
UNGASS 2010

***Country Progress Report
Papua New Guinea***

Reporting Period

January 2008 – December 2010

**PNG National AIDS Council Secretariat
and Partners**

March 2010

Acknowledgements

At the United Nations General Assembly Special Session (UNGASS) held in 2001, 189 Member States adopted the Declaration of Commitment on HIV/AIDS; and PNG was among these States that initially adopted this Declaration.

Every two years member states are required to report to the UN General Assembly, a on their progress towards achieving the goals of the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS. The first UNGASS reporting round was in 2004. PNG submitted its first UNGASS report in 2008.

The notable difference and improvement in the 2010 UNGASS Country Report is the National Composite Index component of the report. It is more in-depth and comprehensive than the last report because the Core Working Group invested greater effort and more funds to ensure the success of the process. In addition, this report covers nearly all of the 25 indicators, unlike the last report where only 16 indicators were reported on.

The National AIDS Council Secretariat (NACS) played a coordinating role for the reporting process with UNAIDS facilitating technical support as required and engaging UNDP, UNICEF and WHO country offices. The UNGASS reporting process requires a wide participation of stakeholders from government agencies, NGOs, faith-based organisations, civil society organisations, bilateral organisations and UN agencies. During the process nearly 50 organisations were consulted on a one-on-one basis to provide relevant data and information. The majority of these organisations also participated in a series of four stakeholder consultations and data vetting workshops held between October 2009 and March 2010 and providing valuable input and working together to achieve a consensus on the data to be submitted.

The successful completion of the UNGASS 2010 Country progress report was the result of efforts invested by many stakeholders, members of the UNGASS Core Working Group and short term consultants during all stages of data collection, synthesis, writing and editing. NACS is indebted to many, but would like to especially acknowledge the key members of the UNGASS Core Working Group: Dr Joachim Pantumari (NACS), Ms Doreen Manadari (NACS), Mrs Agnes Gege (NACS), Mr Tony Lupiwa (NACS), Dr Moale Kariko (PACSO), Mrs Anne McPherson (Igat Hope Inc), Dr. Kitur Uarang (NDoH), and Dr Fumi Yokota (NDoH).

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Valuable data which informed the development of the PNG UNGASS indicators and the discussion of the response included in the report was provided by, among others, NRI, NDoH, PNG IMR, SCiPNG, FHI, and the National Catholic AIDS Office. NACS greatly acknowledges your meaningful contribution to the report.

Finally, without adequate funding , the reporting process would have not been possible. In addition to the funding provided by NACS, UNAIDS, UNDP and UNICEF all provided financial support in a timely manner and NACS gratefully acknowledges this support.

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Status at a glance

Papua New Guinea became the fourth country in the Asia Pacific region to declare a generalized HIV epidemic, after the prevalence of HIV among women attending the Port Moresby General Hospital antenatal care clinic surpassed one percent (1%) in 2003.*

At the end of December 2008 the country recorded a total of 28294 since the first case of HIV was reported in 1987. Females accounted for 59% of the cases while 40% were males. The median ages were 27 in females and 33 years for males. At the same time the number of infected children continues to increase. Ninety-three percent of all reported HIV cases in the country has been reported from eight provinces which includes National Capital District (40%), Morobe (7%), Madang (2%) and the five highlands provinces (Western Highlands Province 17%; Eastern Highlands Province ,15% ; Enga 7%; Southern Highlands Province ,5% and Simbu 2.5%.

The main self-reported route of transmission among reported HIV cases is heterosexual (46.9% in 2008), followed by vertical (1.6%) and homosexual (0.2%); it should be noted that in more than half of the cases (51.4%) no possible route of transmission has been reported, which makes interpreting the above figures harder, especially regarding the very low share for homosexual transmission†.

The peak age for women and men, reported through the routine case reporting system, is also different, while the peak age among women have been the age group 20 – 24, followed by 25 – 29 and 30 – 34. The figure among men is different and the peak age is the 30 – 34 group followed by 25 – 29, 35 – 39 and 40 – 44; indicating the importance of age-mixing in transmitting the virus from older men to younger women‡. Nevertheless, the difference might be related to the fact that many cases among women are found through the ANC clinics, when women tend to be at lower ages.

In the past couple of years, the total number of women testing positive for HIV was clearly higher than men. The results might be related to the nature of case detection system which is heavily dependent on cases reported from ANC centres, to a genuine higher prevalence among women, or a combination of both. The last explanation looks more valid, as the case detection proportion among clients of VCT centres in 2008 has been 4.7% in women versus 3.8% in men. The total number of women and men attending VCT centres did not differ that much in 2008 (23028 women versus 22465 men)§.

The number of people tested has increased exponentially and by the end of December 2008 120,000 people were tested for HIV. The HIV testing has also been scaled up the STI, ANC and TB clients. In 2008, among the 3845 STI patients tested (2388 women and 1457 men); a total of 310 cases of HIV infection were found (8.1%). The prevalence was higher among women

* - NDoH and NACS, 2007

† - ibid

‡ - ibid

§ - NDoH, 2009

(8.2%) than men (7.8%), though the difference was less than what has been found among VCT clients. Among 793 TB patients tested in 2008, 18 cases were found (3.5%)*.

The country has also achieved a lot in scaling up the national ART program. At the end of December 2009 over 6000 PLHIV were put on HAART with an overall survival rate of 83%. The country has also been supported well in striving to implement activities that will have a great impact on the HIV epidemic. The number of partners and stakeholders continue to increase with the focus moving towards scaling up the response in the rural communities and at the same time strengthening partnerships to avoid over laps.

PNG is one of the few countries in the Western Pacific region that has performed outstandingly in scaling up its care and treatment program and achieved at the end of December 2009 a 61% coverage of people on HAART. HIV testing has also been very successful with over 300 facilities accredited to be testing for HIV at the end of 2009. Coupled with this there was an increase of 50% of people testing for HIV between 2007 and 2008 and 260% between 2008 and 2009.

The involvement of PLHIV is also being strengthened with the focus to actively involve PLHIV in all facets of the national response. A lot of effort has been invested in strengthening the national surveillance and M&E systems. The formation of the ProMEST (Provincial Monitoring and Evaluation and Surveillance teams) and the ongoing implementation of the surveillance plan 2008-2010 has contributed a lot to ensuring the availability of quality and timely strategic information to guide implementation. For the first time the country is reporting on behavioural survey (BSS) data that has been generated through BSS undertaken in sub-populations across the country.

The enabling environment for a better and sustained response has been put in place through the implementation of the current National Strategic Plan 2006 – 2010. The plan is in its final year of implementation and a lot has been achieved. The new National HIV Strategy 2011 – 2015 is now being developed. The process for the development of the next strategy has been very consultative and aims to build on from the current achievements to achieve a more targeted and sustainable way on how the country will respond to the HIV epidemic.

A lot of challenges remain for the country and the next few years will determine how the country is going to respond to the epidemic. These include the following key challenges, Political leadership, managing and coordinating the HIV response, strengthening and mobilizing rural communities to strengthen their resolve to respond to the epidemic, strengthening the Health Systems to ensure that the system is primed to adequately provide the full range of prevention, care and treatment and support services. Strengthening the M&E both the national and program levels to guide policies and strengthen evidence based interventions. Addressing these challenges will go a long way in strengthening the community responses and systems to ensure that a better coordinated HIV response is sustained.

* - NDoH surveillance unit database

UNGASS Indicators Overview 2010

Indicators	Value	Method of Data Collection
National Commitment and Action		
Expenditures		
1. Domestic and international AIDS spending by categories and financing sources	Not reported	
Policy Development and Implementation Status		
2. National Composite Policy Index	See Annex	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 Programs: blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programs, services for orphans and vulnerable children, and education.		
3. Percentage of donated blood units screened for HIV in a quality assured manner	100%	Program monitoring/special survey
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	74.5%	Program monitoring and estimates
5. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	11.1%	Program monitoring and estimates
6. Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	27.4%	Program 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	5.0%	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	Sex Workers: 55.8% MSM: 67.0% IDU: Not reported	Program monitoring
9. Percentage of most-at-risk populations reached with HIV/AIDS prevention programmes	Sex Workers: 31.5% MSM: 10.3% IDU: Not reported	Behavioural surveys
10. Percentage of orphans and vulnerable	Not reported	

children whose households received free basic external support in caring for the child		
11. Percentage of schools that provided life-skills based HIV/AIDS education within the last academic year	100%	Curriculum review
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10– 14	Orphans: 75.0% Non-orphans: 87.1%	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*	21.9%	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	Sex workers: 35.3% MSM: 70.6% ISU: Not reported	Behavioural surveys
15. Percentage of young women and men who have had sexual intercourse before the age of 15	7.8%	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	22.4%	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*	38.9%	Population-based survey
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	50.0%	Program monitoring
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	51.4%	Program monitoring
20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Not reported	
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	Not Reported	

Impact		
22. Percentage of young women and men aged 15–24 who are HIV infected	0.79%	HIV sentinel surveillance and population-based survey
23. Percentage of most-at-risk populations who are HIV infected	Sex workers: 5.9% MSM: 4.3% IDU: Not Reported	HIV sentinel surveillance
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	82%	Programme monitoring
25. Percentage of infants born to HIV infected mothers who are infected	40.6%	Spectrum

Overview of the HIV epidemic in Papua New Guinea

Papua New Guinea became the fourth country in the Asia Pacific region to declare a generalized HIV epidemic after the prevalence of HIV among women attending the Port Moresby General Hospital antenatal care clinic passed one percent in 2004.* At the time, this site was one of the very few (n=14) antenatal clinics providing HIV counselling and testing and accordingly was used as the only reliable source of information available about the HIV epidemic in PNG, as it was the only site having trend data†. This situation has changed significantly and since that time, the number of pregnant women receiving counselling and testing as part of the Prevention of Parent to Child Transmission (PPTCT) of HIV programme nation wide has been scaled-up considerably. By 2008 there were a total of 105 ANC sites providing data that could be used for surveillance purposes‡.

Biological studies

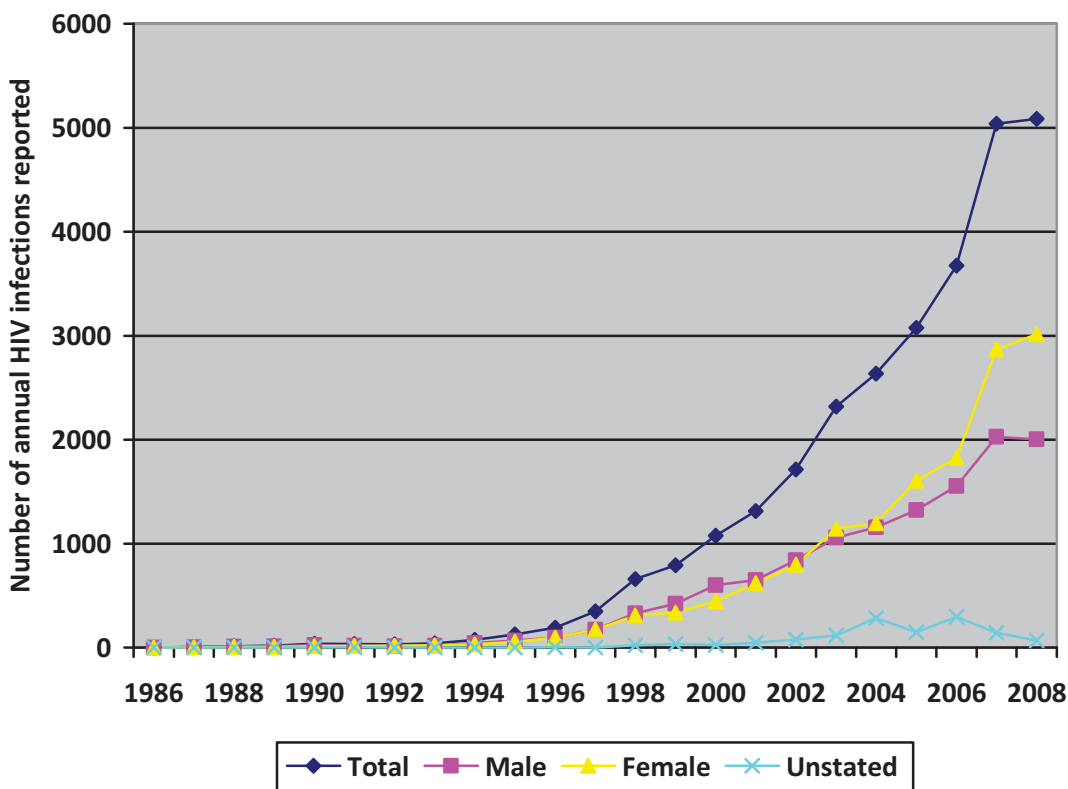
a. National-level trends in the HIV epidemic

HIV infection is a statutory notifiable disease in PNG and case notification reports from clinical and laboratory centres are one of the components of PNG's second generation HIV surveillance system. The total number of HIV infections reported annually since 1987 has increased steadily although it has started to level off between 2007 and 2008, as is shown in the figure.

* - NDoH and NACS, 2007

† - NDoH surveillance unit database

‡ - ibid



In the past couple of years, the total number of women testing positive for HIV was clearly higher than men. The results might either be related to the nature of case detection system which is heavily dependent on cases reported from ANC centres, to a genuine higher prevalence among women, or a combination of both. The last explanation looks more valid as the case detection proportion among clients of VCT centres in 2008 has been 4.7% in women versus 3.8% in men. The total number of women and men attending VCT centres did not differ that much in 2008 (23028 women versus 22465 men) ^{*}.

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^{*} - NDoH, 2009

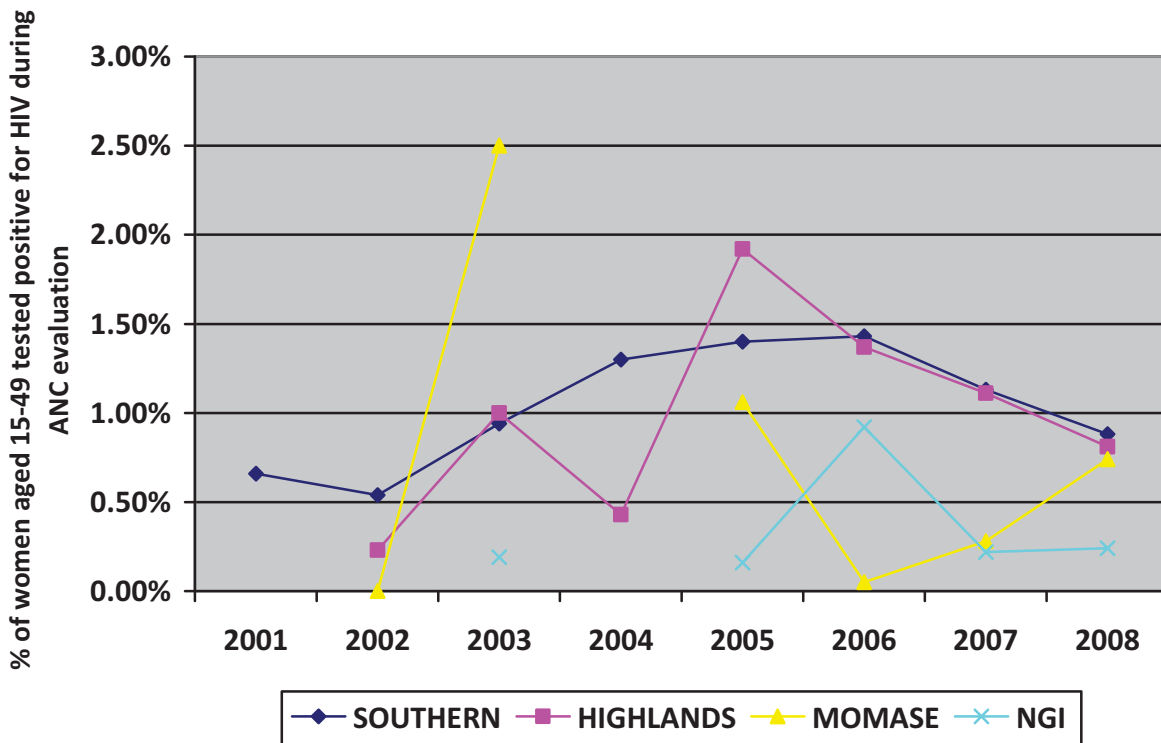
[†] - ibid

which makes interpreting the above figures harder, especially regarding the very low share for homosexual transmission*.

To date no population-based biological surveys have been conducted among the general population in PNG and considering this absence, the best way to monitor the HIV epidemic among the general population is by tracking trends in HIV prevalence at ANC testing sites. In the past decade, alongside the expansion of PPTCT services across the country, the number of ANC centres providing HIV counselling and testing to pregnant women and reporting the prevalence among them to the central surveillance unit at the National Department of Health (NDoH) has increased from one in 2001 to 105 in 2008, covering all the four regions of the country and representing all the 20 provinces. As more ANC clinics start reporting through the system, the built-in bias in it related to geographical representation decreases. However, the bias related to under-utilisation of ANC clinics by some population remains. One should note that utilisation pattern might change over time, sometimes tremendously in a couple of years, which makes even trend data from those centres unreliable.

b. Regional-level trends in the HIV epidemic

Based on data available from this nation-wide system, the HIV epidemic in PNG is not a homogenous one across all the geographical regions. The four regions of Southern, Highlands, Momase, and Islands have different epidemic patterns and trends, as depicted in the following figure. Therefore, using only national figures may be masking the provinces or regions with higher prevalence figures.



* - ibid

c. STI, HIV and TB surveillance

There is also routine HIV testing and counselling in sexually transmitted infection (STI) and tuberculosis (TB) treatment clinics, which provide more insight about the prevalence of HIV in these two groups. In 2008, among the 3845 STI patients tested (2388 women and 1457 men); a total of 310 cases of HIV infection were found (8.1%). The prevalence was higher among women (8.2%) than men (7.8%), though the difference was less than what has been found among VCT clients. Among 793 TB patients tested in 2008, 18 cases were found (3.5%)*.

Currently there is no biological surveillance at place for monitoring the epidemic among the most-at-risk populations (MARPs), like sex workers and men who have sex with men (MSM) or other groups of people at higher risk, like workers in enclave area and their surrounding communities. Nevertheless, there are several reports from service delivery, project-based, biological studies among most-at-risk populations in the National Capital District (NCD) giving some alarming prevalence figures[†]. Although sometimes exceeding the threshold of five percent (more than five percent among sex workers and around four percent among MSM), as they come only from a single source and from a single time period it is still too soon to reach the conclusion that there are pockets of concentrated epidemic in the broader PNG epidemic. Future biological surveillance must include these groups and vigilantly monitor the epidemic among them. In fact, biological surveillance among MARPs is an identified priority area that will be included in the next National Surveillance Plan 2011-2015.

Behavioural studies

In the past few years, mainly since 2006, behavioural surveillance surveys (BSS) have become part of the second generation surveillance system. These studies cover different groups, including women who sell sex in different cities, private industry workforce, truck drivers and the youth population. These studies are designed to be repeated to be able to find any important changes in behaviour among any of those groups. These studies, alongside behavioral data coming from other studies, shape what we know about major risk factors for HIV transmission in PNG and the drivers behind those risk factors which make some groups of people more vulnerable for being infected with HIV and other STIs.

Since the preparation of the last UNGASS report, a systematic literature review has also been conducted which has contributed to increasing knowledge about the HIV epidemic and its drivers in PNG, based on the studies conducted in 2007 and 2008.

a. Knowledge about HIV transmission

Comprehensive knowledge about HIV transmission and how people can prevent themselves and other from being infected with HIV is limited and varies among different groups. In one study in Kimbe, only a little more than one-fifth of youth have comprehensive knowledge based on the UNGASS indicator definition (data from PNGIMR). This study is only from one site and cannot give information about the level of knowledge among other parts of the

* - NDoH surveillance unit database

† - Data from Save the Children Poro Sapot Project

country. Nevertheless, data from BSS among ANC clinic attendants in Port Moresby general hospital on 2008 somehow give similar figures, as around only 24% of young women had a comprehensive knowledge based on the UNGASS definition^{*}.

The DHS conducted in 2006 did not include questions on HIV knowledge using the UNGASS definitions. However, in the previous UNGASS report, it was reported that less than half of the youth population in that study have answered correctly to questions about using condoms and having only one partner. It should be noted that it was not reported what proportion have answered correctly to both of those questions. The actual figure might be much lower than this. In one study, only 2.6% of the sample from 10 sites had a comprehensive knowledge based on abstinence, having one partner, and using condoms[†].

The knowledge among some of the more-at-risk populations has not been higher. In the study among an STI clinic in Lae, only 23% of people (29% among youth) had the comprehensive knowledge[‡]. Nevertheless, the figure among sex workers have been a little bit higher (35%) and much higher among MSM (70%)[§], something what has also been reported in other observations^{**}. However, one has to have in mind that the first figures come from post-intervention studies.

b. Age of sexual debut

Lower age of sexual debut can put people at disproportionately higher risk of HIV and STI's, as it has been shown that women who had sex debut before 18 were three times more likely to have been diagnosed with at least one STI. This figure was one-and-a-half among men^{††}. Based on the DHS results in 2006, around 4% of all young (15-24) men and women have had their first sexual intercourse before 15^{‡‡}. Though there has been no nationally representative study among youth since 2006, the PNGIMR study in Kimbe showed that this figure was 7.8% among the study population, an alarming increase, if corroborated by other studies and not a geographically confined finding. More alarmingly, this figure was even higher in the 15-19 age group, near 13% (PNGIMR). However, this figure has been only 2% among the women attending ANC clinic at Port Moresby general hospital^{§§}. Data from other more-at-risk groups, not unexpectedly, show higher figures, like a 15% among clients of an STI clinic in Lae^{***}.

The lowering sexual debut age, becomes even more alarming when it combines with figures like such as only 27% of people reporting having used a condom in their first sexual

* - NRI and NDoH, 2008.

† - PNGIMR, 2007 a

‡ - NDoH and NRI, 2008

§ - Maibani-Michie G et al 2007.

** - Millan J et al, 2007

†† - PNGIMR, 2007 b

‡‡ - NSO, 2009.

§§ - NRI and NDoH, 2008

*** - NDoH and NRI, 2008

intercourse^{*}; and that for many of people, especially girls, their first sexual experience had been forced upon them[†].

c. Multiple and concurrent sexual relationships

Having multiple concurrent sexual relationships is considered one of the most important risk behaviours, especially to develop and maintain a generalised epidemic. Although the current UNGASS indicator on high-risk sex is not the best indicator for measuring the scale of this behaviour among general population, it can be used as a proxy indicator. While the value for this indicator had been estimated to be 7.5% among women and men 15-49 from the last DHS report (2% among women)^{††}, it has shown again an alarming increase, a figure of 22% among the study population in Kimbe (Data from PNGIMR) and 15% among women attending ANC clinic in Port Moresby general hospital^{§§}. As expected, this figure was even higher among the STI clinic attendees in Lae, 37% (24% among women)^{***}.

d. Condom use

The above-mentioned figures become more important to give meaning to the HIV epidemic in PNG when combined with condom use among people engaged in this form of sexual relationships. This indicator which had a value of 42.5% back to 2006^{††}, is now estimated to be 39% based on the Kimbe study (Data from PNGIMR), but only 4.3% among the ANC clinic attendees at Port Moresby general hospital who reported having sex with more than one partner in the last 12 months^{§§}.

Although there is no conclusive evidence at hand, based on the available information it seems that protective sexual behaviours among the general population and specifically among youth have not improved in the past two years. This should raise concerns about effectiveness and scope of the prevention programmes targeting youth and general population.

There are populations of sex workers and men who have sex with men who require specific attention and prevention programmes. Data from these groups are very limited and only comes from those in contact with the Poro Sapot project (Save the Children) and only in the National Capital District. Condom use among these groups has not been very high, even though already in contact with prevention programmes, and does not go above 50% among either sex workers nor MSM.

e. Economic enclave workers

Populations who are at higher risk of acquiring HIV and other STI's go beyond the "generic" most-at-risk population in PNG. One of the groups at higher risk are people working in economic enclaves, being out of their customary surroundings and in many cases far from their families, combined with having regular access to cash makes them specially vulnerable to engage in transactional sex. Studies in two groups of enclave workers by NRI have shown relative low levels of knowledge about HIV prevention (43%) among one group of them, the petroleum development workers. This group also showed high level of high-risk sex: 43% had sex with more than one sexual partner in the last 12 months, only half of those with high-risk

* - SCiPNG, 2007.

† - PNGIMR, 2007b

sex have used a condom in their last sexual intercourse, and 24% of them had transactional sex in the last 12 months. However, though the condom use among this latter group have been high (78%). The other group, workers in a plantation enclave, showed lower levels of high-risk sex (30%), but lower level of condom use as well (36%).

f. Alcohol and marijuana abuse

The use of marijuana and alcohol is closely associated with unprotected sexual activity and acts of sexual violence, and both of these drugs are available widely and used heavily throughout the country. Because alcohol use is also associated with gender-based violence, the inclusion of drug and alcohol risk reduction strategies in HIV prevention is urgently needed.

g. Gender vulnerabilities

Gender inequities greatly influence the sexual transmission of HIV in PNG.^{*} Women and girls are more vulnerable to HIV infection than men and boys and less able to protect themselves because of the many economic, social, legal, political and cultural disadvantages they face.

Other social and structural factors comprise the environment in which the HIV epidemic is spreading in PNG; including limited employment and income opportunities, and high levels of labour migration. Movement of peoples and poverty contribute to the exchange of sex for cash or goods and services or to satisfy desires increased by long separation times from spouses or partners.[†] The lack of access to basic services and resources, limited availability of protection methods such as male or female condoms, and poor communication infrastructure with deteriorating facilities and roads, are key factors that contribute to vulnerability and risk, and constrain efforts to implement HIV prevention and treatment activities.[‡]

Sexually Transmitted Infections

Surveillance for STI is an important part of the second generation surveillance for HIV. Having an untreated STI significantly increases the probability of HIV transmission and also indicates the presence of other risk factors such as unprotected sex.

In PNG, there has been an STI case reporting-based surveillance system in place from 2001. This system includes reporting of syndromic cases of male and female genital discharge. As genital discharge among women is a non-specific syndrome, and is suggested not to be used as a proxy for STI incidence, the following analyses are only based on genital discharge in men and genital ulcers in both sexes. Nevertheless, the current NHIS includes three other syndromes for more comprehensive STI reporting.

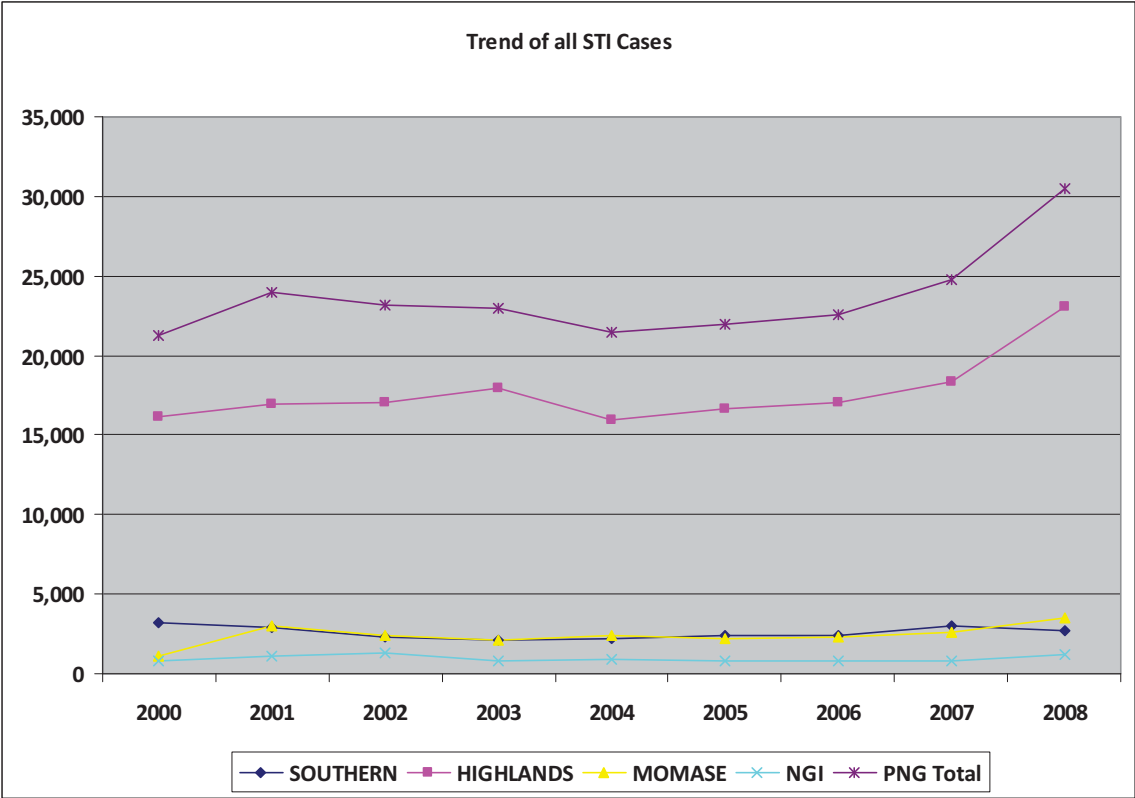
Since the start of the STI reporting system in PNG, the number of participating clinics has increase from 565 nationwide in 2000 to 676 in 2008 (a growth of nearly 20%).

* - NACS 2006

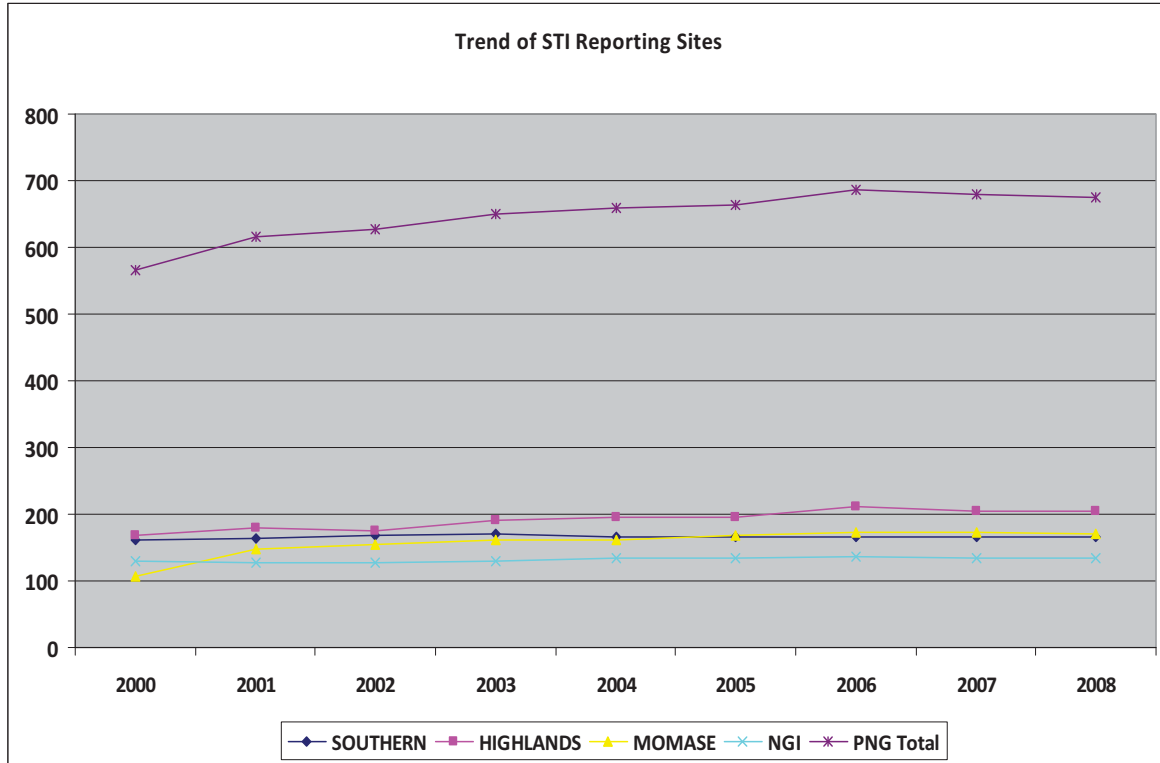
† - NACS and NHASP 2007

‡ - NACS 2008

The following figure shows the numbers of STI cases in the four regions. There is a worrying upward trend.



In the same period, the total number of STI cases reported has increased from 21213 to 30535 (a growth of 44%). This clearly indicates that the increasing number of reported STI cases cannot be simply explained by an increase in the number of reporting sites.



These figures also clearly indicate that the very high share the Highlands region compared to other three regions cannot be explained by higher number of STI reporting sites in this region and is more probably a reflection of a higher incidence of STI in this region.

Estimation of the epidemic and projection of its future trends

The last estimation and projection exercise in PNG took place in 2007, when there was only limited data available across the country and the team had to rely on few reporting sites capable of providing trend data. The data availability has been improved considerably in the past couple of years (from 18 PPTCT sites in 2006 to 105 in 2008), though only 67 sites with 50 or more mothers tested were considered for the estimation exercise. Though this increase has had less effect on providing trend data, it gives a better picture from all over the country. As an example, in 2008 all provinces have reported testing from PPTCT sites.

In 2009, a new estimation and projection exercise was started, as the team collected and scrutinised data from all sources and used the latest version of Estimation Projection Package (EPP) available by that time. This exercise never reached a reporting end because of a series of problems, including changes in threshold for starting ART from CD4 levels of less than 200 to 350 and changes in the EPP packages. Therefore, it was decided that a new round of estimation and projection exercise will be held during 2010. As data from 2009 PPTCT and sentinel site at ANC clinics have not become available by the time of this report, it is not possible to provide the updated estimated prevalence and the number of people living with HIV by the end of 2009.

Introduction to Indicators

The data for all values were validated at the final stakeholders meeting conducted as during the process of preparing the PNG UNGASS Country Report 2010, held on the 23rd and 24th of March 2010 in Port Moresby. There was broad representation at the meeting from government, civil society, research institutes and development partners.

Participants were asked to validate and comment on the data and its value in the context of the epidemic in PNG.

The principles sources of data for the values are and other values are behavioural bio behavioural surveys and program monitoring by National Department of Health, National Research Institute, Institute of Medical Research, Family Health International and Save the Children.

Indicator 1 AIDS Spending

Definition of indicator: Domestic and international AIDS spending by categories and financing sources.

Value

No Value

Challenges and recommendations for indicator improvement:

Challenges

Indicator 2 Government HIV and AIDS Policies

See Annex 2 National Composite Policy Index

Indicator 3 Blood Safety

Definition of indicator

Percentage of donated blood units screened for HIV in a quality assured manner

Recommended measurement tool

FRAME Tool (Framework for Assessment, Monitoring and Evaluation of blood transfusion services): a rapid assessment tool used by the WHO Global Database on Blood Safety.

Actual method of measurement used by this report

National Department of Health Database with data collected from the 20 provincial hospitals which are the only centres for blood donation in PNG.

Value of indicator

In 2008, 8416 units of blood were donated and in 2009, the figure was 9,376. In both years, 100% of donated blood was screened for HIV following the standard operating protocol which is provided by the Central Public Health Laboratory of PNG. Data is drawn from routine programme monitoring from all provincial hospitals and their blood banks. It is important that the number of new HIV infections attributed to blood transfusion is zero. To achieve this goal it is necessary to screen all blood donations individually in a quality-assured manner and, as the data indicates, this is occurring. Moreover, restricting blood donations to volunteers who are not remunerated and having a blood substitution policy contributes to lowering the prevalence of HIV in the pool of blood donors.

Indicator changes compared with previous report

There is no change in the value of this indicator from the 2008 report.

Indicator 4 HIV Treatment: Antiretroviral Therapy

Definition of indicator

Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy

Recommended measurement tool

For the numerator: facility-based antiretroviral therapy registers or drug supply management systems. For the denominator: HIV prevalence estimation models such as Spectrum.

Method of measurement used by this report:

National Department of Health ART Database

Value of indicator

Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy by the end of 2008 (with ART criterion of CD4 < 200)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 15	>= 15	
Number on ART by the end of year				
2942	2253	329	4866	5195
Number needing ART by the end of year				
4566	3329	1005	6890	7895
Percentage on ART by the end of year				
64.4%	67.9%	32.7%	70.6%	65.8%

Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy by the end of 2009 (with ART criterion of CD4 < 200)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 15	>= 15	
Number on ART by the end of year				
3815	2936	427	6324	6751
Number needing ART by the end of year				
5238	3823	1051	8010	9061
Percentage on ART by the end of year				
72.8%	76.8%	40.6%	78.9%	74.5%

There are some quality assurance problems with this data as many ART sites do not report in a timely manner to the National Department of Health or complete reporting forms correctly.

Indicator changes compared with previous report

In the past two year, there has been a huge investment on counselling and testing and providing treatment to those diagnosed and need treatment. Therefore, the coverage has increase significantly from 23% in 2007 to 65% in 2008 and 74% in 2009.

Interpretation of Value in terms of background of epidemic in PNG

There are some concerns regarding the coverage and availability of ART. An alternative procurement system for ART has been implemented within NDoH and ART are dispatched directly to ART dispensing sites after orders from the sites have been processed. All orders must be accompanied by a routine monthly report; a system designed to encourage sites to submit their reports in a timely manner. However, some sites fail to provide monthly reports or submit their ART orders in a timely manner and this can lead to stock outs. They are sometimes delivered to the wrong site – this can be due to a clerical error at NDoH or a mistake by the courier company or airline. If a dispensing site does not have a continuous supply of ART it may not be able to provide PPTCT (PMTCT) or PEP, clients already on treatment may be forced to take an unplanned treatment break and new clients may experience a delay in commencing treatment.

Changes to the CD4 threshold for treatment as outlined in the new National ART treatment guidelines (2009) are not fully understood by all staff at all ART sites and as a result some people eligible for ART may not be receiving it.

Challenges for indicator reporting improvement

There are significant gaps in the knowledge and skills of staff at ART sites related to reporting. For example, there is confusion regarding the definition of someone on ART and whether routine monthly reporting should include clients who receive ART for PPTCT and PEP.

Recommendations for indicator reporting improvement

There is a need to build the capacity of staff in ART sites in data management, protocols and reporting through training, mentoring and improved supervision. All relevant staff need to be familiar with the new protocols for commencement of patients on ART and receive regular in-service training for keeping them up-to-date.

Indicator 5 Prevention of Mother to Child Transmission

Definition of indicator

Percentage of HIV-infected pregnant women who received ART to reduce the risk of mother-to-child transmission

Recommended measurement tool

For the numerator: programme monitoring tools, such as patient registers and summary reporting forms. For the denominator: antenatal clinic surveillance surveys in combination with demographic data, or estimation models such as Spectrum.

Actual method of measurement used by this report

National Department of Health ART database. Data is collected from the registers of ANCs that provide PMTCT services.

Value of indicator

It was seen that 11.1% of HIV infected women who received antiretrovirals to reduce the risk of mother-to-child transmission.

Percentage of HIV infected pregnant women received antiretrovirals to reduce the risk of mother-to-child transmission in 2008

Single-dose Nevirapine only	Prophylactic regimens using a combination of two antiretroviral drugs	Prophylactic regimens using a combination of three antiretroviral drugs	Antiretroviral therapy for HIV-infected pregnant women eligible for treatment	Total
Number of HIV-infected pregnant women who received antiretroviral medicines				
22	33	144	35	234
Estimated number of HIV-infected pregnant women				
2100				
Percentage receiving antiretroviral drugs				
1.0%	1.6%	6.9%	1.7%	11.1%

Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission in 2009

Single-dose Nevirapine only	Prophylactic regimens using a combination of two antiretroviral drugs	Prophylactic regimens using a combination of three antiretroviral drugs	Antiretroviral therapy for HIV-infected pregnant women eligible for treatment	Total
Number of HIV-infected pregnant women who received antiretroviral medicines				
9	12	169	73	263
Estimated number of HIV-infected pregnant women				
2150				
Percentage receiving antiretroviral drugs				

0.4%	0.6%	7.9%	3.4%	12.2%
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There are quality assurance problems with PPTCT (PMTCT) data especially as many ART sites do not report in a timely manner to NDoH or complete data collection forms correctly.

Interpretation of Value in the context of the epidemic in PNG

Coverage of PPTCT remains low; significant numbers of pregnant women do not attend ANCs, especially in rural areas and are not being screened for HIV and prescribed ART for PPTCT if applicable. To improve access to PPTCT there needs to be improvements in the quality and coverage of ante natal care generally. Many ANC centres have closed in recent years particularly in rural areas.

A review of PPTCT was conducted in March 2009 by an Inter-Agency Task Team. The review found that the integration of PPTCT services with maternal and child health (MCH) programmes has been challenging in PNG, given the already low level of MCH service utilization; 60% for antenatal care access, 35% for assisted delivery at a health facility and 20% for family planning compounded by poor quality of services and human resource constraints. Geographical expansion and capacity to deliver PPTCT services remains limited. * There have been problems with staffing within the National Department of Health, with no PPTCT coordinator in the Family Health Section until January 2009. In addition, the Family Health managers and other service managers, including at sub-national level have not had formal training on PPTCT to support them in managing the programme.†

The PPTCT review also found that among senior managers and practitioners as well as partners there is a limited understanding of PPTCT scientific evidence; interpretation of global standards to the PNG context is variable; and there is a hesitancy to initiate paediatric HIV care and treatment services as they are often perceived as too difficult.‡

Although the Health Sector HIV and STI strategy has clear PPTCT objectives, these objectives have not been translated into a costed operational plan and standard operating procedures. There is limited human capacity to manage the programme, particularly at implementation level and there are no systems for linking services and assuring quality implementation of the different interventions e.g. testing and counselling approaches; laboratory internal and external quality assurance (QA); Quality assurance activities provided by the different actors, particularly community groups; use of data to improve service quality and performance

Indicator value changes compared with previous report

Following the expansion of PPTCT programs across PNG, the coverage for PPTCT has increase from 2.3% in 2007 to 11.1% in 2009. While the increase is significant in relative numbers, still around 90% of women needing PPTCT services cannot benefit from them which underpins the

* NDOH et. al. 2009

† NDOH et. al. 2009

‡ NDOH et. al. 2009

importance of the need for more investment, if the country want to reach universal access for to PPTCT services.

Challenges for indicator reporting improvement

There are significant gaps in the knowledge and skills of staff at ANCs related to reporting related to all cases of ART. This is reflected in the quality and timeliness of reports from ANCs.

Recommendations for indicator reporting improvement

Increased capacity of staff at ANCs, VCT centres and ART sites in data management, protocols and reporting through training, mentoring and improved supervision will contribute to better reporting of the value of the indicator.

Indicator 6 Co-management of Tuberculosis and HIV Treatment

Definition of indicator

Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

Purpose of indicator

To assess progress in detecting and treating TB in people living with HIV

Recommended measurement tool: Facility antiretroviral therapy registers and reports; programme monitoring tools

Actual method of measurement used by this report

National Department of Health Database

Value of indicator

Number of adults with advanced HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol and who were started on TB treatment in accordance with national TB programme guidelines has been 127 in 2008 and 170 in 2009. As the estimated number of TB incident cases among people living with HIV is available only for 2008, the value of this indicator will be reported for this year which is 170 over 620 (27.4%)

Interpretation of value in the context of the epidemic in PNG

TB is one of the major causes of morbidity and mortality among people living with HIV. There is a lack of communication between the HIV and TB programs which contributes to under-enrolment of people with TB in ART programs and, similarly an under-enrolment of people on ART with TB in TB programs. There is a lack of screening for HIV in TB programs. A national policy is in place for HIV/TB programs collaboration but needs to be more widely implemented.

Indicator changes compared with previous report

The number of people with TB and advanced HIV co-infection receiving ART has increased since the last report but this increase is not significantly especially given the anecdotal evidence suggesting very high rates of TB among patients with advanced HIV infection.

Challenges for indicator reporting improvement

Overcoming the lack of communication and collaboration the between HIV and TB programs, improving adherence to reporting protocols so that accurate data is reported , building the capacity of staff to report data accurately. It is important to understand what are the barriers to the HIV and TB programs communicating with each other, and as there is an NDoH policy to promote collaboration and communication, what has it had little impact?

Recommendations for indicator reporting improvement

The current reporting mechanism of patients on ART needs strengthening as do quality control mechanisms. Moreover, for this specific indicator, there is also a need for better coordination between TB and HIV programs at both the provincial and national levels. Efforts should be made to screen all HIV patients for TB and test all TB patients for HIV. Data should be disaggregated by age, sex and location.

Indicator 7 HIV Testing in the General Population

Definition of indicator

Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results.

Recommended measurement tool

Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey).

Actual method of measurement used by this report

Institute of Medical Research study in Kimbe.

Value of indicator

It was seen that 5% of women and men aged 15–49 who received an HIV test in the last 12 months knew their results.

Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results (Institute of Medical Research study - Kimbe - 2008)

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of people who have been tested and received their results					
6	12	0	7	11	18
Number of people interviewed					
158	199	64	91	202	357
Percentage of people who have been tested and received their results					
3.8%	6.0%	0%	7.7%	5.5%	5.0%

As per the National Department of Health Data Base, the number of people tested for HIV in 2008 was Male (35,230), Female (85,377), Total (120,607).

Values from other studies

It was seen that 13.8% of women and men aged 15–49 who received an HIV test in the last 12 months and who knew their results

Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results (National Department of Health and National Research Institute, Bio-Behavioural Sentinel Surveillance - Port Moresby General Hospital ANC - 2008)

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of people who have been tested and received their results					
46		4	21	21	
Number of people interviewed					
307		36	119	152	
Percentage of people who have been tested and received their results					

15.0%

11.1%

17.7%

13.8%

Interpretation of value in the context of the epidemic in PNG

It is acknowledged that many people who present for HIV testing do not return to receive their results if the results are not immediately available. The existing HIV testing protocol includes a first screening test, usually a rapid test performed at the point of care, to be followed in case of reactivity by two sequential rapid tests; these last tests are to be performed at the designated confirmatory laboratory, usually at the provincial level. Though a major improvement compared to earlier testing practices requiring referral of all reactive samples to a national laboratory, the current strategy still imposes relatively long wait times for getting the final results, and a high proportion of women never receive their results.

The number of testing sites at the end of 2008:

Southern region	47
Highlands region	81
Momase	34
<u>New Guinea Islands</u>	<u>39</u>
<i>Total</i>	<i>201</i>

A new testing algorithm involving the use of two rapid tests administered at the testing site is currently being piloted and should be rolled out in 2010/2011 across the country. If clients receive confirmed results within 15 or 20 minutes this will significantly increase the number of people who know the results of their test.

Indicator changes compared with previous report

Not reported on in 2008 report.

Challenges for indicator reporting improvement

Conducting population based survey is a labour- and resource-intensive task which cannot, and should not, be repeated in short intervals. Therefore, in between large-scale surveys, countries have to rely on a combination of more local surveys and programme monitoring data. For PNG to rely on the latter source of information, there are considerations that have to be addressed.

While all tests are recorded at facility level, testing sites are not always clear about where to send their reports. The delivery of reports to National Department of Health may also be delayed if they are sent to another agency first. For example, facilities of the Catholic Health Service may send their reports to the national Catholic AIDS office who then forward the to the surveillance unit within the National Department of Health. As this process may take some time it often results in a delay in the supply of testing kits (as well as ART). Without testing kits, there is no testing for HIV and therefore the number of people tested may be lower than the number of people wishing to be tested. Also, if the receipt of reports is delayed then the NDoH database will not reflect the true figure of tests carried out.

Recommendations for indicator reporting improvement

Increase capacity at the facility level in reporting to the National Department of Health and strengthen reporting mechanisms including training, mentoring and supervision of staff. In order to increase the actual numbers of people being tested who know their results, the new testing algorithm needs to be rolled in a timely manner.

Indicator 8 HIV Testing in Most-at-risk Populations

Definition of indicator

Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results.

Recommended measurement tool

Behavioural surveillance or other special surveys

Sex Workers

Actual method of measurement used by this report: Program monitoring data from Save the Children Poro Sapot Project.

Value of indicator

It was seen that 55.8% of sex workers who received an HIV test in the last 12 months knew their results.

Percentage of sex workers who received an HIV test in the last 12 months and who know their results (Save the Children Poro Sapot program data – NCD - 2009)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of sex workers who have been tested and received their results				
402	131	218	315	533
Number of sex workers attending services				
675	280	418	537	955
Percentage of sex workers who have been tested and received their results				
59.6%	46.8%	52.2%	58.7%	55.8%

While these data are reliable as they are based on programme monitoring data, they have not followed the UNGASS reporting guidelines which require data to be collated from behavioural surveillance or other special surveys. It is important to take into account that these figures only reflect testing and counselling figures in a group already attending service provision points in an urban setting.

Interpretation of value in the context of the PNG epidemic – sex workers

Sex workers and those who engaged in non-commercial transactional sex are at increased at risk of acquiring HIV and other STIs. For those women and men engaged in sex work there is a need to strengthen and scale up prevention programmes and improve access to VCT.

Indicator changes compared with previous report

Male sex workers were not included in the previous report. The value reported in the previous report was BSS data whereas, as noted above, the value report here is drawn from routine program data and therefore cannot feasibly be compared with the earlier value.

Men who have Sex with Men

Actual method of measurement used by this report

Programme monitoring data from Save the Children Poro Sapot Project

Value of indicator

It was seen that 67% of men who have sex with men who received an HIV test in the last 12 months and who know their results.

Percentage of men who have sex with men who received an HIV test in the last 12 months and who know their results (Save the Children Poro Sapot program reporting – NCD - 2009)

Age disaggregating		Total
< 25	>= 25	
Number of MSM who have been tested and received their results		
33	44	77
Number of MSM attending services		
52	63	115
Percentage of MSM who have been tested and received their results		
63.5%	69.8%	67.0%

While these data are reliable as they are based on programme monitoring data, they have not followed the UNGASS requirements, as they are not coming from a special survey among men who have sex with men. Therefore, one has to consider that these figures only reflect testing and counselling figures in a group already attending service provision points in an urban setting.

Values from other sources

- In the 12 month period from October 2008 to September 2009, 149 MSM, transgender and male sex workers received counselling and testing from FHI supported projects in NCD*.
- In 2008, a total of 1457 men received HIV testing and counselling at STI clinics across the country. Only 19 reported having anal sex with another man in the past 12 months†.

Interpretation of value in the context of the PNG epidemic – men who have sex with men

Men who have sex with men have a heightened risk of contracting HIV and other STIs, however, the documented knowledge on MSM in PNG is limited. The data provided here is limited to the relatively small numbers who have attended the Poro Sapot service in the

* FHI, 2008

† NHIS, NDoH, 2008

National Capital District (NCD). As is evident from the data on those attending STI clinics across the country, the utilisation of services by MSM is very low. Studies reviewed in the Systematic Literature Review suggest that those who identify as homosexual men reported experiencing discrimination from family and peers and social pressure to marry and have children.*

Indicator changes compared with previous report

As the data collection method in the current report is different from the previous report (programme monitoring data versus survey-based data) it is not possible to compare these two figures.

STI Clinic Clients

Actual method of measurement used by this report

National Department of Health and the National Research Institute Bio-Behavioural Surveys

Value of indicator

It was seen that 24% of STI clinic clients who received an HIV test in the last 12 months knew their results.

Percentage of STI clinic clients who received an HIV test in the last 12 months and who know knew their results (NDoH and National Research Institute Survey – Lae Friends Clinic - 2008)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of STI clinic clients who have been tested and received their results				
28	44	22	50	72
Number of STI clinic clients interviewed				
172	128	83	217	300
Percentage of STI clinic clients who have been tested and received their results				
16.3%	34.4%	26.5%	23.0%	24.0%

Interpretation of value in the context of the PNG epidemic – STI clinic clients

A relatively low number of clients had tested for HIV and received their results, however, HIV prevalence was 4.0% among females (zero among males) suggesting the need for regular HIV testing among STI clients, certainly at a higher rate than 24%. There is a need to ensure increased HIV testing but with informed consent and confidentiality. There is also a need for more support for increased VCT counsellors as acknowledged by staff at the Lae Clinic.[†]

Rural Economic Enclave Workers

In PNG, it has been identified that rural economic enclaves can create contexts of heightened risk of HIV transmission due to the mobility of the workforce, who can be away for long time

* NACS, 2009

† NDoH and NRI, 2009

periods from spouses, partners and families. There is considerable exchange of sex in these areas, increased movement of peoples and access to money and alcohol.

Actual method of measurement used by this report

National Research Institute Behavioural Surveys – 2008 and 2009

Value of indicator

It was seen that 24% of plantation workers who received an HIV test in the last 12 months knew their results.

Percentage of plantation workers who received an HIV test in the last 12 months and who know their results (National Research Institute Survey – 2008).

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of plantation workers who have been tested and received their results				
10	33	9	34	43
Number of plantation workers interviewed				
49	130	52	127	179
Percentage of plantation workers who have been tested and received their results				
20.4%	25.4%	17.3%	26.8%	24.0%

This data is from a representative sample collected through behavioural surveys data collection methods. Only 179 workers (61%) who knew their age that could be used for the calculation of this indicator, and this limits available age group data and can be linked to low educational and literacy levels may call into question the reliability of reporting by interviewees.

It was seen that 28.1% of petroleum development workers who received an HIV test in the last 12 months knew their results

Percentage of petroleum development workers who received an HIV test in the last 12 months and who know their results (National Research Institute Survey - 2008– 2009).

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of petroleum development workers who have been tested and received their results				
6	91	5	92	97
Number of petroleum development workers interviewed				
16	329	25	320	345
Percentage of petroleum development workers who have been tested and received their results				
37.5%	27.7%	20.0%	28.8%	28.1%

The data for plantation and petroleum workforces are from two representative samples collected through behavioural surveys. There were eight men who didn't know their ages.

A probability sample size of 460 was initially identified for both the petroleum development (with 463 sampled) and plantation (with 460 sampled) workforces, with a randomized stratified sampling frame: 1) among 3 categories of work types (Professional/management; technical / skilled; and labourer) across five sites at petroleum development, and 2) among two categories of work types at plantation (management and technically skilled; and with workers from across eight sites. Members of the workforce were randomly selected by types of work from employee lists and by male and female, proportional to the overall workforce and gender distribution.

Interpretation of value in the context of the PNG epidemic – rural enclave workers

Uptake of testing for HIV is not high enough and requires more promotion of VCT sites to increase awareness.*

Interpretation of value as it relates to all groups in the context of the PNG epidemic

Currently there is no exact measurement of the percentage of the most- at- risk population who have received an HIV test and who know their test results. However the recent Systematic Literature Review of HIV research carried out in PNG during the period 2007-2008 reports barriers to accessing VCT sites around the country. Fear of stigma and discrimination was reported as a primary barrier to having a HIV test, due to social beliefs that HIV is associated with transactional sex and promiscuity.

Lack of privacy and confidentiality; lack of appropriate counselling and education; lack of knowledge in terms of where to go for a test and lack of available VCT centres; a lack of information on treatment and limited access to treatment were also reported as barriers to testing. A 2008 site assessment by FHI found that the VCT uptake among the at-risk-population is still very low.†

In PNG, it has been identified that rural economic enclaves can create contexts of heightened risk of HIV transmission due to the mobility of the workforce, who can be away for long time periods from spouses, partners and families. There is considerable exchange of sex in these areas, increased movement of peoples and access to money and alcohol.

Challenges for indicator reporting improvement

There is special need for regular behavioural and bio-behavioural surveys among most-at-risk populations, and to include these surveys into the national surveillance plans. Moreover, strategic information is needed for estimating the size and distribution of these populations across different regions as well as urban and rural areas.

Recommendations for indicator reporting improvement

Conduct regular behavioural and bio-behavioural surveys among most-at-risk populations in a selection of geographical locations, both rural and urban.

* NDoH and NRI, 2009

† FHI, 2008

Indicator 9 Most-at-risk Populations: Prevention Programmes

Definition of indicator

Percentage of most at risk populations reached with HIV prevention programs

Recommended measurement tool

Behavioural surveillance or other special surveys

Sex Workers

Actual method of measurement

Family Health International 2006 National Research Institute Behavioural Survey

Value of indicator

It was seen that 31.5% of sex workers who accessed prevention services and received an HIV test (2006).

Number of sex workers who accessed prevention services and received HIV test 2006 test (NACS first round BSS, 2006, Port Moresby)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of sex workers who know where to go for an HIV test and have been given condoms in the last 12 months				
84		33	51	84
Number of sex workers interviewed				
267		105	162	267
Percentage of sex workers reached with HIV prevention programmes				
31.5%		31.4%	31.5%	31.5%

It was seen that 10.3% of men who have sex with men who accessed prevention services and received an HIV test (2006).

Number of men who have sex with men who accessed prevention services and received HIV test 2006 test (FHI, Save the Children and PNGIMR, 2006, Port Moresby)

Sex disaggregating		Age disaggregating		Total
MALE		< 25	>= 25	
Number of men who have sex with men who know where to go for an HIV test and have been given condoms in the last 12 months				
31		25	6	
Number of men who have sex with men				
267		189	111	

Percentage of men who have sex with men reached with HIV prevention programmes			
10.3%	13.3%	5.4%	10.3%

Interpretation of value in the context of the PNG epidemic

Sex workers and those who engaged in non-commercial transactional sex are at increased at risk of acquiring HIV and other STIs. For those women and men engaged in sex work there is a need to strengthen and scale up prevention programmes and improve access to VCT. Knowledge of their HIV status will affect their health service seeking behaviours. Programs for improving this group's access to VCT services for sex workers should be scaled up across the country.

Indicator changes compared with previous report

No figure for reporting period, value included is from previous report.

Men who have Sex with Men

Definition of indicator

Percentage of men who have sex with men reached with HIV prevention programs

Recommended measurement tool

Behavioural surveillance or other special surveys

Actual method of measurement

Family Health International Behavioural Survey 2006

Value of indicator

It was seen that 10.3% of men who have sex with men who accessed prevention services received an HIV test.

Number of men who have sex with men who accessed prevention services and received an HIV test. (NACS first round BSS – Port Moresby - 2006)

Age disaggregating		Total
< 25	>= 25	
Number of MSM who know where to go for an HIV test and have been given condoms in the last 12 months		
25	6	31
Number of MSM interviewed		
189	111	300
Percentage of MSM reached with HIV prevention programmes		
13.2%	5.4%	10.3%

Interpretation of value in the context of the PNG epidemic

Men who have sex with men have a heightened risk of contracting HIV and other STIs, however, the documented knowledge on MSM in PNG is limited. The data provided here is limited to the relatively small numbers who have attended the Poro Sapot service in the National Capital District (NCD).

Economic Enclave Workers

Actual method of measurement

National Research Institute Behavioural Surveys

Value of indicator (plantation workers)

A. It was seen that 34.1% of plantation workers were reached with HIV prevention programs.

Percentage of plantation workers were reached with HIV prevention programs (National Research Institute Survey - 2008)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of plantation workers who know where to go for an HIV test and have been given condoms in the last 12 months				
4	57	14	47	61
Number of plantation workers interviewed				
49	130	52	127	179
Percentage of plantation workers reached with HIV prevention programmes				
8.2%	43.9%	26.9%	37.0%	34.1%

B. It was seen that 48.1% of plantation workers were reached with HIV prevention programs

Percentage of petroleum development workers reached with HIV prevention programs (National Research Institute Survey - 2008–2009)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of petroleum development workers know where to go for an HIV test and have been given condoms in the last 12 months				
0	175	10	165	175
Number of petroleum development workers interviewed				
17	347	27	337	364
Percentage of petroleum development workers reached with HIV prevention programmes				
0%	50.0%	37.0%	49.0%	48.1%

Indicator changes compared with previous report

Economic enclave workers not reported on in the previous report.

Interpretation of value in the context of the PNG epidemic

Workers in economic enclaves can be classified as “more-at-risk-groups” and as such should be a target group for HIV prevention programs. As they are to some extent a ‘captive’ audience they provide a good opportunity for ongoing prevention programs that go beyond awareness raising and tackle issues of sustained behaviour change.

Challenges for indicator reporting improvement

There is a demonstrated need for regular behavioural and bio-behavioural surveys among most-at-risk populations in a selection of geographical, both rural and urban, locations.

Recommendations for indicator reporting improvement

Conduct regular behavioural and bio-behavioural surveys among most-at-risk populations to develop trend data for more at risk populations.

Indicator 10 Support for Children Affected by HIV and AIDS

Definition of indicator: Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child

Recommended measurement tool: Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)

Value of indicator

No value provided. As per UNGASS reporting guidelines, this indicator only needs to be monitored in settings with high HIV prevalence (5% or greater)

Indicator 11 Life-Skills based HIV Education in Schools

Definition of indicator: Percentage of schools that provided life-skills based HIV education in the last academic year

Recommended measurement tool

School survey or education programme review

Actual Method of measurement used by this report

National curriculum review, reports from teacher in-service and pre-service training programs

Value of indicator

HIV and AIDS and related life-skills learning outcomes are included in the following subjects and grades as follows:

Primary schools (n=3438 in 2009)

Grade 3-5 Health (90 minutes per week)

Grade 6-8 Personal Development (240 minutes per week)

Secondary schools (n=226 in 2009)

Grade 9-10 Personal Development (180 minutes per week)

Grade 11-12 Personal Development is due for implementation in 2010

As the teaching of life skills through the Personal Development curriculum is compulsory, the value of this indicator should be 100%.

Interpretation of value in the context of the epidemic in PNG

Personal Development and Health are compulsory subjects. Personal Development is a life-skills based subject which includes outcomes on HIV and AIDS, reproductive sexual health, sexuality, family planning, puberty, relationships, social justice and drugs and alcohol. All schools within these levels have been instructed to teach all learning outcomes for Health and Personal Development.

Technical and vocational institutions (n=123 in 2009)

Optional Health Education to Prevent HIV and AIDS and STIs (40 hour course)

Teacher education institutions (n=10 in 2009)

Compulsory HIV and AIDS and Reproductive Health pre-service teacher training course (36 hour course). All teacher training colleges have been instructed to include HIV and AIDS and reproductive health as a core teacher training course.

No national survey of schools has been conducted. The Department of Education is considering including the question in the annual school census. HIV and AIDS is now beginning

to be included in the national exams at Grades 8, 10 and 12. Reports have indicated that many schools are implementing the curriculum but some anecdotal reports indicate there is resistance to teaching about condoms, particularly in church -run institutions.

This data does not include private institutions which may use a different curriculum. The 4563 elementary schools do not have HIV and AIDS learning outcomes but their curriculum does include health.

Indicator changes compared with previous report

The life-skills program referred to the 2008 UNGASS report has not been implemented. National pre- and in-service teacher training courses have been established and there has been substantial resource distribution has been implemented including Personal Development units of work books, HIV and AIDS Policy and Guidance Posters, and an HIV and AIDS and STI Resource Book for all teachers.

Since 2007, 100% of primary and secondary student teachers have completed a core life-skills based teacher training course on HIV and AIDS and reproductive health enabling them to teach Personal Development. They also received support materials. 45% of schools acknowledged receipt of 2009 materials distribution including 180,000 copies of an HIV and AIDS textbook for primary and secondary schools. In 2009 814 out of 901 clusters of primary schools had included HIV and AIDS in their in-service plans.

Challenges for indicator reporting improvement

Although all schools have been instructed to teach Personal Development and Health it is not clear if all the HIV, AIDS and STI learning units are being taught and, if so, if they are being taught in line with the approach promoted in the teacher training. Non- government schools are not obliged to implement the Department of Education's curriculum so there is no measure of how many of these schools are teaching Personal Development and Health or quality control.

Recommendations for indicator reporting improvement

NACS should collaborate with the Department of Education to support them in monitoring the implementation of HIV, AIDS and STI components of the Development and Health curriculum. Teaching of Personal Development and Health with particular regard to HIV, AIDS and STIs should also be monitored in non government private schools.

Indicator 12 Orphans: School Attendance

Definition of indicator: Current school attendance among orphans and non-orphans aged 10–14

Recommended measurement tool: Population-based survey (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)

Method of measurement used by this report:

Proxy indicators and achievements in reducing vulnerability to HIV and AIDS amongst school-aged children and young people are listed below. Currently no orphan data is collected by the Department of Education.

Value of indicator

Part A: It was seen that 75% of children who have lost both parents attend schools.

Current school attendance rate of orphans aged 10 – 14 Demographic Health Survey - 2006)

Sex disaggregating		Total
FEMALE	MALE	
Number of children who have lost both parents and who attend school		
13	14	27
Number of children who have lost both parents		
16	20	36
Percentage of children who have lost both parents and who attend school		
81.3%	70.0%	75.0%

Part B: It was seen that 87% of children both of parents are alive are living with at least one parent and who attend school.

Current school attendance rate of children aged 10 – 14 both of whose parents are alive and who live with at least one parent (Demographic Health Survey - 2006)

Sex disaggregating		Total
FEMALE	MALE	
Number of children whose both of parents are alive, who are living with at least one parent and who attend school		
1976	2293	4269
Number of children both of whose parents are alive, who are living with at least one parent		
2228	2676	4904
Percentage of children whose both of parents are alive, who are living with at least one parent and who attend school		

88.7%	85.7%	87.1%
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Interpretation of value in the context of the epidemic in PNG

1. Background data

Net enrolment rate 10-14 years - Prep to Grade 8 (2008)

Male	54.3 %
Female	51.4 %
<i>Total</i>	<i>52.9%</i>

Net enrolment rate Prep-Grade 8 (2008)

<i>Total</i>	<i>60%</i>
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Source: National Department of Education Universal Basic Education Plan (2009)

2. Policy framework

The Department of Education does not collect specific orphan data but has introduced additional measures to reduce vulnerability to HIV and AIDS and the impact on children and young people.

The HIV and AIDS Policy for the National Education System (2005) has been distributed to all schools and to all student teachers and education officers and states that:

School counsellors will be trained to provide counselling and support for students infected and affected by HIV/AIDS and sexual assault and abuse.

The Department of Education endorsed the National Strategy for Most Vulnerable Children (MVC) with its partner, the Department for Community Development, in 2009 and allocated responsibility to the Guidance Branch. Additionally, access and retention strategies for MVC are included in the Universal Basic Education (UBE) Plan launched in 2009. Elementary education became free in 2010 (grades 1 -3).

3. Specific achievements

- In 2008 and 2009 an additional 369 school-based counsellors completed a six week training course which includes a module on HIV and AIDS related vulnerability.
- All 12 Guidance Officers and all 20 Provincial Education Advisers completed training on HIV and AIDS and stigma and discrimination.

- The school based counsellor in-service course was updated to include HIV and AIDS related vulnerabilities and Guidance Officers were re-trained to deliver this training. A new pre-service course on Guidance, Counselling and Behaviour Management was developed and is due for implementation in 2010.
- Development and endorsement of the National Behaviour Management Policy and the Guide to Behaviour Management for Schools: Supplementary Material for National Policy which was the Department's first child-rights based policy and, for example, banned the expulsion of pregnant students.
- The teacher disciplinary code was amended to make discrimination and stigmatization a disciplinary offence.
- Guidance Branch has introduced report and data collecting systems, refined quarterly reports and school counselling follow up reports, and established a national school counsellor database.
- Effective and coordinated relationships have been built with providers and partners, in particular with UNICEF and with the Department of Community Development.
- An additional six Guidance Officers are due to be recruited in 2010.
- In addition to this there was considerable community and school mobilization through a network of volunteer women which included training sessions and resources on increasing enrolment school management, the HIV and AIDS Policy, gender and gender-based violence. HIV and AIDS is a core part of all School Learning Improvement Plans and this is supported in six provinces through Child Friendly Schools training.

Source: Education Capacity Building Program 2009 Annual Report, Basic Education Development Project 2009 Annual Report and Guidance Branch, National Department of Education.

The initiation of staged Universal Basic Education will begin in 2010 with free education for all three elementary grades.

Indicator changes compared with previous report

Data supplied is from previous report.

Challenges for indicator reporting improvement

Although data on orphans and vulnerability is not yet collected by the Department Guidance officers and Standards officers include several related indicators in their school visits including number of pregnancies and implementation of the HIV and AIDS Policy. The Department is considering the use of similar indicators in the annual school census.

Indicator 13 Young People: Knowledge about HIV Prevention

Definition of indicator

Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Recommended measurement tool

Population-based surveys (Demographic Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey).

Actual method of measurement used by this report

Institute of Medical Research Study in Kimbe

Value of indicator

It was seen that 21.9% of young people aged 15–24 both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission.

Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (Institute of Medical Research study in Kimbe)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of young people who gave the correct answers to all five questions				
11	23	10	24	34
Number of young people interviewed				
66	89	64	91	155
Percentage of young people having comprehensive correct knowledge				
16.7%	25.8%	15.6%	26.4%	21.9%

The survey was conducted in 2008. The total sample size was 501, 336 ≥ 25 and 165 < 25 . Less than 25% of young people surveyed in an urban/peri-urban area had comprehensive knowledge of HIV prevention where survey was conducted were able to give the correct answers to all five questions.

Values from other studies

It was seen that 23.9% of young people aged 15–24 both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission

Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (NDoH and National Research Institute sentinel surveillance study in at Port Moresby General Hospital ANC Clinic - 2008)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of young people who gave the correct answers to all five questions				
37		8	29	37
Number of young people interviewed				
155		36	119	155
Percentage of young people having comprehensive correct knowledge				
23.9%		22.2%	24.4%	23.9%

Interpretation of value in the context of the epidemic in PNG:

As young people are likely to have many years of sexual activity ahead of them it is important that they have a comprehensive knowledge of HIV and STI transmission and prevention and have access to programs which will support them to adopt behaviours which protect them against acquiring HIV and other STI.

Indicator changes compared with previous report:

No figure was reported in the previous report as the questions included in the 2006/2007 Demographic and Health Survey (DHS) include one open question regarding knowledge of prevention methods.

Challenges for indicator reporting improvement

There is no nationally representative study among young populations about sexual knowledge and behaviours and the current study from it data is cited is too small in size and only represents one site. There is a need to strengthen research capacity and gather data from all potential sources including non- HIV sectors, such as the education sector.

Recommendations for indicator reporting improvement

A behavioural surveillance survey by the National Research Institute was conducted in July 2009 with high risk youth on the border areas of Sandaun Province using respondent driven sampling. This data has been collected, entered, cleaned and verified and is in preliminary analysis stages.

There is a need for studies among youth about sexual knowledge, their attitudes and their sexual practices. Additionally relevant questions need to be included in other types of surveys of young people (including, perhaps, school exams) in order to provide the data necessary which will support programming for youth and the evaluation of the effectiveness of

investments to date made in raising awareness and encouraging behaviour change. It is also recommended that the National AIDS Council provide guidelines on how this indicator can be incorporated into HIV and non HIV related programs for young people.

Indicator 14 Most-at-risk Populations: Knowledge about HIV Transmission Prevention

Definition of indicator

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

Recommended measurement tool

Special behavioural surveys such as the Family Health International Behavioural Surveillance Survey for most-at-risk populations

Actual method of measurement used by this report

NACS, first round Behavioural Surveillance Survey, 2006, Port Moresby

Value of indicator

It was seen that 35.3% of sex workers both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission

Percentage of sex workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (NACS first round BSS, 2006, Port Moresby - 2008)

Sex disaggregating	Age disaggregating		Total
FEMALE	< 25	>= 25	
Number of sex workers who gave correct answers to all five questions			
113	51	62	113
Number of sex workers interviewed			
320	130	190	320
Percentage of plantation workers reached with HIV prevention programmes			
35.3%	26.9%	37.0%	35.3%

It was seen that 70.6% of men who have sex with men who both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission

Percentage of men who have sex with men who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (NACS first round BSS, 2006, Port Moresby - 2006)

Sex disaggregating	Age disaggregating		Total
MALE	< 25	>= 25	
Number of men who have sex with men who gave the correct answers to all five questions			
212	137	75	
Number of sex workers interviewed			
300	189	111	

Percentage of men who have sex with men having comprehensive correct knowledge			
70.6%	72.4%	67.5%	70.6%

Values from other studies

It was seen that 19% of plantation workers both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission

Percentage plantation workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (National Research Institute Behavioural Surveillance Survey - 2008)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	<25	>25	
Number of young people who gave the correct answers to all five questions				
12	22	11	23	34
Number of young people interviewed				
49	130	52	127	179
Percentage of young people having comprehensive correct knowledge				
25%	18.7%	21.1%	18.11	18.99%

It was seen that 44% of plantation workers both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission

Percentage of petroleum development workers who both correctly identify ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission (National Research Institute Behavioural Surveillance Survey – 2008-2009)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of petroleum development workers gave the correct answer to all five questions				
8	147	5	150	155
Number of petroleum development workers interviewed				
17	338	26	329	355
Percentage of petroleum development workers having comprehensive correct knowledge				
47.1%	43.5%	19.2%	45.6%	43.7%

It was seen that 22.7% of STI clinic clients who both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV.

Percentage of STI clinic clients who both correctly identify ways of preventing the sexual transmission of HIV and who reject (major misconceptions about HIV (NDoH and the National Research Institute Sentinel Surveillance Survey - Lae Friends STI clinic - 2008)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of STI clinic clients gave the correct answer to all five questions				
24	44	24	44	68
Number of of STI clinic clients interviewed				
172	128	83	217	300

Percentage of STI clinic clients having comprehensive correct knowledge				
14.0%	34.4%	28.9%	20.3%	22.7%

Interpretation of value in the context of the epidemic in PNG

The Systematic Literature Review did not identify any studies that reported on HIV knowledge among men who have male to male sex but the few studies among female sex workers revealed that there is higher level of knowledge about HIV among these populations than women not engaged in sex work.

Indicator changes compared with previous report

Not applicable

Challenges for indicator reporting improvement

Lack of data due to limited behavioural surveys among these groups.

Recommendations for indicator reporting improvement

Support service providers currently working with these groups and other groups with the capacity and potential to also work with these groups to conduct research into their sexual health seeking behaviours.

Indicator 15 Sex Before the Age of 15

Definition of indicator

Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15

Recommended measurement tool

Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)

Actual method of measurement used by this report

Population-based survey conducted by the PNG Institute of Medical Research.

Value of indicator

It was seen that 7.8% of young women and men aged 15–24 have had sexual intercourse before the age of 15

Percentage of young women and men aged 15–24 who have had had sexual intercourse before the age of 15 (Institute of Medical Research study in Kimbe)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of respondents who report having first sexual intercourse before 15				
3	6	5	4	9
Number of young people interviewed				
41	74	39	76	115
Percentage of young people having sexual intercourse before 15				
7.3%	8.1%	12.8%	5.3%	7.8%

The survey was conducted in 2008. The total sample size was 501, 336 \geq 25 and 165 < 25. Data is based on a population-based random survey and unlike data provided below, includes both males and females. However it represents only one geographic location.

Values from other studies

It was seen that 0.9% of young women and men aged 15–24 had had sexual intercourse before the age of 15.

Percentage of young women and men aged 15–24 who had had sexual intercourse before the age of 15 (NDoH and National Research Institute sentinel surveillance study in at Port Moresby General Hospital ANC - 2008)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of respondents who report having first sexual intercourse before 15				
3		2	1	
Number of young people interviewed				
153		35	118	

Percentage of young people having sexual intercourse before 15				
2.0%		5.7%	0.9%	

It was seen that 7.1% of young women and men aged 15–24 have had sexual intercourse before the age of 15.

Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15 (National Department of Health ANC - 2008)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of respondents who report having first sexual intercourse before 15				
113		57	56	
Number of young people interviewed				
1124		340	784	
Percentage of young people having sexual intercourse before 15				
10.1%		16.8%	7.1%	

It was seen that 14.9% of young women and men aged 15–24 have had sexual intercourse before the age of 15.

Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15 (NDoH and National Research Institute sentinel surveillance study in at Friends STI clinic in- Lae - 2008).

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of respondents who report having first sexual intercourse before 15				
4	7	2	9	11
Number of young people interviewed				
45	29	19	55	74
Percentage of young people having sexual intercourse before 15				
8.9%	24.1%	10.5%	16.4%	14.9%

It was seen that 9% of young women and men aged 15–24 who attended STI clinic have had sexual intercourse before the age of 15.

Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15 (National Department of Health STI clinics sentinel surveillance - 2008).

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of respondents who report having first sexual intercourse before 15				
15	9	5	19	24
Number of young people interviewed				
186	81	64	203	267
Percentage of young people having sexual intercourse before 15				

8.1%	11.1%	7.8%	9.4%	9.0%
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It was seen that 3.7% of young male and female petroleum workers women and men aged 15–24 who have had sexual intercourse before the age of 15.

Percentage 3.7% of young male and female petroleum workers women and men aged 15–24 who have had sexual intercourse before the age of 15 (National Research Institute study – 2008, Behavioural Surveillance Study - 2009)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of young petroleum development workers who report having first sexual intercourse before 15				
0	1	0	1	1
Number of young petroleum development workers interviewed				
2	25	4	23	27
Percentage of young petroleum development workers having sexual intercourse before 15				
0%	4.0%	0%	4.4%	3.7%

It was seen that 24.3% of young male and female plantation workers aged 15–24 who have had sexual intercourse before the age of 15

Percentage of young male and female plantation workers aged 15–24 who have had sexual intercourse before the age of 15 (National Research Institute Behavioural Surveillance Study - 2008).

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of young plantation development workers who report having first sexual intercourse before 15				
3	6	6	3	9
Number of young plantation development workers interviewed				
13	24	16	21	37
Percentage of young petroleum development workers having sexual intercourse before 15				
23.1%	25.0%	37.5%	14.3%	24.3%

Interpretation of value in the context of the epidemic in PNG

Sexual debut in early teen ages has been shown to be related with higher risk behaviours and even higher HIV prevalence. This is especially true when it is associated with sexual violence, high concurrency of partners, low condom use, penile insertions and penile cutting all of which are not unusual circumstances in PNG.

Indicator changes compared with previous report

Data provided in the previous report was drawn from a much larger sample through the Demography and Health Survey. The percentage of young women and men who had sexual intercourse before the age of 15 was 4.2%. The figure submitted for this report is 7.8% though drawn from a much smaller sample.

Challenges for indicator reporting improvement

There was no nationally representative study conducted during the reporting period among youth populations about sexual knowledge and behaviours. Conducting such studies, or including relevant questions in other surveys which target youth can provide data necessary for HIV prevention programming with young people and for evaluating the effectiveness of investments already made in awareness raising.

Recommendations for indicator reporting improvement

Greater collaboration between research partners could support a more cohesive approach to collecting data for this indicator. There is a need for more extensive population-based health surveys.

Indicator 16 Higher-risk Sex

Definition of indicator

Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months.

Recommended measurement tool

Population-based surveys (Demography and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey).

Actual method of measurement used by this report

Population-based survey conducted by the PNG Institute of Medical Research.

Value of indicator

It was seen that 22.4% of women and men aged 15–49 have had sexual intercourse with more than one partner in the last 12 months.

Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months (Institute of Medical Research study in Kimbe).

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of respondents who have had sexual intercourse with more than one partner in the last 12 months					
1	53	8	14	32	54
Number of respondents interviewed					
99	142	17	54	170	241
Percentage of respondents who have had sexual intercourse with more than one partner in the last 12 months					
1.0%	37.3%	47.1%	25.9%	18.8%	22.4%

The survey was conducted in 2008/2009. The total sample size was 501, 336 \geq 25 and 165 < 25). The findings indicate that only 1% of females compared to 37% of males had sexual intercourse with more than one partner. However, the study was only conducted in one area and therefore is not necessarily indicative of broader populations.

Values from other studies

It was seen that 15.8% of women attending ANC clinic aged 15–49 had sexual intercourse with more than one partner in the last 12 months.

Percentage of women attending ANC clinic aged 15–49 who have had had sexual intercourse with more than one partner in the last 12 months (National Department of Health and National Research Institute Sentinel Surveillance study at the Port Moresby General Hospital ANC Clinic- 2008).

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
47		7	16	24	
Number of respondents interviewed					
307		36	119	152	
Percentage of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
15.3%		19.4%	13.5%	15.8%	

It was seen that 37.5% of male and female STI clients aged 15–49 have had sexual intercourse with more than one partner in the last 12 months.

Percentage of female STI clients aged 15–49 who have had had sexual intercourse with more than one partner in the last 12 months (National Research Institute study in STI Clinic Lae - 2008)

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
39	68	12	19	76	107
Number of respondents interviewed					
162	123	19	56	210	285
Percentage of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
24.1%	55.3%	63.2%	33.9%	36.2%	37.5%

It was seen that 34.3% of women and men aged 15–49 attending STI clinics have had sexual intercourse with more than one partner in the last 12 months.

Percentage of women and men aged 15–49 attending STI clinics who had sexual intercourse with more than one partner in the last 12 months (National Department of Health STI clinics - 2008)

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
172	156	26	85	217	328
Number of respondents interviewed					
597	359	63	203	690	956
Percentage of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
28.8%	43.5%	41.3%	41.9%	31.4%	34.3%

It was seen that 30.1% of plantation workers aged 15–49 have had sexual intercourse with more than one partner in the last 12 months

Percentage of plantation workers aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months (National Research Institute Behavioural Surveillance Survey - 2008).

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
4	45	6	8	35	49
Number of respondents interviewed					
49	114	28	32	111	163
Percentage of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
8.2%	39.5%	21.4%	25.0%	31.5%	30.1%

It was seen that 43.2% of petroleum development workers aged 15–49 who had sexual intercourse with more than one partner in the last 12 months

Percentage of petroleum development workers aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months (National Research Institute Behavioural Surveillance Survey study – 2008 -2009).

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
1	144	1	7	137	145

Number of respondents interviewed					
17	319	4	23	309	336
Percentage of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
5.9%	45.1%	25.0%	30.4%	44.3%	43.2%

Interpretation of value in the context of the epidemic in PNG

Having multiple sexual partners is identified as increasing the risk factors for HIV and STI transmission. Beside data from Kimbe study, other studies have shown relatively high percentages of men and women engaged in higher-risk sex; of special concern can be the figures from pregnant women attending ANC clinic in Port Moresby, where 15% reported having more than one sexual partner in the past 12 months, the figures are more closer to those reported from presumably more-at-risk populations, like STI clinics clients. There is need for more detailed behavioural studies to give context to these findings, like if the sexual relationships were casual, transactional, or more permanent.

Many of the studies in the Systematic Literature Review found that multiple sexual partnerships and concurrent sexual partners are widespread among young and older adults. These partnerships were reported as mostly casual/informal, and not necessarily established by bride price or marriage. In the past there were traditional practices in which men and women were taught the meaning, rules and expectations of marital sexuality including sexual partnerships. Strong beliefs were held regarding the social significance of sexual partnerships in terms of strengthening a clan or strengthening links between two clans. Modern meanings of sexuality in PNG include a greater focus on sexual drive, power and desire (i.e. narratives related to intimacy, pleasure, feelings, and emotions).

Indicator changes compared with previous report

The data included in the previous report is from a demographic health survey whereas the value included here is from a survey conducted in one, urban/peri-urban location – Kimbe.

Challenges for indicator reporting improvement

While many studies have tried to measure higher risk sex in PNG, few of them have used right questions for their data to be included in an UNGASS report. The data collection methods need to be improved and harmonised for the future studies on sexual behaviours.

Recommendations for indicator reporting improvement

Greater coordination between research partners could support a more cohesive approach to collecting data for this and other related indicators.

Indicator 17

Condom Use During Higher-risk Sex

Definition of indicator

Percentage of women and men aged 15–49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse

Recommended measurement tool

Population-based surveys (Demography and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)

Actual method of measurement used by this report: Population-based survey conducted by the PNG Institute of Medical Research.

Value of indicator

It was seen that 38.9% of women and men aged 15–49 who had had more than one partner in the past 12 months who used a condom during their last sexual intercourse.

Percentage 38.9% of women and men aged 15–49 who had had more than one partner in the past 12 months who used a condom during their last sexual intercourse (Institute of Medical Research study in Kimbe).

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of respondents who have had sexual intercourse with more than one partner in the last 12 months and used a condom in their last sexual intercourse					
0	21	3	6	12	21
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
1	53	8	14	32	54
Percentage of respondents who have had sexual intercourse with more than one partner in the last 12 months and used a condom in their last sexual intercourse					
0%	39.6%	37.5%	42.9%	37.5%	38.9%

The survey was conducted in 2008. The total sample size was 501, 336 \geq 25 and 165 < 25)

Values from other studies

It was seen that 4.3% of women aged 15–49 attending ANC clinic had who had more than one partner in the past 12 months used a condom during their last sexual intercourse

Percentage of women aged 15–49 attending ANC clinic who had more than one partner in the past 12 months and who used a condom during their last sexual intercourse (NDoH and the National Research Institute sentinel surveillance study at Port Moresby General Hospital ANC - 2008)

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months and used a condom in their last sexual intercourse					
2		0	2	0	
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
47		7	16	24	
Percentage of respondents who have had more than sexual intercourse with more than one partner in the last 12 months and used a condom in their last sexual intercourse					
4.3%		05	12.5%	0%	

It was seen that 18.5% of women and men aged 15–49 attending STI clinics who had more than one partner in the past 12 months who used a condom during their last sexual intercourse

Percentage of women and men aged 15–49 attending STI clinics who had more than one partner in the past 12 months and who used a condom during their last sexual intercourse (National Department of Health STI clinics - 2008)

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months and used a condom in their last sexual intercourse					
32	21	9	13	31	53
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
141	145	24	79	183	286
Percentage of respondents who have had more than sexual intercourse with more than one partner in the last 12 months and used a condom in their last sexual intercourse					
22.7%	14.5%	37.5%	16.5%	16.9%	18.5%

It was seen that 36.7% of plantation workers aged 15–49 had more than one partner in the past 12 months and who used a condom during their last sexual intercourse.

Percentage of plantation workers aged 15–49 who had more than one partner in the past 12 months and who used a condom during their last sexual intercourse (National Research Institute study - 2008)

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months and used a condom in their last sexual intercourse					
2	16	3	3	12	18
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
4	45	6	8	35	49
Percentage of respondents who have had more than sexual intercourse with more than one partner in the last 12 months and used a condom in their last sexual intercourse					
50.0%	35.6%	50.0%	37.5%	34.3%	36.7%

It was seen that 53.1% of petroleum development workers aged 15–49 had more than one partner in the past 12 months who and used a condom during their last sexual intercourse

Percentage of petroleum development workers aged 15–49 who had more than one partner in the past 12 months who and used a condom during their last sexual intercourse (National Research Institute study – 2009)

Sex disaggregating		Age disaggregating			Total
FEMALE	MALE	15-19	20-24	25-49	
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months and used a condom in their last sexual intercourse					
0	77	0	3	74	77
Number of respondents who have had more than sexual intercourse with more than one partner in the last 12 months					
1	144	1	7	137	145
Percentage of respondents who have had more than sexual intercourse with more than one partner in the last 12 months and used a condom in their last sexual intercourse					
0%	53.5%	0%	42.9%	54.0%	53.1%

A baseline study of 700 men aged 15-49 living in and around sex economic the enclaves was conducted by Population Services International (PSI) in 2009 found the following:

- Consistent condom use with commercial partners in the past month: 87.7%
- Consistent condom use with casual partners in the past month: 66.6%
- Had sex with a commercial partner in the past 12 months: 34%*

* PSI, 2009

Interpretation of value in the context of the epidemic in PNG

There is an ongoing need to strengthen and expand HIV prevention programs among those engaging in higher risk sex activities. While there are some positive signs regarding levels of condom use among some groups with multiple partners there is a need to increase the rates of regular condom use. Ensuring consistent supply of condoms, especially in rural and remote areas remains a problem; however, economic enclaves are often sites where the supply of condoms is more reliable.

Indicator changes compared with previous report

Data from the previous report was from the Demographic Health Survey conducted in 2006-2007 with a sample size of 20,712. All data presented in this report are drawn from relatively small sample size with both random and non-random sampling.

Challenges for indicator reporting improvement

Need to increase sample sizes and include more sites, both urban and rural. Ongoing support for regular surveys

Recommendations for indicator reporting improvement

Regular behavioural surveys of people engaged in higher risk sex.

Indicator 18 Sex Workers: Condom Use

Definition of indicator: Percentage of female and male sex workers reporting the use of a condom with their most recent client

Recommended measurement tool: Special surveys for the numerator and denominator, including the Family Health International Behaviour Surveillance Survey for sex workers

Actual method of measurement used by this report: Programme monitoring data from Save the Children Poro Sapot Project

Value of indicator

It was seen that 50% of female and male sex workers reported the use of a condom with their most recent client

Percentage of female and male sex workers reporting the use of a condom with their most recent client (Save the Children Poro Sapot program monitoring – NCD – 2009)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of sex workers who reported that a condom was used with their last client				
461	144	279	326	605
Number of respondent who reported having commercial sex in the last 12 months				
866	343	531	678	1209
Percentage of sex workers who reported using a condom with their last client				
53.2%	42.0%	52.5%	48.1%	50.0%

While these data are reliable as they are based on programme monitoring data, they have not followed the UNGASS requirements, as they are not coming from a survey among sex workers. Figures only reflect condom use among a special group of sex workers who are already in contact with a prevention program.

Values from other studies

It was seen that 23.7% of female and male STI clients who had had transactional sex workers reported the use of a condom at last paid sex.

Percentage of female and male STI clients who had had transactional sex reporting the use of a condom at last paid sex (NDoH and National Research Institute Sentinel Surveillance survey at Friends STI clinic in– Lae - 2008)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of people having transactional sex who reported that a condom was used with their last client				
7	2	3	6	9
Number of respondent who reported having transaction sex in the last 12 months				
20	18	15	23	38

Percentage of people having transactional sex who reported using a condom with their last client				
35.0%	11.1%	20.0%	26.1%	23.7%

It was seen that 37.8% of female and males plantation workers who engaged in transactional sex reported the use of a condom with their most recent client

Percentage 37.8% of female and males plantation workers who engaged in transactional sex reported the use of who used a condom with their most recent client (National Research Institute Behavioural Surveillance Survey – 2008 - Kimbe)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of plantation workers having transactional sex who reported that a condom was used with their last client				
1	13	2	12	14
Number of plantation workers who reported having transaction sex in the last 12 months				
3	34	11	26	37
Percentage of plantation workers having transactional sex who reported using a condom with their last client				
33.3%	38.2%	18.2%	46.2%	37.8%

It was seen that 78.1 of female and males petroleum workers who engaged in transactional sex who reported the use of a condom with their most recent client

Percentage of female and male petroleum workers engaging in transactional sex who reported the use of a condom with their most recent client (National Research Institute Behavioural Surveillance Survey - 2009)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	< 25	>= 25	
Number of petroleum development workers having transactional sex who reported that a condom was used with their last client				
1	63	3	61	64
Number of petroleum development workers who reported having transaction sex in the last 12 months				
1	81	4	78	82
Percentage of petroleum development workers having transactional sex who reported using a condom with their last client				
100%	77.8%	75.0%	78.2%	78.1%

Interpretation of value in the context of the epidemic in PNG

The figure of 50% in the indicator value is low considering that the data is drawn from programme monitoring of clients attending a specific service for sex workers and therefore having access to prevention programmes. The data would seem to suggest that there is a need to strengthen and expand interventions for both male and female sex workers. Workers

from the petroleum development site had higher rates of condom use than plantation works during transactional sex.

Indicator changes compared with previous report

Figures for condom use with the most recent client are lower in the value reported here than in the previous report. The current value among the sex workers receiving services from Poro Sapot project is 50% which is lower than the 93.7% which was reported 2008 report and was collected through behavioural surveillance survey round one, Other values at the STI and economic enclaves sites show varying levels of condom use at last transactional sex for both men and women.

Challenges for indicator reporting improvement

We have to remember that the above mentioned figures have not come from special surveys among sex workers and only reflect those attending different service provision points or from those indicating transactional sex during BSS with other more at risk populations. There is an urgent need for starting regular behavioural and bio-behavioural surveys among most at risk populations, including sex workers, something that is already reflected in the annual surveillance plan. Moreover, strategic information is needed for estimating the size and distribution of these populations across different regions as well as urban and rural areas.

Recommendations for indicator reporting improvement

Conduct regular behavioural surveys of the target group(s).

Indicator 19 Men Who Have Sex with Men: Condom Use

Definition of indicator: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Recommended measurement tool: Special surveys including the Family Health International Behavioural Surveillance Survey for men who have sex with men

Actual method of measurement used by this report: Programme monitoring data from Save the Children Poro Sapot Project

Value of indicator

It was seen that 51.4% of men reporting the use of a condom the last time they had anal sex with a male partner

Percentage 51.4% of men reporting the use of a condom the last time they had anal sex with a male partner (Save the Children Poro Sapot program monitoring – NCD – 2009)

Age disaggregating		Total
< 25	>= 25	
Number of MSM who reported that a condom was used the last time they had anal sex with another man		
27	47	74
Number of MSM interviewed		
66	78	144
Percentage of MSM who reported that a condom was used the last time they had anal sex with another man		
40.9%	60.3%	51.4%

While these data are reliable as they are based on programme monitoring data, they have not followed the UNGASS requirements as they are not survey based. Therefore, one has to consider that these figures only reflect condom use among MSM populations who have been already in contact with a prevention program.

Values from other studies

It was seen that 21.1% of male STI clients reported the use of a condom the last time they had anal sex with a male partner.

Percentage of male STI clients reporting the use of a condom the last time they had anal sex with a male partner (National Department of Health STI clinics - 2008)

Age disaggregating		Total
< 25	>= 25	
Number of MSM who reported that a condom was used the last time they had anal sex with another man		
1	3	4
Number of STI clients who have had anal sex with another man in the last 12 months		
5	14	19
Percentage of MSM who reported that a condom was used the last time they had anal sex with another man		
20%	21%	21%

Among 359 men attending four STI clinics in 2008, 19 have reported having anal sex with another man and only four (21%) reported using a condom in their last anal sex with another man.

Percentage 50% of men male petroleum workers reporting the use of a condom the last time they had anal sex with a male partner (National Research Institute Behavioural Surveillance Survey -2009)

Age disaggregating		Total
< 25	>= 25	
Number of petroleum development workers who reported that a condom was used the last time they had anal sex with another man		
1	6	7
Number of petroleum development workers who have had anal sex with another man in the last 12 months		
3	11	14
Percentage of MSM among petroleum development workers who reported that a condom was used the last time they had anal sex with another man		
33.3%	54.6%	50.0%

Among the 338 men interviewed during the behavioural survey among petroleum development workers, 14 have reported having anal sex with another man in the past 12 months and seven of them (50%) reported using a condom in their last anal sex with another man.

During the NDoH and NRI sentinel surveillance survey at Friends STI clinic in Lae, around 10% of men and women reported having anal sex and only a third had used a condom at last anal sex.

Interpretation of value in the context of the epidemic in PNG

Men who have sex with men have an increased risk of contracting HIV and the current body of knowledge about them in PNG is weak. Condom use is relatively low which is of concern, especially as it is even lower for younger MSM.

Indicator changes compared with previous report

The figure from the previous report of 88.5% did not match the UNGASS reporting requirements. However it did appear to indicate higher rates of condom use among MSM than are indicated in the value put forward here. It is noted that the relatively low figure for condom use with last partner of 51% is drawn from MSM who already have access to prevention services for this group. It would be expected that the rate of condom use would be higher than it appears to be although it needs to be remembered that the data is not from a special survey but from routine programme monitoring. Nevertheless there appears to be little doubt that there is a need to strengthen and scale up prevention services for men who have sex with men and to increase condom use at anal sex between men and women. Moreover, strategic information is needed for estimating the size and distribution of these populations across different regions as well as urban and rural areas.

Challenges for indicator reporting improvement

There is special need for starting regular behavioural, and bio-behavioural surveys among most at risk populations, including MSM, and include these surveys into the national surveillance plans.

Recommendations for indicator reporting improvement

Conduct regular behavioural surveys of most-at-risk populations

Indicator 20 Injecting Drug Users: Condom Use

Definition of indicator: Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

Purpose of indicator: To assess progress in preventing sexual transmission of HIV

Recommended measurement tool: Special surveys including the Family Health International Behavioural Surveillance Survey for injecting drug users

Value of indicator

No value

Interpretation of value in the context of the epidemic in PNG

Data on injecting drug users in PNG is nearly nonexistent, as it has been generally believed that there is no injecting drug use in the country. However, recent studies are showing that even if non-existent a few years ago, there are now emerging pockets of some injecting drug use. As an example, the petroleum development workers study showed that there were three male workers from PNG people who have injected drugs not prescribed by a physician in the last 12 months.

There is also a concern about increasing levels of penile injection i.e. the practice of injecting various substances to increase penis size; two-thirds (2/3) had used clean injecting equipment.

During the NDoH and NRI sentinel surveillance survey at Friends STU clinic in Lae, one female client reported injecting a drug not prescribed by a doctor. Cross analysis indicated that she had also exchanged sex and a condom was used at last paid sex. She was negative for both HIV and syphilis.

From the data, penile injection is higher in the petroleum samples and penile cutting is higher in the STI, petroleum and plantation samples than injecting drug use and strategies for education in the use of clean needles (drugs, tattoos and penile injecting) and cutting utensils (circumcision and penile foreskin slitting) during these practices would be important due to the elevated potential risk of HIV transmission. Though there is no biological data supporting this argument at this stage.

Injecting practices rarely ever happen in isolation and injecting practices requires more research in the geographic areas and groups where it is reported. Further questions have been developed to optimize information on surveillance BSS surveys on injecting drug and other injecting and cutting practices when reported.

Little is known about there is sharing of equipment and the scale of such practices, while questions on these are included in all BSS; there is also a study being done by IMR on circumcision that also gives information on other cutting practices.

Indicator changes compared with previous report

There is a need for more formative studies on the extent of injecting drug use as an emerging high-risk behaviour in some parts of PNG and also other injecting practices such as penile injection.

Challenges for indicator reporting improvement

As injecting drug use is a potentially emerging issue, there are inherent challenges in collecting data and also in defining what constitutes injection practices in PNG. If there is a significant body of injecting drug users in PNG they may be difficult to access for research purposes. However it is important to increase research focus in this area.

Recommendations for indicator reporting improvement

Ensure that behavioural surveys include questions related to injecting drug use and ensure that those trained in conducting these surveys have a good understanding of injecting practices.

Indicator 21 Injecting Drug Users: Safe Injecting Practices

Definition of indicator: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

Purpose of indicator: To assess progress in preventing injecting drug use-associated HIV transmission

Recommended measurement tool: Special surveys including the Family Health International Behaviour Surveillance Survey for injecting drug users

Actual method of measurement used by this report

Value of indicator

There is no value

Interpretation of value in the context of the epidemic in PNG

The issue is not what drugs or other substances are being injected but how they are being injected and whether existing or emerging practices constitute a risk for HIV and other blood born diseases transmission.

Indicator changes compared with previous report:

Not reported on in previous report

Challenges for indicator reporting improvement:

As injecting drug use is a new issue, there are inherent challenges in collecting data and also in defining what constitutes injection practices in PNG. If there is a significant body of Injecting drug users in PNG they may be difficult to access for research purposes. However it is important to maintain a watching brief on this issue.

Recommendations for indicator reporting improvement:

Ensure that behavioural surveys include questions related to injecting drug use and ensure that those trained in conducting these surveys have a good understanding of injecting practices.

Indicator 22 Reduction in HIV Prevalence

Definition of indicator: Percentage of young people aged 15–24 who are HIV infected

Recommended measurement tool: WHO guidelines for HIV sentinel surveillance

Actual method of measurement used by this report: National Department of Health Database drawn from anti-natal clinics.

Value of indicator

It was seen that 74% of young people women attending ANC clinics aged 15–24 HIV infected.

Percentage of young people women attending ANC clinics aged 15–24 who are HIV infected (National Department of Health Sentinel Surveillance – ANC - 2008).

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of people tested positive for HIV				
11		3	8	
Number of young people tested for HIV				
1489		442	1047	
Percentage of young people tested positive for HIV				
0.74%		0.76%	0.68%	

It was seen that 0.79% of young people women aged 15–24 attending ANC clinics were HIV infected.

Percentage 0.79% of young people women aged 15–24 attending ANC clinics who are HIV infected (National Department of Health Sentinel Surveillance – ANC - 2009)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of people tested positive for HIV				
28		8	20	
Number of young people tested for HIV				
3537		1004	2533	
Percentage of young people tested positive for HIV				
0.79%		0.80%	0.79%	

Values from other studies

It was seen that 1.3% of young women aged 15–24 attending ANC clinic at Port Moresby General Hospital were HIV infected

Percentage of young women aged 15–24 attending ANC who are HIV infected (NDoH and National Research Institute Sentinel Surveillance survey at National Research Institute ANC – Port Moresby General Hospital ANC - 2008)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of people tested positive for HIV				
2		0	2	
Number of young people tested for HIV				
154		36	118	
Percentage of young people tested positive for HIV				
1.30%		0%	1.69%	

It was seen that 3% of young people aged 15–24 were HIV infected in Kimbe.

Percentage of young people aged 15–24 who are HIV infected (Medical Research Institute study in Kimbe)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	15-19	20-24	
Number of people tested positive for HIV				
1	2	1	2	3
Number of young people tested for HIV				
34	66	38	62	100
Percentage of young people tested positive for HIV				
2.94%	3.03%	2.63%	3.23%	3.0%

Interpretation of value in the context of the epidemic in PNG

HIV prevalence among the lower two age groups of adults is generally considered as a proxy for HIV incidence, as it reflects relatively recent infection. Once considered in the background of other behavioural data, this figure indicates relatively high risk and vulnerability among youth.

Indicator changes compared with previous report

Not reported in previous report.

Challenges for indicator reporting improvement

In the absence of integrated bio-behavioural surveillance among general population, sentinel surveillance among women attending ANC clinics is the standard proxy for prevalence among general population. However, one has to consider relatively low utilisation of ANC services,

especially in rural areas, and the fact that not all women attending ANCs consent for being tested.

Recommendations for indicator reporting improvement

Implement the proposed IBBS Survey and improve HIV surveillance generally.

Indicator 23 Most-at-risk Populations: Reduction in HIV Prevalence

Definition of indicator

Percentage of most-at-risk populations who are HIV-infected

Purpose of indicator

To assess progress on reducing HIV prevalence among most-at-risk populations

Recommended measurement tool

UNAIDS/WHO Second Generation Surveillance Guidelines; Family Health International guidelines on sampling in population group

Actual method of measurement used by this report

Programme monitoring data from Save the Children Poro Sapot.

Value of indicator

It was seen that 5.86% of sex workers were HIV-infected

Percentage of sex workers who are HIV-infected (Save the Children Poro Sapot project – NCD - 2009)

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	<25	>=25	
Number of sex workers tested positive for HIV				
50	6	30	26	56
Number of sex workers tested for HIV				
675	280	418	537	955
Percentage of sex workers tested positive for HIV				
7.41%	2.14%	7.18%	4.84%	5.86%

It was seen that 4.35% of men who have sex with men were HIV-infected

Percentage of men who have sex with men who are HIV-infected (Save the Children Poro Sapot program monitoring – NCD - 2009)

Age disaggregating		Total
< 25	>= 25	
Number of MSM tested positive for HIV		
1	4	5
Number of MSM tested for HIV		
52	63	115
Percentage of MSM tested positive for HIV		
1.92%	6.35%	4.35%

Values from other studies

It was seen that 4% of women at higher risk attending an STI clinic who are HIV-infected

Percentage of women at higher risk attending an STI clinic who are HIV-infected (NDoH and National Research Institute Sentinel Surveillance survey at Friends STI clinic in Lae - 2008).

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	<25	>=25	
Number of STI clients tested positive for HIV				
12	0	8	4	12
Number of STI clients tested for HIV				
172	128	83	217	300
Percentage of STI clients tested positive for HIV				
6.98%	0%	9.64%	1.84%	4.00%

While there were no male STI clients diagnosed HIV positive; two times more younger women were diagnosed positive than those over 25 years.

Data from Hope Worldwide (Oct 08 – Sep 09 Port Moresby) indicated the following prevalence figures:

- Female sex workers - 33/292 (11.30%)
- Men who have sex with men - 11/151 (7.28%)*

Interpretation of value in the context of the epidemic in PNG

From the limited information available there appears to be relatively high prevalence of HIV infection among female sex workers and MSM. Prevalence of HIV among male sex workers is lower but still significant. If confirmed through larger-scale and survey -based studies, those figures would indicate a concentrated epidemic amongst most-at-risk populations.

Indicator changes compared with previous report

Not reported on previously

Challenges for indicator reporting improvement

Strengthening sentinel surveillance among sex workers and MSM

Recommendations for indicator reporting improvement

Improved surveillance which effectively captures HIV infection rates among sex workers and MSM.

* Hope Worldwide 2009

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

Definition of indicator: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Recommended measurement tool

Program monitoring tools; cohort/group analysis forms

Method of measurement used by this report

NDoH ART database

Value of indicator

The overall 12-month survival on ART has been 82.1% in 2009.

Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (NDoH ART database - 2009).

Sex disaggregating		Age disaggregating		Total
FEMALE	MALE	<15	>=15	
Number of adults and children who are still alive and on ART at 12 months after initiating treatment				
446	313	2	757	1455
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				
345	488	3	830	1772
Percentage of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy				
91.4%	90.7%	66.7%	91.2%	82.1%

Interpretation of indicator in the context of the epidemic in PNG

It should be noted that the age and sex disaggregated data come only from four bigger sites with computerised database system. The total comes from all ART sites where data were available and calculated manually; it includes most of the ART providing centres. While 82% is a relatively good one-year survival rate on treatment, the higher figures among the more advanced sites indicate that it is possible to still increase this value by improving the quality of clinical as well as non-clinical care for PLHIV who are on ART.

Indicator changes compared with previous report

In 2008, the universal access report also reported a similar figure.

Challenges for indicator reporting improvement

Without a computerised database for ART at each site which feed into the central database, it is very hard to have updated survival data. In addition, all sites have to have an analysis of the main reasons for death or drop out from treatment.

Recommendations for indicator reporting improvement

Expansion of electronic data management to all ART sites.

Indicator 25 Reduction in Mother-to-child Transmission

Definition of indicator

Percentage of infants born to HIV-infected mothers who are infected

Purpose of indicator

To assess progress towards eliminating mother-to-child HIV transmission

Recommended measurement tool

Spectrum, or other statistical modelling that uses programme coverage and efficacy studies

Method of measurement used by this report

The recommended tool (Spectrum)

Value of indicator

It was estimated that by the current combination of PPTCT regimens and their coverage, 873 infants have been born from with HIV from 2150 pregnant women living with HIV (40.6%).

Interpretation of indicator

This high value shows the combination of very low (11%) coverage of PPTCT programs and the dominance of less effective regimens among those receiving any PPTCT regimens.

Indicator changes compared with previous report

No value was reported in the previous report.

Best Practice

Systematic Literature Review

Practice: HIV and AIDS research in Papua New Guinea systematically collected, reviewed, synthesized and distributed.

1. Summary of the practice

The first systematic literature review of HIV and AIDS related research in PNG.

2. Purpose and objectives

The purpose of the review was to address the need for greater HIV research coordination and to address the gaps in accessing HIV knowledge in order to guide the national response in PNG. A systematic literature review was identified as the best way to synthesize the literature and assess the quality of studies and critically appraise each individual study in order to identify valid and applicable evidence

The objectives of the review were to:

- Systematically collect and review Papua New Guinean research studies on HIV, AIDS or STI conducted or published in 2007 and 2008.
- Assess the quality and reliability of HIV, AIDS, STI research studies conducted or published in 2007 and 2008.
- Synthesize research findings under common thematic areas.
- Identify relevant recommendations for researchers, policy makers, practitioners and stakeholders.

2. Level of intervention

A total of 2735 citations were identified from five different sources which included:

- I. Local and relevant agencies (NACS, NGOs, FBOs, CBOs, research and academic institutions, relevant government departments, international donors and partners involved in HIV work and represented in PNG)
- II. Key informants (researchers, deans of academic and research institutions, librarians of research institutions and universities),
- III. Electronic databases (PubMed, Medline, EBSCO Host, EMBASE, PsychInfo),
- IV. Internet search engines (Google and Google Scholar)
- V. 'Snowballing' (included reviewing reference sections of included studies to find additional studies that might fit the inclusion criteria).

Out of the total number of citations identified 62 studies were included in the review using an inclusion and exclusion criteria that was based on the type of studies, types of Participants and types of outcome measures. Data was extracted from each of the 62 articles using a purposely-developed extraction forms that included key findings, study limitations and generalisability.

3. Prospective users of the practice

A systematic literature review of HIV/AIDS could be undertaken by a range of agencies with existing research capacity or access to personnel with research skills. A similar practice could be undertaken by post graduate level students with access to a relevant databases and supervision or mentoring from skilled social researchers either locally or internationally. The process could be particularly valuable in developing countries where there is known to be a significant body of research conducted on HIV and AIDS and where such research is not regularly collated, analysed and synthesized.

4. Problem addressed

Although the response to HIV in PNG is significant in scale, a considerable amount of current knowledge is based on anecdotal evidence, some of which comes from other countries. For an effective response to the rapidly increasing HIV epidemic it is important to have reliable local evidence to provide knowledge into underlying factors driving the epidemic. There is a need for evidence to guide programming, interventions and policies. Papua New Guinea's own research data is very important in providing information that is required for all areas of the response. There is also a need for greater coordination of all HIV related research so PNG can continue to fill the gaps with quality information that can be generalized for the wide population.

5. Context and history

Since the first HIV cases were detected in 1987 there have been over 2700 PNG HIV research publications most of which have been social and behavioural research. However, these study publications were not accessible to policy planners, intervention programs and researchers because there was no central data base or databases where all stakeholders have easy access to information.

6. Steps in implementation

The National Research Agenda which was as launched in 2008 identified HIV research priorities for PNG. The National AIDS Council Secretariat Research Advisory Committee strongly recommends research in the priority areas so that information for the different areas of HIV response in PNG is available to policy planners, prevention strategies and intervention programmers and researchers.

The Research Agenda stresses the need for better coordination of HIV related research to address gaps identified in the research agenda. For better coordination the NACS Research Coordination Unit was established in October 2008. The role of this unit is to coordinate all HIV related research conducted in Papua New Guinea. It also is the Secretariat to the National AIDS Councils Research Advisory Committee which gives ethical clearance and provides technical advice to improve research study designs proposals.

7. Resources required for the practice

Skilled researchers with a comprehensive understanding of qualitative research, access to search engines, financial resources, preferably the support of a research institute and if necessary, mentoring and supervision.

8. Impact

The impact of the Systematic Literature Review will be measured against its use in supporting program design and policy development in PNG.

9. Source of practice and dialogue

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Major challenges and remedial action

In the second half of 2009, NACS commenced work on the development of the National HIV Strategy for PNG (NHS) which will cover the period 2011 – 2015 and follow-on from the current NSP (2006-2010). As part of the process of developing the plan, the opportunity has been taken to reflect on the successes and failures of the current strategic framework. Much of the discussion in this section of the report is drawn from the *Concept Paper – National HIV and AIDS Strategy (2011-2015)* prepared as part of the development of the NHS.

The two priority areas for the NHS are prevention and care and treatment. All the other key areas such as gender, leadership, coordination strengthening decentralisation, capacity building, GIPA, research, surveillance, monitoring and evaluation (M&E) are fundamental requirements to achieving these two major priorities.

Prevention

Prevention of HIV transmission continues to be one the major challenges in the National response to date. Current interventions fall short of a comprehensive response. Prevention projects, which have been shown by reviews and evaluations to be making achievements are largely donor driven programs which lack scale and alignment with provincial responses. The Independent Review Group (IRG) concluded that PNG's prevention response is inadequate in nature, intensity and scale and emphasised the pressing need for PNG's HIV response to move beyond HIV awareness raising and address the broad broad-based structural and social factors that impact on HIV transmission.

Integration of gender into HIV prevention programs has not occurred in a systematic and comprehensive way with the exception of the Poro Sapot project and the Education Sectors. There is little evidence of surveillance data informing education and prevention programming. There are no programs for mobile males and females and young women involved in trans-generational sex and only limited programs for out of school youth. Some reviews found that the understanding by project staff of the elements of evidence-informed approaches needed considerable strengthening. Churches are well positioned to play a significant role in prevention, however most have been primarily focussed on HIV awareness raising and promotion of abstinence and faithfulness. The negative attitudes of some churches towards condom use limit their role in effective HIV prevention.

Key lessons learned include the need to identify and prioritise those people at high risk and geographical priority areas for prevention programming; the need for repeated and consistent interventions; the need for research on sexual practices to inform interventions; the need to review, reflect and learn from experience; the need to maintain consistent condom supplies and understand that condom distribution does not equal condom

promotion; and the need for strategies to address stigma and discrimination when working with vulnerable groups.

HIV Counselling and Testing

The annual exponential growth in the number of people presenting for HIV counselling and testing (HCT) is one of the major successes in PNG's HIV response.

However there is a need to improve the quality of service delivery in all sites including ensuring that all services are user friendly and welcoming of all clients; expansion of HCT beyond fixed stand alone VCT facilities to include mobile testing; and increasing the coverage of HCT at the local government level in rural areas.

Care, Treatment and Support

There have been significant achievements in the roll out of antiretroviral therapy (ART) across PNG, especially in the last few years. However, many issues are affecting access to quality treatment services including limits in the types of counselling available; a concentration of centres in provincial capitals; and lack of involvement of people living with HIV in counselling. Too little is known about ART adherence and retention and because of ART stock outs in some provinces people have been forced to endure drug "holidays" and go on second line treatment.

There is a need to build capacity to scale up treatment programs across the country including at district-based facilities and this will be a priority in the NHS. Options for community-based treatment will be explored given the difficulties for people in remote areas accessing health centres. Work by the Clinton Foundation and the National Department of Health (NDoH) ADB Rural Enclaves project provides models for expanding primary healthcare to support expanded treatment services. Given the very high rates of STIs in PNG there is also a need to ensure consistent supply of STI drugs and condoms.

Prevention of parent-to-child transmission (PPTCT) is vital for reducing the impact of the epidemic as well as reducing stigma towards mothers, children and fathers who are HIV positive or affected. Figures for 2008 indicate that only 8.6% of all pregnant women in PNG are provided with HIV information, counselling and testing and only 4.6% of all HIV positive pregnant women who delivered in health facilities were provided with ART prophylaxis. There are significant barriers within the health system which contribute to low PPTCT service coverage and uptake.

Enhanced efforts are required to reduce parent to child transmission of improved ANC service provision. Violence against women who disclose their HIV status discourages women from either testing or letting others know of her status. This needs to be addressed if women are to take up PPTCT in larger numbers. The participation of male partners in PPTCT is critical.

Multi-drug resistant TB (MDR-TB) is an emerging concern in PNG and poses an

immediate challenge to HIV care. As part of the continuum of care approach, HIV services need to be better integrated with TB services and reliable supplies of TB drugs including second line therapies and training on management of MDR-TB are required. While some improvements between TB and HIV services is evident, the IRG has noted integrated services for HIV, TB, malaria, ST, Family Planning and nutritional support linked to home-based care and community support teams are a rarity the majority of provinces. There is a need to scale-up models of integrated delivery of HIV care through approaches that ensure that all aspects of a comprehensive program are delivered through a range of players. Pilots of two initiatives are being undertaken (FHI's Continuum of Care and the Clinton Foundation program) and link services such as HCT; treatment and care of HIV related opportunistic infections; TB/HIV care and treatment; post-exposure prophylaxis; ART for children and adults; prevention of mother-to-child transmission; laboratory support; and home based care and peer support.

GIPA – The greater involvement of PLHIV

The greater involvement of PLHIV in the HIV in the response remains sub-optimal due to the lack of meaningful inclusion in all aspects of the HIV response, and limited capacity of PLHIV and advocacy organisations. Strengthening the role of HIV positive people and PLHIV groups is an important and necessary remedial action and will be addressed in the NHS. The engagement of PLHIV is all the more urgent as PNG scales up the national response to achieve universal access to prevention treatment, care and support services. The meaningful involvement of PLHIV will strengthen the national response.

Gender

Gender inequities greatly influence the sexual transmission of HIV in PNG. Women and girls are more vulnerable to HIV infection and less able to protect themselves because of the many economic, social, legal, political and cultural disadvantages. Numerous studies have established that gender based violence including rape is a serious problem in PNG severely affecting the lives of many women and girls.

There is a need to create multi stakeholder partnerships which to develop gender sensitive responses in areas of health, justice, education, economic and social studies. Support is needed for programs which motivate men and boys to actively participate in prevention including setting up clinics for men and boys. Research needs to be conducted to better understand male and female perceptions of sex, violence, sexual practices and how this links to men's notions of masculinity and desire. Male leaders who can advocate on behalf of gender equality need to be identified and supported.

Leadership

Political leadership has been on the wane since the 2007 election when a number of key supporters of the HIV response in Parliament lost their seats. Evidence of the lack of support was the dramatic cut in NACS funding in the 2009 budget. The leadership role of men and

women living with and affected by HIV needs to be strengthened. Male and female community leaders and elders need to be engaged as agents of change. The role of leaders in the public and private sectors as champions for effective HIV prevention needs to be strengthened. All leaders, particularly religious leaders need to promote accurate, consistent and mutually reinforcing prevention messages that are in line with Government of PNG strategies and policies.

Capacity

Current operational barriers to scaling up a comprehensive response are the limitations and weaknesses within key organisations and systems. Current operational barriers include: poor planning, inappropriate prioritisation and low capacity to track and show results of HIV prevention, care and treatment programs, limited human and institutional capacity to manage and deliver HIV programs, corruption, lack of accountability and poor coordination. In the absence of effective government services, NGOs including church based agencies, and the private sector are providing most of the prevention, treatment, care and community support activities. However increased funding for these organisations is highlighting gaps in their capacity for effective program management, including program design and monitoring, and raises issues of long-term sustainability.

Current approaches to capacity building will need to be overhauled. Training, particularly one-off training programs have become a vehicle for “capacity building” but little consideration is given to establishing minimum competency standards for training participants. In addition lack of training follow-up, including on-the-job technical support has been lacking.

Research, Surveillance, M&E

Under the current NSP some improvements have been made in national HIV surveillance and research systems. However, much more effort is needed to improving the quality and timeliness of information. There should be an emphasis on operational research especially at service delivery points. The country’s rich cultural diversity requires both quantitative and qualitative research with a variety of methods, approaches, localities and scale to provide the background for developing relevant responses for specific populations in specific contexts. The planned Integrated Bio-Behavioural Survey (BBS) will for the first time undertake a representatively sampled national survey that collects bio-behavioural data. The IBBS has the potential to go a long way towards improving understanding of the epidemic in PNG.

Investments should be continuously made to support national efforts in strengthening the national monitoring and evaluation and surveillance systems and to improve the quality of data collected from different sources using different methodologies. Priority should be given to systematic quality assurance auditing of data and verification at all levels of collection, management and analysis to improve the quality of information collected through surveillance and program monitoring.

Community & Family Support

The need for strategies to address communities most affected by HIV is becoming apparent. The growing number of orphans and vulnerable children, people living with HIV and households requiring income support and assistance highlights the need for new areas of support, particularly for community driven responses. Efforts need to focus on mitigating the impact of HIV on households and communities; addressing stigma and discrimination, the role of sorcery and other traditional beliefs; and strengthening the understanding of the effects of HIV on households and how households cope where one or more of its members are living with HIV.

The IRG has highlighted the lack of models in PNG that provide outreach services linking facility based health services to family and community support, including home based care. There is a need to establish a clear framework with clearly articulated responsibilities for home based care.

Support the country have received from its development partners

As it has been mentioned in the 2008 UNGASS report from PNG, “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.” Two years after this statement, it still holds its validity as the number of stakeholders in the past two years has increased and the role of them has also become more important.

The development partners play a significant role in supporting the government of PNG (GoPNG) and the civil society stakeholders to provide better quality services to a higher number and broader range of people of PNG. At the same time these partners have supported the national stakeholder to strengthen the national leadership and stewardship of the whole response.

The Australian Government, through the AusAID programme, is traditionally the major bilateral development partner to the GoPNG and the HIV and AIDS national response. Currently, the support to PNG from Australia is through the PNG-Australia HIV and AIDS Programme, called as “Sanap Wantaim” or “Standing Together”. The other major bilateral and multilateral development partners are United States Agency for International Development (USAID), New Zealand’s International Aid and Development Agency (NZAID), Asian Development Bank (ADB), Global Fund to fight HIV and AIDS (GFATM), and the UN system. The World Bank, British High Commission and the European Union are among the other development partners to the PNG national response.

The GFATM support is coordinated by the country coordination mechanism (CCM) and is based on the proposal developed and submitted by this multi-sectoral mechanism. The global fund support has been coming through the round four grant application which PNG successfully applied for in 2005 and covers a total of USD 30 million for a period of five years, which will be ended by August 2010. Unfortunately, the round nine grant proposal from PNG was unsuccessful as it failed to pass the technical review panel (TRP).

The support of other development partners is based on their own programmes which are developed through a consultation with national partners and have to be in consistence with the national strategic plan for HIV and AIDS response. For a more effective and harmonised support from the development partners, a development partners forum (DPF) has been established for the major development partners and their main governmental and civil society (national and international NGO’s) partners to sit together on a monthly basis and review the process and supporting the PNG national response.

The major implementing partners of development partners, beside the GoPNG departments, are local and international NGO’s, faith based organisations (FBO’s) and the private sector active in HIV and AIDS, as well as research bodies.

The contribution of the development partners into the HIV and AIDS response, based on the seven focus areas of the national strategic plan in 2008 and 2009 has been as follows:

Development Partner	2008 (PGK)	2009 (PGK)
<i>I. Treatment, counselling and support:</i>		
AusAID	9,100,000	12,600,000
NZAID	820,500	766,500
UN	3,762,000	3,461,000
<i>II. Education and prevention</i>		
ADB	424,000	429,000
AusAID	18,100,000	22,700,000
UN	1,675,000	704,000
US	7,290,000	7,290,000
<i>III. Epidemiology and surveillance</i>		
ADB	393,000	299,000
UN	243,000	611,000
<i>IV. Social and behavioural research</i>		
ADB	603,000	1,035,000
AusAID	1,100,000	2,300,000
<i>V. Leadership, partnership and coordination</i>		
ADB	340,000	597,000
AusAID	10,100,000	11,000,000
UN	728,000	1,833,000
<i>VI. Family and community support</i>		
AusAID	3,700,000	7,500,000
<i>VII. Monitoring and evaluation</i>		
ADB	296,000	330,000
AusAID	3,400,000	3,700,000
UN	486,000	1,222,000

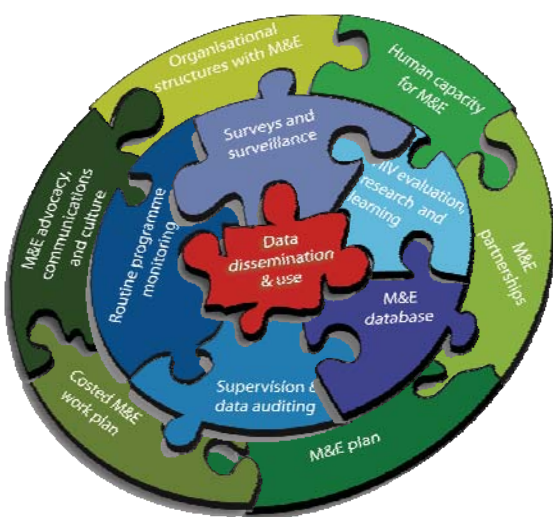
One has to remember that the above figures are not exact figures, as many of the development partners have not had their work plans following the same titles as the national strategic plan. Moreover, AusAID and ADB have had investment in areas not exactly covered by the seven focus area. AusAID have invested 33.9 and 38.9 million PGK in HIV mainstreaming and health sector in 2008 and 2009, respectively. They have also invested 6.2 and 13.8 million PGK in PNG organisations and individual capacity building in the two respective years. ADB have also invested a little above one million in 2008 and less than 900,000 PGK in civil works and equipments in 2008 and 2009, respectively.

It has to be mentioned that there are other development partners, like Clinton Foundation, who are part of the DFP but as they have received the majority of their funds from other donors, like AusAID, their contribution have not been mentioned in the above table.

Monitoring and Evaluation Environment

Introduction

The National Monitoring and Evaluation (M&E) system in PNG is guided by the “third one” of the **three ones principle** of having one national M&E system which is linked to the National Strategic Plan. Like any fully functioning national HIV M&E system it is comprised of the 12 components of: 1) organisational structures with HIV M&E functions, 2) human resources capacity for HIV M&E, 3) partnerships to plan, coordinate and manage the HIV M&E system, 4) national multi-sectoral HIV M&E plan, 5) annual costed national HIV M&E work plan, 6) advocacy, communications, culture for HIV M&E, 7) routine HIV programme monitoring, 8) surveys and surveillance, 9) national and sub-national HIV databases, 10) supportive supervision and data auditing, 11) HIV evaluation and research, and 12) data dissemination and use. These 12 components should be integrated with each other following the three tiers of “people. Partnership and planning”, “collecting, verifying and analysing data”, and “using data for decision making”, as it is depicted below.



The components of a national HIV M&E system have been translated locally in the NSP 2006-2010 and are specifically covered in three out of the seven focused areas of the national strategy. These are (1) focus area III (epidemiology and surveillance), (2) focus area IV (social and behavioural research) (3) focus area VII (monitoring and evaluation).

Integration of the 12 components in National Monitoring and Evaluation in PNG

1. Organisational structures with HIV M&E functions

There has been a lot of progress in country to ensure that all M&E functions are realigned to existing structures and at the same time to ensure that these functions are fully realised and strengthened.

The M&E unit at the National AIDS Council Secretariat (NACS), the Surveillance Unit at the National Health Information System (NHIS) and the Surveillance and M&E unit within the National STI and HIV and AIDS program at the National Department of Health (NDoH) are the three main national structures with HIV M&E functions. Beside these three structures, the National Research Institute (NRI) and the PNG Institute of Medical Research (PNGIMR) are the two main research institutions who design and implement many of the HIV related surveillance and survey studies. The NACS Research Coordination Unit (RCU) is the main coordinating body for all HIV related research in PNG.

The main challenge is to ensure that there is regular and meaningful communication between the coordinating body with all the stakeholders to ensure that the comprehensive HIV/AIDS responses is monitored through this structure and monitoring reports are utilized to inform programming.

2. Human resource capacity for HIV M&E

There are two national teams - the NACS M&E Unit and the NDoH Surveillance/NHIS units. Both teams are struggling to address the planning, programming and logistical demands involved in coordinating the national M&E framework. They also have commitments to other priority areas such as the development of the new national HIV strategy. NDOH has strived over the past two and half years to increase its capacity to strengthen the STI and HIV and AIDS surveillance and M&E program. The program is currently managed by a staff of seven (7). These include staff with expertise in epidemiology, demography, statistics and mathematics. Department of health have just recruited four regional program M&E staff to support the regional program. Continuous short and long term capacity building of staff at national and sub nation levels involved in M&E is critical to ensure quality monitoring outcomes.

At the provincial level most provincial AIDS council secretariats (PACS) do not have positions or staff dedicated to M&E. There is a need for ongoing capacity development for all people engaged in HIV M&E, including partners in civil society. Although development partners have invested heavily in this area in past few years, a more coordinated approach to capacity development within the national M&E framework is required and need to be a higher priority for stakeholders, especially development partners.

3. Partnerships to plan, coordinate and manage the HIV M&E system

A high-level, overall M&E coordination mechanism is still in its initial stages of development. This mechanism, called the National M&E Oversight Committee (NOC), is chaired by the Director of NACS with representation from NDoH, NRI, PNGIMR, National Statistical Office (NSO), key government departments (Planning and Monitoring, Education Community Development), the PNG Alliance of Civic Society Organizations (PACSO), the private sector - Business Alliance Against HIV/AIDS (BAHA), faith based organizations, International NGOs, and the Development Partner Forum.

The main terms of reference for this committee is to coordinate all HIV and AIDS related M&E activities areas amongst all stakeholders at national and sub-national levels.

At the technical level, a Surveillance Technical Working Group (STWG) exists at NDoH which is responsible for providing coordinated technical oversight for all the STI and HIV and AIDS data gathering and management requirements, guidelines, and procedures. The STWG is chaired by NDOH and is comprised of representatives from NDOH, NACS, NRI, ADB, WHO, UNAIDS, UNDP, FHI, Igat Hope (an organisation of people living with HIV), PNGIMR, University of PNG and AusAID. Currently the STWG does not cover technical issues specific to programme monitoring data beyond the surveillance system.

The key challenge for the HIV and AIDS M&E system in this area is to ensure adequate coordination at both high and technical levels and ensure provision of necessary M&E support to subnational levels where implementation occurs.

4. National multi-sectoral HIV M&E plan

The NSP is into its last year of implementation and a lot has been achieved. These includes an over arching M&E framework that formed the basis for the monitoring of the HIV response over the last four years.

The new National HIV Strategy 2011-2015 is in development and with it a M&E framework will be developed that will form the basis to monitor the epidemic in the medium term.

The main challenge for the next national HIV strategy 2011-2015 is to ensure that the M&E framework is target driven and realistic enough to adequately monitor the trends in HIV and its associated risk behaviours to enable a better response. Another important challenge is for the M&E plan to embrace, to the extent possible, all the reporting commitments of the country and for the development partners to limit their reporting requirements to the national HIV M&E plan.

5. Annual costed national HIV M&E work plan

Annual work plans are available however they have never been successfully costed. The HIV/STI surveillance plan for 2007-2010 was developed through a consultative process and costed adequately which facilitated resources mobilization for its implementation. Besides costing a plan, the main challenge is to mobilise resources based on that plan and effectively use them for achieving M&E targets.

6. Advocacy, communications, culture for HIV M&E

Although very little has happened in this area, it can be argued that there is an increasing receptiveness to the incorporation on M&E into HIV programming.

7. Routine HIV programme monitoring

At the provincial level a coordinating mechanism known as ProMEST (Provincial Monitoring and Evaluation Surveillance), has been established in the last two years. Nineteen out of 20 provinces have formed ProMEST but there are significant challenges involved in ensuring they are fully functional accountable for providing quality data both for their respective provincial programme managers and the national M&E system. It has been observed that those provinces which have a well functioning ProMEST are generally better at reporting HIV related data compared to those where ProMEST are not functioning.

One of the overall challenges related to routine HIV programme monitoring is the existence of parallel reporting mechanisms. In addition to ProMEST and provincial surveillance systems, many implementing partners, mainly NGOs and FBOs, have their own systems and, have not been accountable to use the ProMEST monitoring tools and guidelines to report to the provincial and national levels. Instead they report using other formats and frameworks in line with the conditions set by their parent organisation or donor(s).

8. Surveys and surveillance

NDoH is the peak government body to coordinate all surveillance activities for STI and HIV and AIDS. Its core mandates includes reporting on (1) HIV and AIDS cases (2) STI cases (3) Conducting annual sentinel surveys on STI clients, ANC clients and TB patients. (4) Conduct Behavioural surveillance surveys (BSS). The surveillance reports for all these are available. NDOH in partnership with NRI in designing and conducting behavioural and bio-behavioural surveys. NDOH intends to initiate similar arrangements with PNGIMR to support BSS in implementation comprehensive second generation surveillance. The BSS component of the surveillance system has been sub-contracted to NRI who has so far completed one round of the BSS and are conducting the third rounds of BSS among different most-at-risk and more-at-risk groups. IMR have conducted bio-behavioural studies at different sites over the past ten years.

An integrated bio-behavioural survey among general population is being plan for this year.

Another challenge is a limited surveillance among MARPs either by NDOH or other technical institutions which limits comprehensible programming targeting this group

A lot has been achieved in the area of surveillance and program monitoring. The main challenge is to ensure that quality, accurate and timely surveillance strategic information is generated to guide planning and timely evidence based interventions.

9. National and sub-national HIV databases

With technical and financial support from development partners the M&E unit of NACS has established the HIV and AIDS data centre using the country response information system (CRIS). Aligning all HIV and AIDS data from all the sources is still in train.

10. Supportive supervision and data auditing

NACS have a policy of decentralization of M&E and surveillance to the provinces, including the reallocation of resources, delegation of power, infrastructural support and local capacity building. NDoH Surveillance unit with the assistance of WHO and Centre for Disease Control (CDC) Bangkok are currently piloting quality assurance and improvement tools that will improve data quality.

Implementing the policy faces many challenges. There are also ongoing issues related to the quality management of data coming from the provinces, and specific data quality assurance and control mentoring programmes for staff are required.

11. HIV evaluation and research

The National HIV/AIDS Research Agenda (2008-2013) was launched in 2008. For the first time the Research Coordination Unit of NACS has conducted a **Systematic Literature Review of HIV & AIDS Research in Papua New Guinea 2007-2008** with financial and technical support from AusAID. A thorough systematic review of 62 relevant studies in carried out or published in 2007 and 2008 has synthesised many the socio-cultural and bio-behavioural dimensions of HIV and AIDS including family values, economic and gender perspectives.

A national Research Advisory Committee (RAC) has been established and is functioning to ensure ethical design and implementation of HIV and AIDS research and compatibility of research with the HIV and AIDS Management and Prevention (HAMP) Act. The RAC is comprised of members from all research and academic institutions within Papua New Guinea, NGOs, CBOs, donor organizations, NDoH as well as representation of People Living with HIV and AIDS (PLHIV).

Another aspect of national monitoring and evaluation of the HIV and AIDS environment is the existence of the Independent Review Group (IRG). This a group of inter-disciplinary consultants engaged by NACS with funding support from AusAID and the United Nations. The IRG group carries out a regular assessment of the National Strategic Plan (NSP) and its achievements in the seven focus areas

The AusAID funded **Strengthening HIV Social Research Capacity in Papua New Guinea Project** is a collaboration between IMR and the National Centre in HIV Social Research, University of New South Wales and is contributing to building the capacity for HIV social research in PNG. The project is designed to position social research as a central component of the evidentiary base for 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.

An important challenge is the translation of research into the day-to-day practice of service providers and programme managers. Operations research is a subject not embraced by either service providers or researchers.

12. Data dissemination and use

While relatively good-quality data and information is being produced in PNG it is not consistently or systematically being passed on, and promoted to, programme planners and managers. There is a demonstrated need for an agreed plan on how to regularly update policies and programmes based on the regular review of available knowledge on the HIV epidemic and response in PNG.

Although there has been a lot of information generated and written about the epidemic in PNG, having program planners and policy makers to use this information for policy development and planning has been the main challenge.

Annex 1 Consultation and Preparation

Process of developing the 2010 UNGASS report

- The Surveillance Division, and Monitoring & Evaluation Section of Policy, Planning Division of NACS led the 2010 UNGASS report process, and supported by the UNAIDS and the UNDP Offices in PNG. The 2010 PNG Country UNGASS Report is the result of wide consultation and finalization of available NCPI information, program data and behaviour and knowledge information generated from the national response activities between 2008 and 2009.
- An invitation to form the Core Working Group was sent to 150 Government, non-government, faith based, development partners and Un systems in the country. After the first National consultation in October - November 2009, where about 80 stakeholders attended, the Core Working Group was formalized among the stakeholders who responded. Despite a record level attendance, PACSO, Igat Hope Inc, NDoH, WHO, UNAIDS, UNDP, and NACS were the only stakeholders that concurred to be on the Core Working Group. The Team Leader selected to lead and coordinate the UNGASS report process.
- The HIV and AIDS program directors, program managers and the monitoring and evaluation advisers and officers of the stakeholders participating in the national response contributed to the UNGASS report process. The National Department of Health, Surveillance Section was heavily responsible for collection and analysis of the program indicators, supported by the three data bases it established between 2007 and 2008. All the program data on ART and HCT reported by the nineteen provincial hospital laboratories, and the National Catholic AIDS Office – a faith based organization; and others were entered into the specific databases for reproduction of quarterly and annual reports; hence these data were verified for inclusion in the UNGASS report.

Apart from PNGIMR, for the first time, the NRI was actively involved in the generation of the behaviour and knowledge information through special surveys conducted in the economic enclaves; and the sentinel surveillance sites targeting the pregnant women and the STI clients in Port Moresby and Lae, the major cities in PNG.

The PNGIMR alone, or in collaboration with SCiPNG, World Vision and FHI continues to play crucial role in generating the data and information on the indicators on ART, HCT, and behaviour and knowledge of most at risk populations in the communities through out the country.

The Igat Hope Inc, the non-government organization comprising and representing the PLHIV was deeply involved in the collaboration, other NGOs and CSOs, particularly for indicators relating to ART, HCT, and knowledge and behaviour of most at risk populations.

- In total, there were 4 major consultations and 10 plus coordination meetings conducted by the UNGASS Core group for the purpose of the Report. Out of the 4 consultations, there 2 UNGASS stakeholder process consultations and 2 data vetting consultations. There were smaller follow up consultations for data vetting, and one provincial trip to verify data from the stakeholders. The main purposes of stakeholders consultation were to;

- present draft data and information for the 2010 UNGASS Country Report for Stakeholders comments and feedback
 - allow stakeholders contributing program data and narrative information to validate the draft data and information
 - seek stakeholders and partners support in order to finalize the UNGASS Draft Report ; and
 - reach consensus in the finalization of PNG UNGASS Country Report 2010
- The process for completing the NCPI for the 2008 PNG UNGASS Country Report, a local consultant was identified and engaged to provide required data and information for the NCPI component which is also Indicator 2. For the 2010 UNGASS Country Report, the same local consultant was unavailable when he was appointed to the position of Director of National Census, National Statistical Office, which led to the Core Working Group deciding NACS has to be supported to conduct the NCPI survey.

In February 2010, about 15 persons were identified by NACS from its list of interviewers from the past surveys, and instituted a two days training on NCPI questionnaires by the Core Working Group. From the training, 9 from the 15 persons were selected as the interviewers, and further 3 days for piloting of the questionnaires by them. The actual NCPI survey was conducted for 10 days, and another 10 days for data analysis and finalisation of the NCPI. It was a complete new experience for the Core Working Group.

- The final stakeholders consultation workshop was opened by the Acting Director of the National AIDS Council Secretariat on behalf of the Minister for Health & HIV, and the closing on the second day by the Chairman of the Parliamentary Select Committee on HIV/AIDS.

At each of the stakeholder consultation workshops, the Leader of the Core Working Group usually highlighted the UNGASS Report Process, and the stakeholders who generated data were invited to present their data. For the final workshop, on the first day, the stakeholders (NDoH, NRI, SciPNG and FHI) were selected to present and comment on their data. At the plenary sessions the participants contributed in the discussion and validation of data, giving them opportunity to share as well as critiques on the methodologies of data collection. On the second day, the participants were organised into four working groups to further discuss and agree on the NCPI, the program and behaviours and knowledge indicators of the most at risk populations. For each of the working groups, facilitators were appointed and the guiding questions and reporting sheets were provided. At the end of the 2 days workshop, all the presentations, group work reports and useful discussion points were recorded and collated for the final UNGASS country report.

- The level of representation and attendance at meetings by government, civil society, faith based and bilateral/multilateral sectors were satisfactory, however the participation by the key organizations like NDoH, NRI, PACSO, SCiPNG, FHI, Igat Hope, NACS and United Nations Systems like UNAIDS, UNDP, WHO and UNICEF was excellent.
- The notable assistance, in terms of financial and technical assistance, came from UNAIDS, UNDP, UNICEF and NACS. The NACS was the lead government agency in preparation, conduct of NCPI, collation of data and finalization of the UNGASS report.

- There were challenges encountered, the most notable being the sudden withdrawal of the local consultant, almost jeopardizing the NCPI component, and the entire UNGASS Report process. The other challenges were:
 - stakeholders too territorial for their data, unwilling to share their data; and restricting data collation and validation
 - stakeholders refusing to report to the National Data Centre of NACS, preferring to disseminate program data and reports to development partners and donors supporting their HIV intervention programs
 - there was no clear evidence that technical expertise exists within NACS for NCPI despite it been done in 2008, it was due largely to poor twinning arrangement in place at technical and specialist levels of M&E.
 - short time frame for compiling the report, resulting from NACS and UNAIDS delaying the starting date to November 2009, due to the lead agency (NACS) undergoing management changes.

- There were definite lessons learnt from this reporting round of the UNGASS report; and these are:
 - in general, the national specialist advisers and technical officers of NACS, for the first time, were fully involved and controlled the entire UNGASS Report process
 - the second UNGASS Report process has allowed for the capacity building of the technical officers of NACS working in surveillance and monitoring sections, elevating their confidence, and preparing them for the 2012 UNGASS Report
 - NCPI component of the UNGASS Report, especially for PNG, has to take place ahead of the other components, this is to adequately raise awareness, and to maximise utilisation of the technical officers for program indicators, and behaviour and knowledge indicators for most at risk populations.
 - Staff burn out has to be minimised in the future, if the NCPI component can be conducted and completed at least 6 weeks before the data vetting process.

Annex 2 National Composite Policy Index

NCPI Data Gathering and Validation Process

Describe the process used for NCPI data gathering and validation:

The UNGASS 2010 Core Group conducted NCPI training for 15 interviewers who were nominated to implement the NCPI survey and of the 15 interviewers trained only 7 remained to implement the survey.

Consent

Letters of consent for participation in the NCPI survey were sent out by the Director of the National Coordinating Body for various Government and Civil Societies informing them of the purpose of the survey and requested their participation.

Sample Selection and Sample Size

Seventy One (71) stakeholders at National level were identified by the Core Group as key national HIV program implementers. Of these stakeholders, 50 were nominated to participate in the survey. 20 were from the Government sector while 30 were from Civil Society. Apparently only thirty nine (39) interviews were conducted (16 from Government and 23 from Civil societies, this is 19 more than 2008 report where just 20 interviews were conducted.

Data Collection Methods

Desk review, face to face interviews, self administered questionnaire

Survey Implementation Period

Questionnaires were piloted over two days with interviewers and the survey itself was conducted over two weeks in Port Moresby and Goroka.

Data Management

Survey data was entered into Epi Data Database where analyses were done using Epi Info and Excel.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:

There were no major disagreements with respect to the responses. Some interviewees particularly those in the Government sector, had limited knowledge of existing laws and policies and a poor understanding of the level and scope of current HIV programs.

Highlight concerns – if any, related to the final NCPI data submitted such as data quality, potential misinterpretation of questions and the like:

As above, there were concerns with regards to the lack of knowledge of some of the interviewees. However, with regards to the analysis of the data, there was a thorough review of the data by the NCPI review team and consensus was reached on how the data should be presented and on its quality.

NCPI Respondents

[Indicate information for **all** whose responses were compiled to fill out (parts of) the NCPI in the below table; add as many rows as needed]

NCPI - PART A [to be administered to government officials]

	Organization	Names/Positions	Respondents to Part A [indicate which parts each respondent was queried on]				
			A.I	A.II	A.III	A.IV	A.V
1	National Department of Transport	Lucy Pius/Acting HR					
2	National AIDS Council Secretariat	Mr. Wep Kanawi/Acting Director	✓	✓	✓	✓	✓
3	National Capital District Provincial AIDS Committee	Rose Apini/Provincial Counselling Coordinator	✓	✓	✓	✓	✓
4	PNG Forestry Authority	Lesly Elias/Policy Manager Authority	✓	✓	✓	✓	✓
5	National Department of Health	Dr. Ismel Kitur/Epidemiologist	✓	✓	✓	✓	✓
6	National AIDS Council Secretary	Ishmael Robert/Provincial Liaising Officer	✓	✓	✓	✓	✓

7	National Department of Education	Information blocked	✓	✓	✓	✓	✓
8	National Volunteer Services	Tony Kluhdapaloh /Volunteer Placement Program Manager	✓	✓	✓	✓	✓
9	National AIDS Council Secretariat	Louis Mara /Provincial Liaising Officer	✓	✓	✓	✓	✓
10	Capacity Building Service Centre	Dr. John Millan/ART specialist	✓	✓	✓	✓	✓
11	PNG National Sports Federation	Loretae Hasu/M&E Officer	✓	✓	✓	✓	✓
12	Correctional Institutional Services	Mr Eko /Coordinator AIDS Desk	✓	✓	✓	✓	✓
13	Department of Community Development	Joseph Klapat /Member of NAC & Departmental Secretary	✓	✓	✓	✓	✓
14	National Planning Department	Rhoda Yani/Senior HIV Program Officer	✓	✓	✓	✓	✓
15	Papua New Guinea Defence Force	Lt .Col Gideon Kendino/Director Health Services	✓	✓	✓	✓	✓
16	Department of National Planning & Monitoring	Manager Planning and Monitoring Unit	✓	✓	✓	✓	✓

	Organization	Names/Positions	Respondents to Part B [indicate which parts each respondent was queried on]			
			B.I	B.II	B.III	B.IV
1	Baptist Union Church	Pastor Michael Pagasa /HIV/AIDS Project Manager	✓	✓	✓	✓
2	AusAIDS	Joe Anang/Project Consultant	✓		✓	✓
3	Friends Foundation	Rory Sitapai/Program Manager	✓	✓	✓	✓
4	Nambawan Supa	Mrs Loka Kulu /Manager HR	✓	✓	✓	✓

5	Care International PNG	Peter Raynes /Country Director	✓	✓	✓	✓
6	JICA	Davis Kia/Not stated	✓	✓	✓	✓
7	PNG Sexual Health Society	Dr. Sylvester Lahe / Secretary Board of PNG SHS	✓	✓	✓	✓
8	Family Health International (FHI)	William Yeka/Senior Technical Officer- M&E	✓	✓	✓	✓
9	National Catholic AIDS Office	Sr. Tarcisia Hunhoff/NAC Member &HIV Program Coordinantor	✓	✓	✓	✓
10	Marie Stops	Jet Riparip /ProgramCoordinator	✓	✓	✓	✓
11	Anglicare StopAIDS	Dominica Abo/Director	✓	✓	✓	✓
12	Salvation Army	Christine Gee/Coordinator HIV Desk	✓	✓	✓	✓
13	ADB	Kel Brown/Deputy Team Leader	✓	✓	✓	✓
14	Hope Worldwide	John Kuman & Peter Sine/Coordinators HIV Program	✓	✓	✓	✓
15	Apostolic AIDS Association	Lako Manson /Project Coordinator	✓	✓	✓	✓
16	Susu Mamas	Margaret Rombuk /Clinical manager	✓	✓	✓	✓
17	PACSO	Dr. Moale Kariko/Secretary Board of PACSO	✓	✓	✓	✓
18	Tingim Laip (Burnet Institute)	Judy Tokeimota/Regional Coordinator	✓	✓	✓	✓
19	PNG- Australia HIV/AIDS Program (Sanap Wantaim)	Dr. Ninkama Moiya /HIV&AIDS Adviser	✓	✓	✓	✓
20	WHO	Dr. Fabian Ndenzako/HIV Surveillance Adviser	✓	✓	✓	✓
21	Clinton Foundation	Mr Prescott Chow/Deputy Country Director	✓	✓	✓	✓
22	National HIV Training Unit- IEA	Thomas Lisenia /Team Leader	✓	✓	✓	✓
23	UNESCO	Andrew Angobe/Not Stated	✓	✓	✓	✓

Part A
[to be administered to government officials]

I – STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes	
-----	--

Period covered:

The National Strategic Plan - 2006 - 2010

New National HIV Strategy (NHS) 2010 – 2015 is currently under development.

IF NO or NOT APPLICABLE, briefly explain why.

IF YES, complete questions 1.1 through 1.10; IF NO, go to question 2.

1.1 How long has the country had a multisectoral strategy?

Number of Years:

Medium Term Plan (2000 – 2005)

National Strategic Plan (2006 – 2010)

National HIV Strategy (2010 – 2015)

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors	Included in strategy	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 (Refer to below list)	Yes	No

Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry, Provincial Government Departments and the National Coordinating Body the National AIDS Council.

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

Funding support from:

- **1. Respective National and Provincial Government Agencies Annual Activity Plans (AAP)**
- **2. NACS Development Budget**
- **3. NACS Grants Scheme**
- **4. Bilateral/Multilateral Agencies (AusAID, United Nations Agencies, Global Fund to fight TB, AIDS and Malaria, Clinton Foundation, NZAIDS, USAID, JICA)**
- **5. International NGOs including faith based organisations**

1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?

IF YES, when was this needs assessment conducted?

Social Mapping (2004), High Risk Setting Strategy (2004/5) and regular program based evaluations

IF NO, explain how were target populations identified?

1.5 What are the identified target populations for HIV programmes in the country?

Most at risk populations - Sex workers, Men who have Sex with Men, Highway Drivers, Plantation workers, Maritime workers, Uniform services, Mine Workers, Youth (in and out of school), Mobile Men with Money (MMM), Prisoners.

1.6 Does the multisectoral strategy include an operational plan?

Yes	
------------	--

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes	
b. Clear targets or milestones?	Yes	
c. Detailed costs for each programmatic area?	Yes	
d. An indication of funding sources to support programme implementation?	Yes	
e. A monitoring and evaluation framework?	Yes	

1.8 Has the country ensured “full involvement and participation” of civil society* in the development of the multisectoral strategy?

Active involvement		
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IF active involvement, briefly explain how this was organised:
National AIDS Council coordinated the involvement of civil society at national, provincial and district levels.

IF NO or MODERATE involvement, briefly explain why this was the case:

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes	
-----	--

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

	Yes, some partners	
--	--------------------	--

IF SOME or NO, briefly explain for which areas there is no alignment / harmonization and why

- **Some partners do not report to the National AIDS Council**
- **Implementation of parallel programs.**

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes		
-----	--	--

* - Civil society includes among others: networks 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 groups (including men who have sex with men, sex workers, injecting drug users, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

2.1 **IF YES**, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	Yes		
b. Common Country Assessment / UN Development Assistance Framework	Yes		
c. Poverty Reduction Strategy (MTDS)	Yes		
d. Sector-wide approach	Yes		
e. Other: <i>Education HIV and AIDS Plan, National Agriculture Plan, Fisheries HIV/AIDS Plan, PNG Ports, National Sports Commission, Department of Health HIV Strategic Plan.</i>	Yes		

2.2 **IF YES**, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)		
HIV prevention	Yes	
Treatment for opportunistic infections	Yes	
Antiretroviral treatment	Yes	
Care and support (including social security or other schemes)	Yes	
HIV impact alleviation	Yes	
Reduction of <i>gender</i> inequalities as they relate to HIV prevention/treatment, care and/or support	Yes	
Reduction of <i>income</i> inequalities as they relate to HIV prevention/treatment, care and /or support	Yes	
Reduction of stigma and discrimination	Yes	
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	
Other: Orphans and other vulnerable children		

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes		
-----	--	--

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

Low						High
0	1	2	3	4	5	

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes		
-----	--	--

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

Behavioural change communication	Yes	
Condom provision	Yes	
HIV testing and counselling	Yes	
Sexually transmitted infection services	Yes	
Antiretroviral treatment	Yes	
Care and support	Yes	
Others: <i>[write in]</i>		

If HIV testing and counselling is provided to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g, indicate if HIV testing is voluntary or mandatory etc):

HIV testing in the military is part of the routine process for internal medical checks otherwise it is voluntary for all other uniform services

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes

5.1 **IF YES**, for which subpopulations?

a. Women	Yes	
b. Young people	Yes	
c. Injecting drug users	Yes	
d. Men who have sex with men	Yes	
e. Sex Workers	Yes	
f. Prison inmates	Yes	
g. Migrants/mobile populations	Yes	
h. Other: PLHIV	Yes	

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Implementation of HIV AIDS Management and Prevention (HAMP) Act through respective implementation Agencies :

- Courts, Police, Ombudsman Commission, Public and the Legal fraternity and village courts including**

- **Traditional problem solving systems**

Briefly comment on the degree to which these laws are currently implemented:

- **Although the HAMP Act came into effect in 2004, there is a low level of knowledge of the Act among the general population and legal assistance to follow up on discrimination outlawed under the Act is difficult for most people to access.**

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes	
-----	--

6.1 **IF YES**, for which subpopulations?

a. Women	Yes	
b. Young people	Yes	
c. Injecting drug users	Yes	
d. Men who have sex with men	Yes	
e. Sex Workers	Yes	
f. Prison inmates	Yes	
g. Migrants/mobile populations	Yes	
h. Other: <i>[write in]</i>	Yes	

IF YES, briefly describe the content of these laws, regulations or policies:

- **Summary Offences Act 1977, Sections 55, 56, and 57 and Section 123 of the Criminal Code Act 1974 (living off the earnings of prostitution)**
- **Criminal Code Act 1974, Section 120 deals with the offence on sexual penetration, “against the order of nature”, while section 212 covers acts of “gross indecency between male persons”.**
- **Health Insurance Policies which discriminate against people with HIV**

Briefly comment on how they pose barriers:

The Summary Offences Act and the Criminal Code criminalise consensual sex between adults (sex work, male to male sex); health insurance policies prevents PLHIV from accessing health insurance

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

Yes	
-----	--

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes	
-----	--

7.2 Have the estimates of the size of the main target populations been updated?

	No
--	----

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy

Estimates of current and future needs		
---------------------------------------	--	--

7.4 Is HIV programme coverage being monitored?

Yes	
-----	--

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

Yes	
-----	--

(b) *IF YES*, is coverage monitored by population groups?

Yes	
-----	--

IF YES, for which population groups?

- Both male and female youth
- HIV/STI and TB patients coming through VCT and STI treatment facilities
- PLHIV accessing treatment and home and community based care
- Pregnant mothers attending antenatal clinics

Briefly explain how this information is used:

- Planning and budgeting
- Awareness raising and education
- Advocacy for resource mobilisation

(c) Is coverage monitored by geographical area?

Yes	
-----	--

IF YES, at which geographical levels (provincial, district, other)?

Provincial, district and facility levels

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes	
-----	--

<i>IF NO</i> , briefly explain why not and how AIDS programmes are being managed:

2.1 IF YES, when was it created?

Year: **1997**

2.2 IF YES, who is the Chair?

Name: **Sir Peter Barter** Position/Title: **Chairman**

2.3 IF YES, does the national multisectoral AIDS coordination body:

have terms of reference?		Yes	
have active government leadership and participation?		Yes	
have a defined membership?		Yes	
<i>IF YES</i> , how many members?	15		
include civil society representatives?		Yes	
<i>IF YES</i> , how many?	6		
include people living with HIV?		Yes	
<i>IF YES</i> , how many?	1		
include the private sector?		Yes	
have an action plan?		Yes	
have a functional Secretariat?		Yes	
meet at least quarterly?		Yes	
review actions on policy decisions regularly?		Yes	
actively promote policy decisions?		Yes	
provide opportunity for civil society to influence decision-making?		Yes	
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?		Yes	

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes		
-----	--	--

IF YES, briefly describe the main achievements:

- **Development of the National HIV Prevention Strategy (2010 – 2015)**
- **Sector policies, strategies and programs that are linked to the national HIV/AIDS response strategy**
- **Establishment of the Business Coalition against HIV and AIDS (BAHA), IGAT Hope, PNG Alliance of Civil Society Organisations (peak organisations for the civil society response to HIV)**
- **Development of the National M & E Framework**
- **Establishment of sub committees under NAC e.g. Research Advisory Committee, NSP Steering Committee, Work Place Policy, Behaviour Change Advisory Committee)**
- **Development of Provincial and District HIV Plans**
- **Joint Budget Planning Framework**
- **Parliamentary HIV Committee (Select Committee on AIDS)**

Briefly describe the main challenges:

- **Institutional capacity of partner organisations and understanding of the importance of partnership and collaboration**
- **Commitment from Government and political leaders**
- **Lack of knowledge on HIV and AIDS especially among community, church and political leaders**

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Percentage: **Not known**

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes	
Technical guidance	Yes	
Procurement and distribution of drugs or other supplies	Yes	
Coordination with other implementing partners	Yes	
Capacity-building	Yes	
Other: Funding, Resource allocation and technical Support,	Yes	

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

	No
--	----

6.1 **IF YES**, were policies and laws amended to be consistent with the National AIDS Control policies?

	No
--	----

IF YES, name and describe how the policies / laws were amended:

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

The HAMP Act outlaws discrimination against people with HIV and supports people to protect themselves from HIV infection, however other laws such as the Summary Offences Act and the Criminal Code outlaws certain activities such as sex work and male to male sex thereby hindering the implementation of the HAMP Act and corresponding National AIDS Control Policies.

Overall, how would you rate the *political support* for the HIV programme in 2009?

2009 Very Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

Since 2007, what have been key achievements in this area:

- Increased government funding for HIV programs especially at the district level
- Outspoken support for HIV programs from some political leaders
- Endorsement by the national government of the National HIV Prevention Strategy and the Pacific AIDS Commission Report
- Funding allocated by the national government for the purchase of antiretroviral drugs

What are remaining challenges in this area:

- Relatively low level of government funding, particularly in comparison to international donors
- Inconsistent levels of government funding from one year to the other
- Lack of knowledge of HIV among political leaders and lack of commitment to the national response
- Lack of understanding of the national response by political, community and church leaders

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		
-----	--	--

1.1 **IF YES**, what key messages are explicitly promoted?

Check for key message explicitly promoted

a. Be sexually abstinent	Yes
b. Delay sexual debut	Yes
c. Be faithful	Yes
d. Reduce the number of sexual partners	Yes
e. Use condoms consistently	Yes
f. Engage in safe(r) sex	Yes
g. Avoid commercial sex	No
h. Abstain from injecting drugs	No
i. Use clean needles and syringes	No
j. Fight against violence against women	Yes
k. Greater acceptance and involvement of people living with HIV	Yes
l. Greater involvement of men in reproductive health programmes	Yes
m. Males to get circumcised under medical supervision	No
n. Know your HIV status	Yes
o. Prevent mother-to-child transmission of HIV	Yes
Other:	

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

Yes	
-----	--

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

Yes		
-----	--	--

2.1 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?

	No
--	----

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

Yes	
-----	--

IF NO, briefly explain:

--

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

Check which specific populations and elements are included in the policy/strategy

	IDU	MSM	Sex Workers	Clients of sex workers	Prison inmates	Other populations [write in]
Targeted information on risk reduction and HIV education		✓	✓	✓	✓	PLHIV, Youth, Orphans & Women
Stigma and discrimination reduction		✓	✓	✓	✓	PLHIV, Youth, Orphans & Women
Condom promotion		✓	✓	✓	✓	PLHIV, Youth, Orphans & Women
HIV testing and counselling		✓	✓	✓	✓	PLHIV, Youth, Orphans & Women
Reproductive health, including sexually transmitted infections prevention and		✓	✓	✓	✓	PLHIV, Youth, Orphans

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	
-----	--

1.1 *IF YES*, does it address barriers for women?

Yes	
-----	--

1.2 *IF YES*, does it address barriers for most-at-risk populations?

Yes	
-----	--

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes	
-----	--

IF YES, how were these determined?

- 2007 HIV prevalence estimation and projection report
- Health facility reports
- Numbers of people accessing VCT services and rates of infection determined through VCT
- STI prevalence reports

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

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy	Agree		

Nutritional care		Don't Agree	
Paediatric AIDS treatment		Don't Agree	
Sexually transmitted infection management	Agree		
Psychosocial support for people living with HIV and their families		Don't Agree	
Home-based care		Don't Agree	
Palliative care and treatment of common HIV-related infections		Don't Agree	
HIV testing and counselling for TB patients		Don't Agree	
TB screening for HIV-infected people	Agree		
TB preventive therapy for HIV-infected people	Agree		
TB infection control in HIV treatment and care Facilities		Don't Agree	
Cotrimoxazole prophylaxis in HIV-infected people	Agree		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree		
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree		
HIV care and support in the workplace (including alternative working arrangements)	Agree		
Other: <i>[write in]</i>			N/A

3. Does the country have a 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 mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

Yes	
-----	--

IF YES, for which commodities?:

- *ARV, drugs for opportunistic infections (OI), HIV test kits and condoms*

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?

2009	Very Poor										Excellent	
		0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- Rapid scale up of ART in 2008 & 2009
- Increased testing rates at VCT sites and increase in referrals to care and treatment centre
- Increased number of testing and treatment sites

What are remaining challenges in this area:

- Expansion of treatment into district level facilities
- Monitoring and evaluation of ART and VCT programs
- Training of health workers as ART prescribers and counsellors
- Procurement and distribution of ART, OI drugs and HIV test kits
- Health facility reporting on VCT and ART

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes		
-----	--	--

5.1 **IF YES**, is there an operational definition for orphans and vulnerable children in the country?

Yes	
-----	--

5.2 **IF YES**, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	
-----	--

5.3 **IF YES**, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

	No
--	----

IF YES, what percentage of orphans and vulnerable children is being reached?

V. MONITORING AND EVALUATION

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

Yes		
-----	--	--

IF NO, briefly describe the challenges:

--

1.1 **IF YES**, years covered: **2006 - 2010**

1.2 **IF YES**, was the M&E plan endorsed by key partners in M&E?

Yes	
-----	--

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

Yes	
-----	--

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

		Yes, but only some partners	
--	--	-----------------------------	--

IF YES, but only some partners or IF NO, briefly describe what the issues are:

- **Some partners engaged in delivering HIV programs do not report directly to the National AIDS Council, disregarding the three ones principle.**
- **Monitoring and coordination needs strengthening at all levels - national , provincial, district and community**

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	Yes	
IF YES , does it address:		
routine programme monitoring	Yes	
behavioural surveys	Yes	

HIV surveillance	Yes	
Evaluation / research studies	Yes	
a well-defined standardised set of indicators	Yes	
guidelines on tools for data collection	Yes	
a strategy for assessing data quality (i.e., validity, reliability)	Yes	
a data analysis strategy	Yes	
a data dissemination and use strategy	Yes	

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

Yes		
-----	--	--

3.1 **IF YES**, what percentage of the total HIV programme funding is budgeted for M&E activities? 8 %

3.2 **IF YES**, has *full* funding been secured?

	No
--	----

IF NO, briefly describe the challenges:

Most development partners funding for monitoring and evaluation does not come directly to National AIDS Council

3.3 **IF YES**, are M&E expenditures being monitored?

	No
--	----

4. Are M&E priorities determined through a national M&E system assessment?

Yes	
-----	--

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

It is done every 6 months by the Independent Review Group

IF NO, briefly describe how priorities for M&E are determined:

5. Is there a functional national M&E Unit?

Yes		
-----	--	--

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

5.1 IF YES, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	Yes	
in the Ministry of Health?		No
Elsewhere?		

5.2 IF YES, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff: 7 – 6 National and 1 international			
Position:	Manager	Full time	2005
Position:	Senior M & E Officer	Full time	2005
Position:	Statistician	Full time	2007
Position:	M & E Officer	Full time	2009
Position:	M & E Officer	Vacant	
Number of temporary staff:			
Position:	M& E specialist	Long term consultant	2005
Position:	Data Entry Officer	Temporary	2007

5.3 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 for inclusion in the national M&E system?

Yes	
-----	--

IF YES, briefly describe the data-sharing mechanisms:

Reporting on a quarterly basis

What are the major challenges?

Consistent timely reports
Dissemination
Provincial level manpower

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

	Yes, but meets irregularly	
--	----------------------------	--

6.1 Does it include representation from civil society?

Yes	
-----	--

IF YES, briefly describe who the representatives from civil society are and what their role is:

- PACSO, PLHIV, Faith based organisations, community based organisations, National Department of Health
- Identify indicators
- Review policies and validate reports

7. Is there a central national database with HIV- related data?

Yes	
-----	--

7.1 **IF YES**, briefly describe the national database and who manages it

A fulltime statistician who manages all program and surveillance data with the support of the two monitoring and evaluation officers

7.2 **IF YES**, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. **Yes**

7.3 Is there a functional* Health Information System?

At national level	Yes	
At sub-national level IF YES, at what level(s)? Provincial and District Level s	Yes	

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

Yes	
-----	--

9. To what extent are M&E data used

9.1 in developing / revising the national AIDS strategy?:

Low High

0 1 2 3 4 5

Provide a specific example:

M & E Data is used for programs at all levels

What are the main challenges, if any?

Timely and comprehensive reporting

Dissemination of reports

Coordination, collection and consolidation of HIV data

9.2 for resource allocation?:

Low High

0 1 2 3 4 5

Provide a specific example:

- **Increased annual funding for M&E program**
- **Established provincial level committee in all provinces – Provincial Monitoring, Evaluation and Surveillance Teams (PROMEST)**

What are the main challenges, if any?

- **Capacity building in terms of technical expertise, manpower at national and provincial levels**
- **Coordination and networking with stakeholder at all levels**

9.3 for programme improvement?:

Low High

0 1 2 3 4 5

Provide a specific example:

- **Implementation of reporting forms at all levels and equipping of PROMEST in all 20 provinces**

What are the main challenges, if any?

- Capacity in technical expertise at program level
- Timely and comprehensive reporting from data sources to PROMEST and National Data Centre

10. Is there a plan for increasing human capacity in M&E at national, subnational and service-delivery levels?:

Yes, but only addressing some levels

10.1 In the last year, was training in M&E conducted

At national level?		No
IF YES, Number trained:	36	
At subnational level?	Yes	
IF YES, Number trained:	100	
At service delivery level including civil society?	Yes	
IF YES, Number trained:	100	(combined with sub national)

10.2 Were other M&E capacity-building activities conducted other than training?

Yes

IF YES, describe what types of activities:

Implementation of the revised M&E forms
Resourcing of twenty PROMESTs

Overall, how would you rate the *M&E efforts* of the HIV programme in 2009?

2009	Very Poor											Excellent
		0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

Establishment of PROMEST in all 20 provinces
Implementation of revised M&E and surveillance forms
Resourcing all 20 provinces with M&E equipment (computers, projectors, fax machines)

What are remaining challenges in this area:

Technical capacity at all levels (manpower, expertise, logistics, funding)
Timely and comprehensive reports

Part B

[to be administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

I. HUMAN RIGHTS

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

Yes	
-----	--

1.1 **IF YES**, specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision:

HIV and AIDS Management and Prevention Act (2003)

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes	
-----	--

2.1 **IF YES**, for which populations?

a. Women	Yes	
b. Young people	Yes	
c. Injecting drug users	Yes	
d. Men who have sex with men	Yes	
e. Sex Workers	Yes	
f. Prison inmates	Yes	
g. Migrants/mobile populations	Yes	
h. Other:		

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.

Ongoing training for organizations to ensure workplace policies are consistent with 12 guiding principles of workplace policy.

PACSO (PNG Alliance of Civil Society Organizations) and BAHA (Business Against HIV and AIDS) were established and include the implementation of the Act as part of their organizational mandate.

Provisions have been made in the National M&E Strategy for monitoring the implementation of the Act

A notable development at the political level was the establishment of a separate HIV and AIDS portfolio at the government level to support the implementation of the Act. The Minister for Health is officially the Minister of Health and HIV.

Briefly describe the content of these laws:

- **HAMP ACT: Protection of rights of PLHIV; protection of confidentiality of testing and status; prohibition of discrimination against populations infected and affected; safeguards from intentional infection by HIV. However, law is nonspecific in terms of penalties for violations of human rights.**

Briefly comment on the degree to which they are currently implemented:

Through Court, Police, Ombudsman Commission, Legal fraternity system.

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

Yes	
-----	--

3.1 **IF YES**, for which subpopulations?

a. Women	Yes		
b. Young people	Yes		
c. Injecting drug users		No	
d. Men who have sex with men	Yes		
e. Sex Workers	Yes		
f. Prison inmates	Yes		
g. Migrants/mobile populations	Yes		
h. Other:			

IF YES, briefly describe the content of these laws, regulations or policies:

- **Summary Offences Act 1977: Section 55, 56, and 57, Living off the earnings of prostitution and Section 123 of the Criminal code ACT 1974**

- Criminal Code, Section 120 deals with the offence on sexual penetration “ against the order of nature” while section 212 covers acts of “ gross indecency between male persons.
- HAMP ACT 2003 contains provisions which make the above unlawful:
To stigmatise a person with HIV or a person belonging to a group presumed to be at risk of HIV
- To deny a person access without reasonable excuse to a means of protection from infection of himself or another by HIV.
- Health Insurance Policies (of private companies, NTI, etc.) which discriminate against people with HIV
- Some Church policies prevent promotion of condom use or discourage ART, and provide false information about faith healing

Briefly comment on how they pose barriers:

The Summary Offences Act and the Criminal Code criminalise consensual sex between adults (sex work, male to male sex); health insurance policies prevents PLHIV from accessing health insurance

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

Yes	
-----	--

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

HAMP Act: Prohibits discrimination and stigmatisation of PLHIV in employment & access to services; promotes access to prevention, treatment and care

HIV/AIDS Workplace Policy: Prohibits discrimination and stigmatisation of PLHIV in employment and provides access to prevention, treatment and care

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

Yes	
-----	--

IF YES, briefly describe this mechanism:

There is no separate mechanism specifically to record, document and address such cases. Police, courts & judiciary are identified as mechanisms in place (if there are charges made or court cases), however they are not well known to the public and relevant law enforcement is weak.

Some organisations provide limited resources to address cases of discrimination (largely untested) including the Ombudsman Commission, Indigenous Civil Rights Advocacy Forum , Transparency International and the Family Sexual Violence Action Committee.

5. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?

Yes	
-----	--

IF YES, describe some examples:

The development of the current NSP included input from Igat Hope, National Youth Commission and National Council of Women

The development of the new National HIV Strategy has adopted an inclusive approach involving input from PLHIV, women and men in sex work, men who have sex with men and students and other youth (National Youth Commission/Department of Community Development).

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

a. HIV prevention services	Yes	
b. Antiretroviral treatment	Yes	
c. HIV-related care and support interventions	Yes	

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

National Department of Health and NAC promote these services through national and provincial public health service delivery as well as the Church Medical Services network. Some access to treatment is provided by private corporations. Prevention services are coordinated by NAC and provincial AIDS committees, including supply of IEC materials and condoms. Training in home-based care, counselling and related skills are also provided through the national government.

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes	
-----	--

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes	
-----	--

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

Yes	
-----	--

IF YES, briefly describe the content of this policy:

The National Strategic Plan 2006 – 2010 identifies strategies for risk populations, however, the new National HIV Strategy will have a greater focus on prevention, treatment, care and support for most-at-risk populations

9.1 **IF YES**, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes	
-----	--

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

User friendly, gender specific and non judgemental counselling and testing services. Specific programs for sex workers and men who have sex with men such as Save the Children Poro Sapot project

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

Yes	
-----	--

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

Yes	
-----	--

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

Yes	
-----	--

IF YES, describe the approach and effectiveness of this review committee:

The research protocols and guidelines are in place to ensure privacy, confidentiality, stigma and discrimination issues are addressed in all researches undertaken in PNG.

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 commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes	
-----	--

– 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

Yes	
-----	--

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	
-----	--

13. In the last 2 years, have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV 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 systems for HIV casework

Yes	
-----	--

PACSO, BAHA, Faith based organisations, members of PLHIV groups and the Media Council).

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

a. the national AIDS strategy?



b. the national AIDS budget?



c. national AIDS reports?



Comments and examples:

Six civil society organisations are represented on the NAC. The current NSP was prepared with CSO involvement and the new HIV strategy, currently under development will reflect significant input from civil society organisations including PLHIV.

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. developing the national M&E plan?



b. participating in the national M&E committee / working group responsible for coordination of M&E activities?



c. M&E efforts at local level?



Comments and examples:

- a) CSO have been involved in developing the national plan
- b) CSO are members of the National M&E Oversight Committee

c) CSO are active in local level M&E efforts (projects, communities, programs)

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

Low High
0 1 2 3 4 5

Comments and examples:

Formal representation exists in many cases but this by itself may not result in meaningful contributions (due to lack of experience, stigma and other factors).

Formal representation exists in many cases but this by itself may not result in meaningful contributions (due to lack of experience, stigma and other factors).

PLHIV played a significant role in the launch of the Pacific AIDS Commission report and the National HIV Prevention Strategy 2010 – 2015 held at Parliament House, Port Moresby, 11 March 2010. Over 50 PLHIV were involved and included MSM, female and male sex workers and transgender participants. PLHIV formed a guard of honour for the guests and presented red ribbons to key stakeholders. Four nominated representatives spoke openly in public for the first time about human rights and the discrimination they faced. Two other representatives then presented the two documents to be launched. The response from PLHIV after the launch was that this was the first time that they ever felt their cries had been heard publicly and this made them feel they belonged to the broader society of the country. The public speeches also stimulated a debate on the culturally sensitive issues of sexual identity and HIV disclosure.

6. To what extent is civil society able to access:

a. adequate financial support to implement its HIV activities?

Low High
0 1 2 3 4 5

b. adequate technical support to implement its HIV activities?

Low High
0 1 2 3 4 5

Comments and examples:

Some CSO, especially international NGOs are extremely skilled in accessing support while others need to have their capacity built.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for youth			51-75%	
Prevention for most-at-risk-populations				
- Injecting drug users	<25%			
- Men who have sex with men				>75%
- Sex workers			51-75%	
Testing and Counselling			51-75%	
Reduction of Stigma and Discrimination			51-75%	
Clinical services (ART/OI)		25-50%		
Home-based care				>75%
Programmes for OVC		25-50%		

Overall, how would you rate the efforts to increase *civil society participation* in 2009?

2009	Very Poor											Excellent
		0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

- Formation of PACSO, Igat Hope, BAHA, Friends Frangipane
- Amendment to National AIDS Council Act has increased CSO representation on the NACS Council
- AusAID (funding through Sanap Wantaim) and other development partners (ex: Clinton Foundation) more accessible for some NGOs
- NACS small grants program

What are remaining challenges in this area:

- Lack of coordination & communication amongst CSO, and between CSO and government
- Networking of national CSO (PACSO, Igat Hope) to provincial and district levels weak
- Lack of capacity of national CSO in general
- Need for MOU between NGOs directly-funded by other donors and the NACS to clarify roles & responsibilities re: NACS/PACS

III. Prevention

1. Has the country identified the specific needs for HIV prevention programmes?

Yes	
-----	--

IF YES, how were these specific needs determined?

Yes, with the recently launched HIV Prevention Strategy, needs were determined through a series of consultative meetings with stakeholders at national and provincial levels.

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

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access		
Blood safety	Agree		
Universal precautions in health care settings		Don't Agree	
Prevention of mother-to-child transmission of HIV		Don't Agree	
IEC* on risk reduction	Agree		
IEC on stigma and discrimination reduction	Agree		
Condom promotion	Agree		
HIV testing and counselling	Agree		
Harm reduction for injecting drug users		Don't Agree	
Risk reduction for men who have sex with men	Agree		
Risk reduction for sex workers	Agree		
Reproductive health services including sexually transmitted infections prevention and treatment	Agree		
School-based HIV education for young people	Agree		
HIV prevention for out-of-school young people		Don't Agree	
HIV prevention in the workplace	Agree		
Other:			

0 1 2 3 4 5 6 7 8 9

* - IEC = information, education, communication

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes		
-----	--	--

IF YES, how were these specific needs determined?

The National Strategy Plan includes treatment, care & support as a major strategy with a goal to decrease morbidity and mortality related to HIV disease. The National Department of Health has taken on this strategy, conducted needs assessments, situation analysis and developed a health sector HIV strategy to scale up the program

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

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy	Agree		
Nutritional care		Don't Agree	
Paediatric AIDS treatment		Don't Agree	
Sexually transmitted infection management	Agree		
Psychosocial support for people living with HIV and their families		Don't Agree	
Home-based care		Don't Agree	
Palliative care and treatment of common HIV-related infections		Don't Agree	
HIV testing and counselling for TB patients		Don't Agree	
TB screening for HIV-infected people	Agree		
TB preventive therapy for HIV-infected people		Don't Agree	
TB infection control in HIV treatment and care facilities		Don't Agree	
Cotrimoxazole prophylaxis in HIV-infected people	Agree		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree		
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree		
HIV care and support in the workplace (including alternative working arrangements)		Don't Agree	
Other:			

Annex 3 Contributors

LIST OF CONTRIBUTORS FOR THE COMPILATION OF THE 2010 UNGASS PNG COUNTRY REPORT

The table below shows the names of people and or organizations that have provided data and / or information; and provided technical assistance during the 2010 UNGASS reporting process.

1. Organizations and / or people who have provided data for the whole UNGASS report

No	Name	Position	Organization
1	Mr. Meagan Morrison	M& E Officer	Anglicare Stop AIDS
2	Ms Dominica B. Abo	Director	Anglicare Stop AIDS
3	Mr Shiv Nair	Country Director	Family Health International (FHI)
4	Mr. Richard Jones	Private Consultant	
5	Mr John Moni	HIV Testing Database Manager	National Department of Health (NDoH)
6	Mr. Namarola Lote	Statistician	PNG Institute of Medical Research
7	Mr. Sam Ghanshyam Jethwa	Country Program Manager	Save the Children, PNG (SCiPNG)
8	Ms Evelyn Ofasio	Port Moresby Program Manager	World Vision
9	Mr. Clement Bundo		National Catholic AIDS Office
10	Mr. Terry Opa	Communications and Knowledge Management Advisor	PNG-Australia HIV and AIDS Program
11	Mr. Christopher Hearshey	Project Manager	Poros Support Project (Save the Child)
12	Ms Lydia Seta		Poros Support Project (Save the Child)
13	Ms Delvin Kupundu	M&E Officer	Poros Support Project (Save the Child)
14	Mr. Jonathan Wala	M&E Officer	Poros Support Project (Save the Child)
15	Dr. Wilfred Kaleva	Manager - Research	NACS

		Coordination Unit	
16	Mr. Marcel Burro	Surveillance Officer	NACS
17	Mr. Bomal Gonopa	Legal Advisor	NACS
18	Mr. Michael Aglua	Manager - Policy, Planning & Evaluation (PPE)	NACS
19			Business Coalition against HIV and AIDS (BAHA)
20	Ms Cynde Robinson	Country Director	Population Services International (PSI)
21	Kayleen Sapak	Social and Behavioral Researcher	National Research Institute (NRI)
22	Frances Akuani	Social and Behavioral Researcher	National Research Institute (NRI)
23	Francis Kupe	BSS Statistician	National Research Institute (NRI)

2. Individuals who participated in the questionnaire survey for the National Composite Policy Index (NCPI) indicator

2.1 Interviewers

2.1.1 Mr Dunstan DIRUA

2.1.2 Mr Michael John MIRIA

2.1.3 Mr Kenneth LAO

2.1.4 Mr Kila Gege

2.1.5 Mr Don LIRIOPE

2.1.6 Mr Cletus SIKAS

2.1.7 Mrs Sebeya LUPIWA

2.1.8 Mr Charles Tenakanai

2.1.9 Ms Naomi Libeli

2.2 Interviewees

NO	NAMES	POSITION	ORGANIZATION
1	Lucy Pius	Acting HR	National Department of Transport
2	Mr. Wep Kanawi	Acting Director	National AIDS Council Secretariat
3	Rose Apini	Provincial Counselling Coordinator	NCD Provincial AIDS Committee
4	Lesly Elias	Policy Manager	PNG Forestry Authority
5	Dr. Ismel Kitur	Epidemiologist / National	National Department of

		Surveillance Coordinator	Health
6	Ishmael Robert	Provincial Liaising Officer	National AIDS Council Secretary
7	Information blocked		National Department of Education
8	Tony Kluhdapaloh	Volunteer Placement Program Manager	National Volunteer Services
9	Louis Mara	Provincial Liaising Officer	National AIDS Council Secretariat
10	Dr. John Millan	ART specialist	Capacity Building Service Centre
11	Lorettae Hasu	M&E Officer	PNG National Sports Federation
12	Mr Eko	Coordinator AIDS Desk	Correctional Institutional Services
13	Joseph Klapat	Member of NAC & Departmental Secretary	Department of Community Development
14	Rhoda Yani	Senior HIV Program Officer	National Planning Department
15	Lt .Col Gideon Kendino	Director Health Services	Papua New Guinea Defence Force (PNGDF)
16		Manager Planning and Monitoring Unit	Department of National Planning & Monitoring

		CIVIL SOCIETY ORGANIZATIONS	
1	Pastor Michael Pagasa	HIV and AIDS Project Manager	Baptist Union Church
2	Joe Anang	Project Consultant	AusAID
3	Rory Sitapai	Program Manager	Friends Foundation
4	Mrs Loka Kulu	Manager HR	Nambawan Supa
5	Peter Raynes	Country Director	Care International PNG
6	Davis Kia		JICA
7			PNG Sexual Health Society
8	William Yeka	Senior Technical Officer - M&E	Family Health International (FHI)
9	Sr. Tarcisia Hunhoff	NAC Member & HIV Program Coordinator	National Catholic AIDS Office

10	Jet Riparip	ProgramCoordinator	Marie Stops
11	Dominica Abo	Director	Anglicare StopAIDS
12	Christine Gee	Coordinator HIV Desk	Salvation Army
13	Kel Brown	Deputy Team Leader	ADB
14	John Kuman & Peter Sine	Coordinators HIV Program	Hope Worldwide
15	Lako Manson	Project Coordinator	Apostolic AIDS Association
16	Margaret Rombuk	Clinical manager	Susu Mamas
17	Dr. Moale Kariko	Secretary Board of PACSO	PACSO
18	Judy Tokeimota	Regional Coordinator	Tingim Laip (Burnet Institute)
19	Dr. Ninkama Moiya	HIV&AIDS Adviser	PNG- Australia HIV/AIDS Program (Sanap Wantaim)
20	Dr. Fabian Ndenzako	HIV Surveillance Adviser	WHO
21	Mr Prescott Chow	Deputy Country Director	Clinton Foundation
22	Thomas Lisenia	Team Leader	National HIV Training Unit-IEA
23	Andrew Angobe		UNESCO

2.3 NCPI indicator Review Team

No	Names	Positions	Organizations
1	Agnes Gege	Key National Facilitator	NACS
2	Dr. John Millan	ART Specialist	National Department of Health- CBSC Proect
3	William Yeka	Snr Technical Officer	FHI – M&E
4	Bomal Gonapa	Legal Adviser	NACS
5	Christopher Hershey	Program Manger	Save the Children – Poro Sapot Project
6	Loe Kulumbu	Project Officer - HIV Desk	Department of Community Development
7	Peter Sine	Project Manager	Hope Worldwide
8	Bolkin J. Sil	Behavioural Change Communicaiton Adviser	NACS
9	Tony Kluhdapaloh	Project Placement Manger	National Volunteer Services
10	Garry Laka		PNG Sustainable Development
11	Babara Vele		ICRAFT
12	Ben Kapa	Volunteer	Red Cross
13	Margaret Marabe	PLWH	Igat Hope

14	Ishmael Robert	PLO	NACS
15	Louis Mara	PLO	NACS
16	Dr. Singh Bhandari	UN M&E specialist	
17	Elizabeth Moli		National Department of Education
18	Valentine Tangoh	Acting Counseling and Care Adviser	NACS
19	Marcel Burro	Surveillance Officer	NACS

3. UNGASS Core Group members – for coordination, direction and technical advice for the UNGASS reporting process and compilation of the final report

NAME	DESIGNATION / POSITION	ORGANIZATION
Dr Joachim PANTUMARI	UNGASS Country Focal Person and Senior Medical Advisor	National AIDS Council Secretariat (NACS)
Dr Moale KARIKO	National Coordinator	PNG Alliance of Civil Society Organizations (PACSO)
Mr Don LIRIOPE	Member	Igat Hope INC
Mrs Annie McPHERSON	National Coordinator	Igat Hope INC
Dr Isimel KITUR	Epidemiologist / National Surveillance Coordinator	National Department of Health (NDoH)
Dr Fabian NDENZAKO		World Health Organization (WHO)
Dr Ali FEZZADEH	Monitoring and Evaluation (M&E) Advisor	UNAIDS
Mr Tony LUPIWA	Senior Research Officer	NACS
Dr Singh BHANDARI	M&E Specialist	UNDP
Mrs Agnes GEGE	Statistical Officer	NACS
Ms Doreen MANDARI	Senior M&E Officer	NACS

4. Other technical advice

NAME	DESIGNATION / POSITION	ORGANIZATION
Dr Holly ARUWAFU	Medical Anthropologist and HIV Surveillance Specialist	Asian Development Bank (ADB) / National Research Institute (NRI)
Mr Shane MARTIN		Capacity Building Service Center (CBSC)
Dr John MILLAN	ART Advisor	CBSC
Dr Angela KELLY	Social Researcher	Papua New Guinea Institute of Medical Research (PNGIMR)

Professor Peter SIBA	Director	PNGIMR
Mr William YEKA	Senior Technical Officer – M&E	Family Health International (FHI)
Ms Apa PARUNGA	ART Database Manager	National Department of Health (NDoH)
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Dr Fumihiko YOKOTA	Epidemiologist	ADB / NDoH
Mr Tim RWABUHEMBA	Country Coordinator	UNAIDS
Mr Peterson MAGOOLA	HIV and AIDS Programme Associate	UNDP
Ms Cristiana MORF	HIV and AIDS Specialist	UNICEF
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5. Funding source / financial assistance

- National AIDS Council Secretariat (NACS)
- UNICEF
- UNAIDS