, particularly to civil society organizations

Information on priority needs and services	**Yes**	
Technical guidance / materials	**Yes**	
Drugs/ supplies procurement and distribution	**Yes**	
Coordination with other implementing partners	**Yes**	
Capacity building		
Other: *(write in)*		

1. Has the country reviewed the national policies and legislation to determine which, if any, are inconsistent with the National AIDS control policies?

Yes	

- **NSP developed as a result of MTP**
- **HAMP Act developed after a comprehensive review of appropriate laws, legislations, regulations and policies in**

These are milestone achievements in terms of policy and legal environment

6.1 ***IF YES,*** were policies and legislations amended to be consistent with the National AIDS control policies

Yes	

6.2 ***IF YES***, which policies and legislations were amended and when?*

Policy/Law:	Year:
Relevant Acts, Laws, Polices and Regulations on Rights Issues, freedom of choice, protection such Ethic Law, Public Health Act were reviewed to cater for the provisions stated under the NACS Act. This review led to formulation and enactment of HAMP Act in 2003	**2002**

[List as many as relevant]

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and 2005											
2007 Poor											Good
	0	1	2	3	4	5	6	**7**	8	9	10
2005 Poor											Good
	0	1	2	3	4	5	6	7	8	9	10
Comment on progress made since 2005											

III. Prevention

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general* population?

Yes	No	N/A

IF YES, what key messages are explicitly promoted?
√ Check for key message explicitly promoted.

Be sexually abstinent	√
Delay sexual debut	√
Be faithful	√
Reduce the number of sexual partners	√
Use condom consistently	√
Engage in safe(r) sex	√
Avoid commercial sex	√
Abstain from injecting drugs	√
Use clean needles and shringes	**Not available**
Fight against violence against women	√
Greater acceptance and involvement of people living with HIV	√
Greater involvement of men in reproductive health programmes	√
Other *(write in)*	

1.2 In the last year, did the country implement an activity on programme to promote accurate reporting on HIV by the media?

Yes	

2.0 Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes	

3.5 Is HIV education part of the curriculum in:

Primary schools?	**Yes**	
Secondary schools?	**Yes**	
Teacher training?	**Yes**	

2.2 Does the strategy/ curriculum provide the same reproductive and sexual health education for young men and young women

Yes	

2.3 Does the country have an HIV education strategy for out of school young people?

Yes	

3 Does the country have policy or strategy to promote information, education and communication and other preventive health interventions for vulnerable sub-populations?

Yes	

IF No, briefly explain

3.1 IF YES, which sub-populations and what elements of HIV prevention do the policy/ strategy address?

√ Check for policy/ strategy included?

	IDU	MSM	Sex worker	Clients of sex workers	Prison inmates	Other sub-populations *(write in)*
Target information on risk reduction and HIV education		√	√	√	√	
Stigma and discrimination reduction		√	√	√	√	
Condom promotion		√	√	√	√	
HIV testing and counselling		√	√	√	√	
Reproductive health, including STI prevention and treatment		√	√	√	√	
Vulnerability reduction (e.g, income generation)	N/A	N/A	√	N/A	N/A	
Drug substitution therapy		N/A	N/A	N/A	N/A	
Needle and syringe exchange		N/A	N/A	N/A	N/A	

Overall, how would rate policy efforts in support of HIV prevention in 2007 and in 2005?											
2007 Poor											Good
	0	1	2	3	**4**	5	6	7	8	9	10
2005 Poor											Good
	0	1	2	3	4	5	6	7	8	9	10
Comments on progress made since 2005 –											

4 Has the country identified the district (or equivalent geographical / decentralized level) in need of HIV prevention programmes?

Yes	

IF NO, how are HIV prevention programmes being scaled-up?

IF YES, what extent have the following HIV prevention programmes been implemented in identified districts* in need?
√ Check the relevant implementation level for each activity or indicate N/A if not applicable?

HIV Prevention programmes	**The service is available in**		
	***All* districts* in need**	***Most* districts in need**	***Some* districts in need**
Blood safety	√		
Universal precautions in health care settings	√		
Prevention of mother –to- child transmissions of HIV			√
IEC on risk reduction		√	
IEC on stigma and discrimination			√
Condom promotion	√		
HIV testings and counselling		√	
Harm reduction and injection drug users			**Not available**
Risk reductions for men who have sex with men			√
Risk reduction for sex workers		√	
Programmes for other-most-at risk populations			√
Reproductive health services including STI prevention and treatment	√		
School- based AIDS education for young people	√		
Programmes for out-of –school young people			√
HIV prevention at workplace		√	
Other programmes *(write in)*			

*Districts or equivalent geographical /de-centralized government levels in urban and rural areas

Overall, how would rate policy efforts in support of HIV prevention in 2007 and in 2005?

2007	Poor									Good
	0	1	2	3	4	5	6	**7**	8	9	10
2005	Poor									Good
	0	1	2	3	4	5	6	7	8	9	10

Comments on progress made since 2005 – **No comparison at this stage of the reporting**

IV. Treatment, care and support

1 Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care and home and community based care).

Yes	

IF YES, does it give sufficient attention to barriers fro women, children and most at risk populations?

Yes	

2. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support?

Yes		

In Some places considered hot spots such as mining sites and large urban centres. The epidemic is ' generalized' and prevalence is more severe in some parts of the country

IF NO, how are HIV and AIDS treatment, care and support services being scaled up?

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts* in need?

√ Check the relevant implementation level for each of activity or indicate N/A if not applicable.

HIV treatment , care and support services	The service is available in		
	All districts* in need	*Most* districts in need	*Some* districts in need
Antiretroviral therapy		√	
Nutritional Care			**Not Available**
Paediatric AIDS treatment			√
Sexually transmitted infection management		√	
Psychosocial support for people living with HIV and their families			√
Home- based care			√
Palliative care and treatment for common HIV related infections			√
HIV testing and counselling for TB patients			√
TB screening for HIV- infected people			√
TB therapy for HIV infected people			√
TB infection control in HIV treatment and care facilities			√
Cotrimoxazole prophylaxsis in HIV infected people		√	
Post exposure prophylaxsis (e.g. occupational exposure to HIV, rape)			√
HIV treatment services in the workplace or treatment referral system through the workplace		√	
HIV care and support in the workplace (includiong the alternative working arrangements)			√
Other programmes *(write in)*			

*Districts or equivalent geographical /de-centralized government levels in urban and rural areas

3. Does the country have policy for developing/ using generic drugs or parallel importing of drugs for HIV?

Yes	

4. Does the country have access to regional procurement and supply management mechanism for critical commodities, such as antiretroviral drugs, condoms and substitution drugs?

Yes	

IF YES , for which commodities? *(write in)*
Condoms, ARVs drugs, Test kits and Opportunistic Infection drugs

5. Does the country have a policy or a strategy to address the additional HIV- or AIDS related needs for orphans and vulnerable children (OVC)?

Yes	No	N/A

5.1 IF YES, is there an operational definition for OVC in the country?

	No

5.2 IF YES, does the country have a national action plan specifically for OVC?

5.3 IF YES, doe the country have an estimate of OVC being reached by existing interventions?

5.4 IF YES, what percentage of OVC is being reached? % *(write in)*

Overall, how would you rate the efforts to meet the needs of the orphans and orphans and other vulnerable children ?											
2007 Poor											Good
	0	1	2	3	**4**	5	6	7	8	9	10
2005 Poor											Good
	0	1	2	3	4	5	6	7	8	9	10
Comment on progress made since 2005 In 2005, it was realized that orphans and vulnerable children in PNg did not receive special medical support, school related assistance, emotional of psychological support including counselling and other material or social support like clothing, extra food, childcare and legal support from the national government. UNICEF supported the government to conduct a number of situation analysis to contribute to stonger empirical decision making. In 2007, four-year national strategy for protection, care and support to OVCs in PNG wasdeveloped by the OVC national Action Committee. The strategy draws from local knowledge and international experience to deliver 39 actions for children over 4 years. Key objectives identified for the strategy include improved social protection; legal protection and justive; extended community care in the community, and human services coordination.											

IV Monitoring and Evaluation

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

		In progress	

1.1 IF YES, was the M&E Plan endorsed by the key partners in M&E?

yes	No

IF YES, was the M&E Plan developed in consultation with the civil society, including people living with HIV?

yes	No

IF YES, have key partners aligned and harmonised their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, most partners	Yes, but only some partners	No

2. Does the Monitoring and Evaluation plan include:

a data collection and analysis strategy	**Yes**	
behavioural surveillance	**Yes**	
HIV surveillance	**Yes**	
a well defined standardized set of indicators	**Yes**	
guidelines on tools for collection	**Yes**	
a strategy for assessing quality and accuracy of data	**Yes**	
a data dissemination plan	**Yes**	

3. Is there a budget for the M&E plan?

Yes	Years covered: **Annual Budget allocation since 2006**		

3.1 IF YES, has funding been secured?

Yes	

4. Is there a functional M&E Units or Department

Yes		

IF NO, what are the main obstacles to establishing a functional M&E Unit/ Deparments

4.1 IF YES, is the M&E Department/Unit based

in the NAC (or equivalent)	**YES**	
in the Ministry of Health		**NO**
elsewhere *(write in)*		

4.2 IF YES, how many and what type of permanent and temporary professional staff are working in the M&E Unit/ Department?

Number of permanent staff	**4 Fulltime staff**	**Since 2005**
Position *(write in)* **Manager- Policy and M&E**	**Fulltime**	**2005**
Position *(write in* **M&E Advisor (Joint UN- Program)**	**Fulltime**	**2005**
Position *(write in)* **Senior M&E Officer**	**Fulltime**	**2006**
Position *(write in)* **Statistician**	**Fulltime**	**2006**
Number of temporary staff	**None**	

4.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/ Department for review and consideration in the country's national reports?

Yes	

IF YES, does this mechanism work? What are the major challenges

The data collection mechanism has been developed and is has been introduced to the provinces since the end of 2007. there is good response from the provinces in terms of cooperation, but data is not collected from all provinces as expected. Some of the challenges are

- Lack of capacity to follow up with the partners to collect required data
- Lack of centralised data flow system
- Coordination mechanism with provincial data collection system is weak

4.4 IF YES, to what degree do UN, bi-laterals and other institutions share their M&E results?

Low				High	
0	1	2	**3**	4	5

5. Is there a M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No	Yes, but meets irregularly	**Yes, meets regularly**

IF YES, date last meeting: **26/11/2007**

5.1 Does it include representation from civil society, including people living with HIV?

	No

IF YES, describe the role of civil society representatives and people living with HIV in the working group?

Does the M&E Unit/ Department manage a central national database?

	No	

6.1 IF YES, what type is it? *(write in)*

6.2 IF YES, does it include information about the content, target populations and geographical coverage of programmatic activities, as well as their implementing organizations?

6.3 Is there a functional * Health Information System?

National level	**Yes**	
Sub-national level IF YES, at what level(s) *(write in)*	**Yes**	

**regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels)*

6.4 Does the country publish at least once a year an M&E report on HIV, including surveillance data?

Yes	

6. To what extent is M&E data used in planning and implementation?

Low				High	
0	1	2	**3**	4	5

What are examples of data use?
• **Step up ART Administration** • **Identify development programs for target groups**

What are the main challenges of data use?
Data not easily accessible because a data flow system was not established for a long time and is not in existence to date.

7. In the last year, was training in M&E conducted?

At national level?	**Yes**	
IF YES, Number of individuals trained; *(write in)*	**435**	
At sub-national level?	**Yes**	
IF YES, Number of individuals trained; *(write in)*	**421**	
Including civil society?	**Yes**	
IF YES, Number of individuals trained; *(write in)*	**96**	

Overall, how would you rate the M&E efforts of the AIDS programme in 2007 and 2005?										
2007 Poor										Good
	0	1	2	3	4	**5**	**6**	**7**	8	9	10
2005 Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
Comment on progress made since 2005 Great efforts are being done to establish an effective M&E system in country. While there was no M&E unit and no data reporting in 2005, the newly established M&E at NACS, and the surveillance team at NDOH are working against the clock to set up and establish systems for data reporting on the HIV epidemic and the National response. While plans are being finalized, investment on capacity building at national and provincial levels, establishing infrastructure, and developing systems was the main focus of the limited M&E staff in country. Ranking for 2005 could not be done as there was no proper assessment done at that time.											

PART B

[To be administered to representatives from non governmental organizations, bilateral agencies and UN organizations]

2. Human rights

4. Does the country have laws and regulations that protect people living with HIV against discrimination? (such as general non-discrimination provisions or provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)
5.

Yes	

IF YES, specify *[write in]* **HIV/ AIDS Management and Prevention Act – HAMP (August 2003)**

6. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations

Yes	

3.1 ***IF YES,*** for which sub-populations?

Women	**Yes**	
Young People	**Yes**	
IDU		**No**
MSM		**No**
Sex Workers		**No**
Prison Inmates		**No**
Migrant/mobile populations		**No**
Others [write in]		

IF YES; Briefly explain what mechanisms are in place to ensure these laws are implemented.

- The National AIDS Council Secretariat (NACS) has been established under the section 20 of the *National AIDS Council Act* (1977), to oversee the coordination and implementation of the HAMP Act in collaboration with its network of implementing partners made up of Government departments, NGOs, Churches, Civil society and private sector organizations and donors.
- A user friendly tool kit on HAMP Act was produced in 2003 for the employers and workers to formulate their HIV and AIDS Workplace Policies.
- Series of trainings were held for the organizations to ensure framing up workplace policy is consistent with 12 guiding principles of workplace policy.
- PACSO (PNG Alliance of Civil Society Organizations) and BAHA (Business Against HIV and AIDS) were recently established to include the implementation of the Act as part of their organizational mandate.
- Provisions were made in the National M&E Strategy for monitoring the implementation of the Acts
- A notable development at the political level was the appointment of a separate Government Minister to advocate and lobby, among other HIV and AIDS related issues, for the Government support towards the implementation of this Act.

IF YES, Describe any systems of redress put in place to ensure the laws are having their desired effect:

- Organizations such as IGAT HOPE is supported to promote among other HIV issues, the rights of the people affected by HIV as stipulated under the HAMP Act
- Increased donor support (both technical and finance) is being provided for effective coordination and implementation of relevant sections of the Act.
- Increased partnership and net-working is being forged amongst the key stakeholders, NGOs and civil society groups to harmonize and complement their activities where necessary, and to reduce duplication and inefficiency.
- Since the enactment of the Bill on Discrimination and Stigmatization covered under the HAMP Act, increasing number of affected people have come out of anonymity and made admission in public their HIV status.
- With the extensive outlay of information on rights and protections issues, number of people accessing VCT services, have increased significantly.
- At the political level bi-partisan political commitment has been ensued to increase the profile

3. Does the country have laws, regulations or policies that present obstacles to an effective? HIV prevention, treatment, care and support for vulnerable sub-populations?

Yes	

IF YES, for which sub population?

Women		**No**
Young People mostly		**No**
IDU (The cases of IDU is not so common in the country, hence no specific policy is in place for this group)	**Not applicable**	
MSM	**Yes**	
Sex Workers	**Yes**	
Prison Inmates	**Yes**	
Migrant/mobile populations		**No**
Other [*write in* **PLHIV**		

IF YES; Briefly explain what the contents of these laws, regulations and how they pose barriers.

- The Underlying Law (Act) 2000 (sections 3 and 4) include customary laws which stipulate that female commercial sex work (prostitution) and MSM (sodomy) are crimes under the PNG Law.
- Stigmatization and discrimination against these marginalised and most at risk groups therefore remain high and drives them 'underground' where they are less accessible to care and assistance. This makes it hard for the NGO's and civil society groups to respond effectively.
- Failure to formulate appropriate Act to decriminalize the activities of the sex workers and MSM, drive the groups to maintain anonymity while increasing their network, membership, client-base and other related activities.
- The current estimate of MSM is numbered between 3,000 (2007 estimate).
- The physical and sexual violence against the women is continually on the increase, impacting on the possibility of increased new cases of STIs, HIV and AIDS infections.
- The HAMP Act is too broad and does not have provisions that cater for the legal protection of the persons discriminated on the grounds of their preference of their sexual partners and sexual activity.
- This aspect of the law has not been contested in PNG court of law.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes	

HAMP Act, National Gender Policy, Workplace Policy for Education

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and or most-at-risk populations?

Yes	

IF YES; Briefly describe this mechanism?

There are institutions and NGOs in the country that have developed their database to document HIV and AIDS information for their own monitoring and planning purposes.

- Catholic Church through its VCT centres through out the country record and documents cases of abuse and discriminations.
- Other NGOs such as Save the Children has pooled together data on MSM and sex workers through its Sapot Project initiatives.
- Police and CIS department have records of complainants on HIV and AIDS related abuses.
- Under the NHASP initiative, extensive Social Mapping exercise was initiated throughout the country. The situational profile of HIV and AIDs at district level provide useful data on how HIV and AIDs is perceived at different cultural settings.
- Pooling together all information from various organizations under one national system is the major challenge that needs to be addressed.

6. Has the Government, through political and financial support, involve most-at-risk populations in governmental HIV-policy design and programme implementation?

Yes	

IF YES; Briefly describe some examples.

Listed below are some of the policies and programs in which the Government through NACS, involved the participations of youths, women, representatives of MSM and sex workers and other marginalised groups.

- National Strategic Plan (2006)
- HAMP Act (2003)
- Development of Workplace policy initiatives
- Social Mapping Exercises
- National Gender Policy
- National Youth Policy
- 100% Condom Use Policy

7. Does the country have a policy of free services for the following:

HIV prevention services	Yes	
Anti-retroviral treatment	Yes	
HIV-related care and support interventions	Yes	

IF YES*;* given the resource constraint, briefly describe what steps are in place to implement these policies;

- HIV Prevention Services are established in all Government health facilities, over 60 VCT sites and NGOs service centres and outlets throughout the country are promoting HIV Prevention messages.
- ART services are offered free and available in the Government service sites (hospitals, clinics and health centres) and NGO, FBO,CBO clinics. Access to this service by remote communities is major problem
- HIV- related care and support interventions are promoted through partnership with NGOs and community based organizations (CBO's). Relevant information and advocacy materials are provided to the communities to strengthen community participation towards the care and support for the affected members of their communities.
- The Home-Based Care, an initiative of the Catholic Church in the country is currently tried out in number of areas The approach is quite effective approach and can be easily rolled out to other r parts of the country

8. Does the country have a policy to ensure equal access for women and men to prevention, treatment, care and support? In particular, to ensure access for women outside the context of pregnancy and child birth?

Yes	

9. Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support?

Yes	

9.1 Are there differences in approaches for different most-at-risk populations?

Yes	

IF YES; briefly explain the differences?

- Due to nature of the disease, different approaches are deemed necessary in provision of care and treatment among the members of different at-risk population groups.
- Under the HAMP Act (in compliance with the National Constitution) provision on person's the rights to privacy and confidentiality is stated. Hence, care and treatment are accorded under this provision. Example:
  - female sex workers feel comfortable to seek counselling or treatment by female medical /social work

  - likewise the MSM would be inclined to seek help from same-sex counsellor or physician.
- The VCT/ STI treatment and care sites are made gender-sensitive to ensure equal and free access.

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment. assignment/relocation, appointment, promotion, termination)?

Yes	

Employment Act, HAMP Act

11. Does the country have a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national /local ethical review committee?

Yes	

National AIDS Council Act

11.1 ***IF YES***, does the ethical review committee include representatives of the civil society and people living with HIV?

Yes	

IF YES; describe the effectiveness of this review committee.

- The committee has been in operation for number of years and is quite effective on research matters..
- The committee operates under chairmanship of the Divine University, one of the three leading tertiary institutions in the country.
- The members of the committee consists of representatives from the Universities, Research institutions, NSO, NACS, NDOH, NDOE, representatives from donors, NGOs and civil society groups
- Conference was conducted recently with the stakeholders and partners to set the research agenda for the Research Advisory Committee and NACS to pursue.
- The committee has new guidelines drawn up (based on research proposals) and meeting regularly.
- So far, --- (number) of research proposals are submitted, including ---(number) researched relating to HIV/ AIDS.

12. Does the country have the following human rights monitoring and enforcement mechanisms?

-Existence of independent national institutions for the promotion and protection of human rights, including human rights commission, law reform commissions, watch dogs and ombudspersons which consider HIV-related issues within their work.

Yes	

Ombudsman Commission, ICRA, Amnesty International, Transparency International, NGO watchdog. Law Reform Commission, Police and National Magisterial system

-Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

	No

-Performance indicators or benchmarks for

a) compliance within human rights standards in the context of HIV efforts

	No

b) reduction of HIV-related stigma and discrimination

	No

IF YES; on any of the above questions, describe some examples;

13. Have any members of the judiciary (including labour courts/employment tribunals) been trained /sensitized to HIV and aids and human rights issues that may come up in the context of their work?

Yes	

14. Are the following legal support services available in the country?

- Legal aid system for HIV and AIDS case work?

Yes	

- Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV?

	No

- Programmes to educate, raise awareness among people living HIV concerning their rights

Yes	

15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance?

Media	Yes	
School education	Yes	
Personalities regularly speaking out	Yes	
Other (*write in*) **Performing Theatre Groups**: This has become very popular way of educating people, especially young people on HIV and AIDS. Under the NHASP initiative, theatre groups were established in every province. To ensure that the information is accurate, groups were trained to use standard scripts that promote gender equality and human rights issues.		

Overall how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005

2007	Poor										Good
	0	1	2	3	4	5	**6**	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10

Comments on progress made since 2005

- Since there was no reporting done in the previous round of UNGASS to use as benchmark, it would not be realistic to compare the progress made since 2005.
- Nonetheless, the country has made improved significantly in policy development for the HIV and AIDS in recent years, particularly in regard to development of the Workplace policies and National Gender Policies

Overall how would you rate the effort to enforce the existing policies, laws and regulations in 2007 and in 2005											
2007	Poor										Good
	0	1	2	3	**4**	5	6	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10

Comments on progress made since 2005.

- Number of very appropriate and have been developed, including the NACS Act (1997), HAMP Act (2003) 100% Condom use policy, Blood transfusion policy, Blood testing policy, National Gender Policy.

The enforcement mechanisms to achieve the desired outcomes remains the main challenge for the country

II. Civil society participation

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulation?

   Low 0 1 2 3 **4** 5 High

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on AIDS or for the current activity plan (e.g. attending planning meetings and reviewing drafts)

   Low 0 1 2 3 4 **5** High

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included?

   a. In both the National Strategic Plan and national reports?

   Low 0 1 2 3 **4** 5 High

   b. In the national budget?

   Low 0 1 **2** 3 4 5 High

4. Has the country included civil society in a National Review of the National strategic Plan?

Yes	No

   IF YES, when was the last review conducted? Year: (write in) **Review of NSP in 2007,**

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?

   Low 0 1 2 3 **4** 5 High

List the types of organizations representing civil society in HIV and AIDS efforts

CIVIL SOCIETY ORGANIZATIONS	NON-GOVERNMENT ORGANIZATIONS
• Igat Hope • Friends Foundation • 3 Angels • PNG Alliance of Civil Society Organizations (PACSO) • Catholic Secretary • Angli-care Stop Aids • Salvation Army • PNG Council of Churches • PNG Media Council	• Business Against HIV and AIDS • Save the Children • Hope Worldwide • Red Cross • Christian Children's Fund • World Vision

6. To what extent is civil society able to access

- adequate financial support to implements it HIV activities?

Low					High
0	1	2	3	**4**	5

b. adequate technical support to implements it HIV activities?

Low					
0	1	2	**3**	4	5

Overall how would you rate the efforts to increase civil society participation in 2007 and 2005?

2007	Poor										Good
	0	1	2	3	4	5	6	**7**	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10

Comments on progress made since 2005

- The recognition and involvement of Civil Society in all areas of HIV and AIDS is very significant.. Financial and technical support is positive, a reflection of the critical roles they play in the fight against HIV and AIDS
- Comparison with 2005 is not possible since no UNGASS Report has been produced for this period.

III. Prevention

1. Has the country identified the district (or equivalent geographical / decentralized level) in need of prevention programmes?

Yes	

IF NO, how are HIV prevention programmes being scaled-up?

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts in need?

√ Check the relevant implementation level for each activity or indicate N/A if not applicable?

HIV Prevention programmes	**The service is available in**		
	***All* districts* in need**	***Most* districts in need**	*Some* **districts in need**
Blood safety	√		
Universal precautions in health care settings	√		
Prevention of mother –to- child transmissions of HIV		√	
IEC on risk reduction		√	
IEC on stigma and discrimination			√
Condom promotion		√	
HIV testings and counselling		√	
Harm reduction and injection drug users			
Risk reductions for men who have sex with men			√
Risk reduction for sex workers			√
Programmes for other-most-at risk populations			√
Reproductive health services including STI prevention and treatment		√	
School- based AIDS education for young people	√		
Programmes for out-of –school young people			√
HIV prevention at workplace			√
Other programmes *(write in)*			

*Districts or equivalent geographical /de-centralized government levels in urban and rural areas

Overall how would you rate the efforts in implementation of HIV prevention programmes in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	**6**	7	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10

Comments on progress made since 2005

The implementation of HIV prevention activities is encouraging, but there is more needs to be done as yet. Since the development of the NSP 2006-2010, HIV prevention activities are being increasingly scaled up reaching people in different areas and different groups that are most at risk.

IV. Treatment, Care and Support.

1. Has the country identified the district (or equivalent geographical / decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes	

IF *NO,* how are HIV and AIDS treatment, care and support being scaled-up?

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in identified districts* in need?

√ Check the relevant implementation level for each activity or indicate N/A if not applicable?

HIV and AIDS treatment, care and support services	**The service is available in**		
	***All* districts* in need**	***Most* districts in need**	*Some* **districts in need**
Antiretroviral therapy		√	
Nutritional Care			√
Paediatric AIDS treatment			√
Sexual transmitted infection management		√	
Psychosocial support for people living with HIV and their families			√
Home-based care			√
Palliative care and treatment fro common HIV-related infections			√
HIV-testing and counselling for TB patients			√
TB screening for HIV-infected people			√
TB preventive therapy for HIV-infected people			√
TB infections control in HIV treatment and care facilities	√		
Cotrimoxazole prophylaxis in HIV- infected people	√		

*District or equivalent geographical de-centralized governmental level in urban and rural areas.

HIV and AIDS treatment, care and support services	**The service is available in**		
	***All* districts* in need**	***Most* districts* in need**	*Some* **districts in need**
Post exposure prophylaxis (eg; occupational exposures to HIV, rape)		√	
HIV treatment services in the workplace or treatment referral systems through the work place	√		
HIV care and support in the workplace (including alternative working arrangements)			√
Other programmes *(write in)*: **OVC Care and support**			√

* Districts or equivalent geographical /de-centralized levels in urban and rural areas

Overall how would you rate the efforts in the implementation of HIV treatment , care and support in 2007 and in 2005?											
2007	Poor										Good
	0	1	2	3	4	5	6	**7**	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10

Comments on progress made since 2005
Treatment has started in country in 2005, there are great efforts being made to scale up treatment, care and support throughout the country. In 2007, the number of sites providing ART has reached 38, whole it was very limited in 2005. the total number of people on treatment reached 2250 by December 2007.

2. What percentage of the following HIV programmes or services is estimated to be provided by civil society

Prevention for Youths		**25-50%**		
Prevention for vulnerable sub-pop;				
-IDU	**<25%**			
-MSM				**>75%**
-Sex workers			**50-75%**	
Counselling and Testing			**50-75%**	
Clinical services (OI/ART)*		**25-50%**		
Home-based care				**>75%**
Programmes for OVC			**50-75%**	

* Opportunistic infections

Does the country have a policy or strategy to address the additional HIV and AIDS -related needs of orphans and other vulnerable children (OVC)?

Yes		

5.1 ***IF YES***, is there an operational definition for OVC in the country?

Yes	

5.2 ***IF YES,*** does the country have a national action plan specifically for OVC?

Yes	

5.3 ***IF YES,*** does the country have an estimate of OBC being reached by existing interventions?

	No

5.4 ***IF YES***, what percentage of OVC is being reached? % *(write in %)*

Overall how would you rate the efforts in the implementation of HIV treatment , care and support in 2007 and in 2005?												
2007	Poor										Good	
	0	1	2	3	4	5	**6**	7	8	9	10	
2005	Poor										Good	
	0	1	2	3	4	5	6	7	8	9	10	
Comments on progress made since 2005 **The National situation analysis was conducted in 2005 and published in 2006, and a national coordination mechanism was established in 2006. drafting the National Action Plan for OVCs 2007-2008 was led by the government and costed by the UN. Programs designed in 2007 targeting village –level and FBO response, in 2006, a child Protection legislation was passed recognizing OVCs as vulnerable and also limiting the use of institutional care for OVCs. An intensive program will be rolled out in 2008**.												