SCALING UP TOWARDS UNIVERSAL ACCESS IN PAPUA NEW GUINEA

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ANNEX 1 Resources for the Response
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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral Treatment
ARV	Anti-retroviral
AusAID	Australian Agency for International Development
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CSO	Civil Society Organization
FBO	Faith Based Organisation
GFATM	Global Fund to fight AIDS, TB and Malaria
GoPNG	Government of Papua New Guinea
HIV	Human Immunodeficiency Virus
HRSS	High Risk Setting Strategy
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MTDS	Medium Term Development Strategy
NAC	National AIDS Council
NACS	National AIDS Council Secretariat
NDoH	Department of Health
NGO	Non-governmental Organisation
NHASP	National HIV/AIDS Support Project
NSP	National Strategic Plan
PMTCT	Prevention of Mother to Child Transmission
PNG	Papua New Guinea
STI	Sexually Transmitted Infection
SWAP	Sector Wide Approach
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCCT	Voluntary Confidential Counselling and Testing
WHO	World Health Organization

1.0 Introduction

This report presents Papua New Guinea's response to scaling up towards Universal Access. This new initiative places greater emphasis on scaling up prevention, treatment, care and support within the country. This will be achieved through enhancing the multi-sectoral national response and strengthening sector processes and systems, especially in the health sector, accompanied by strong leadership and extensive advocacy. Universal Access builds on the 3x5 Initiative. It recognises that greater country ownership and leadership, together with periodic oversight and accountability, are needed to achieve treatment and prevention goals and that commitment and partnerships at all levels are critical to drive and sustain the response. Scaling up for Universal Access is intended to strengthen the country's resolve to achieve the Millennium Development Goals and the National Strategic Plan 2006 to 2010. It aims to promote greater participation, coordination and linkages between donors, government and civil society, to achieve a stronger implementation of the "Three Ones" in PNG.

The objectives of this report are to:

- Describe the current epidemic in PNG, the patterns and trends and likely impacts
- Outline the current targets for implementation of the national response
- Provide an overview of what has been achieved to date
- Identify challenges and constraints in implementation primarily within the health sector
- Develop achievable targets for 2010 and a roadmap for implementation.

In developing the targets for 2010, a workshop was held with key stakeholders in Papua New Guinea. Participants at this workshop reviewed the current targets of National Strategic Plan 2006-2010 and GFATM and agreed to new targets in order to scale up towards Universal Access. The table summarising current and future targets is attached at Annex 3.

2. Overview of the Epidemic

2.1 HIV/AIDS Epidemic

Papua New Guinea has a serious HIV and AIDS epidemic which has been classified as a generalised epidemic. The cumulative number of reported cases of HIV reached 12341[1] in early 2005. While the epidemic is largely concentrated in urban centres and major economic enclaves, it has reached into every province and is appearing in the remote parts of PNG. Infection rates among young women between ages of 15 and 29 are two to three times higher than men in the same age groups, highlighting their vulnerability.

Adult prevalence rates are estimated to be between 0.9% and 2.5%, although there are higher estimates in some communities. The National Consensus Workshop on HIV/AIDS held in 2004 concluded that between 25,000 and 69,000 people between the ages of 15 and 49 were probably infected across the country. Since the first case was identified in PNG in 1997, diagnosed cases have increased by around 30% a year.

[1] NACS/NDOH June 2005 Quarterly Report

A recent study commissioned by AusAID estimates that there were 64,000 people living with HIV and AIDS in PNG in 2005[2]. The data from this study shows that 54% of those living with HIV and AIDS are in urban areas with an adult prevalence rate in urban areas of 6.17%. The model predicts that the total number of people living with HIV and AIDS will increase to 120,000 in 2010 and to 537,000 in 2025 with an adult population prevalence rate of 10.88%. The model also predicted that during 2005, there would be 14,509 new infections.

2.2 Determinants of the Epidemic

The environment in which the epidemic has been established is characterized by:

- Heterosexual transmission, which accounts for 94 percent in those cases where the mode of transmission has been reported.
- The high rates of STIs amongst both men and women in PNG. WHO estimates that there are more than one million new STI cases in PNG every year. This is the highest rate in the Asia Pacific Region.
- Sexual behaviour patterns - early commencement of sexual activity (averaging 15-16 years), multiple partnering within and outside of marriage and polygamy in some areas.
- High levels of sexual violence and sexual coercion against women.
- High levels of stigma and discrimination. Misunderstanding about transmission, cultural beliefs around illness and death, and fear of people infected with HIV.
- Economic decline, increasing population density and a rapid increase in poverty. Most poverty is in rural areas and is highest in female headed households leading to an increase in commercial sex.
- Pattern of economic development - reliant on enclave extractive developments where local populations provide services - including sex - for cash. These include areas in and around mines, logging camps, and oil palm plantations.
- Spread of HIV through movement of populations associated with logging, fisheries, shipping and transport operations as well as urban migration.
- Low rates of employment among youth, limited employment opportunities for school leavers, particularly girls.

2.3 Development context

Social and human development indicators have worsened since 1980s and PNG is now ranked as having the lowest social indicators in the Pacific. Its human development indicators are equally poor. These include:

- high rates of maternal and infant mortality – maternal mortality rates are around 930 per 100,000 live births; and infant mortality is around 58 per 1000 live births. Mortality rates among infants younger than five is also very high.
- major health problems including the high rates of preventable diseases
- increasing rates of HIV and AIDS
- high illiteracy rates particularly amongst women, and low enrolments in schools

[2] AusAID. HIV Epidemiological Modelling and Impact (HEMI) Study. Report 1: Epidemiological model and scenarios. Oct 2005. This model also looked at impact of intervention scenarios through expansion of programs between 2005 and 2025

- limited capacity of the formal sector to provide employment for the rapidly increasing young population
- reduced spending on health and education .

Given this picture, it is unlikely that PNG will achieve the Millennium Development Goals by 2015.

The economic deterioration since the nineties has severely impacted on living standards and increased levels of hardship among people particularly in rural areas. It has also contributed to deterioration in the provision and maintenance of infrastructure and on basic service delivery. There are limited opportunities for income generation and maintaining sustainable livelihoods. High crime rates and major issues relating to governance are impacting on economic performance. Women experience a greater burden of social and economic disadvantage and violence and sexual exploitation towards women and children is high. The critical safety net through the *wantok* system is under increasing stress and family violence and breakdown is more common.

2.4 Impact of the Epidemic

An economic impact study commissioned by AusAID in 2002 concluded that HIV has the potential to impact on the economies of the household, firm, and the national economy leading to a significant increase in poverty[3]. It was projected to occur in three main ways:

- A decline in the numbers of workers and worker productivity and a rise in the cost of employment.
- A shift in the composition of demand as households and possibly government, shift expenditure toward health, medical services and funeral costs.
- A loss of domestic savings feeding through to lower investment.

The recent HEMI study through its modelling shows that the epidemic will result in a fall in real GDP of around 1.3% by 2025[4].

The social impact of HIV/AIDS in PNG is likely to mirror that seen in other countries such as those in sub-Saharan Africa. From baseline information taken in 2005 it is predicted that by 2010:[5]

- 85,000 people will have died (1% of population)
- maternal orphans will number around 29,000
- over 5000 teachers will be affected
- around 25,000 people will be seeking treatment and care for HIV and AIDS
- around 53% of these people will be able to access care and only 20% will have access to treatment

There is also increasing evidence of impact on basic services. Provincial hospital staff, PNG's Defence forces and the Department of Education are reporting a growing demand for the repatriation of bodies to their home areas with consequent burdens on already limited budget allocations. The NASFUND, PNG's National Superannuation

[3] AusAID. Potential Economic Impact of HIV/AIDS Epidemic in PNG. Feb 2002

[4] HEMI Draft report 2. Current and Future Social, Economic and Security Impacts AusAID 2005

[5] ibid

Fund, reported in a public enquiry in early 2005 that they are dealing with three death claims a week due to AIDS.

As infection rates rise it is expected that the already fragile health system in PNG will be overburdened and will be at risk of total collapse. The National Health Plan 2000-2010 states:

> "It has been estimated that if the epidemic is left to run at the present rate of increase, 70% of the hospital beds in the country could be occupied by AIDS patients in 2010. For every 5% increase in HIV prevalence in PNG, the total national spending on health will need to increase by 40%. At a 10% HIV prevalence rate, tuberculosis will rise 50-fold to 30% of the population"

It is evident in PNG, as elsewhere, that the cost of caring for an increasing number of people with HIV and AIDS will impact severely on the health system. Port Moresby General Hospital is already struggling to cope with the number of AIDS patients occupying medical ward beds. Currently around 15% of its hospital beds are occupied by people with HIV and AIDS, and around 20% of tuberculosis patients being treated at the hospital are also HIV positive.

Again using baseline data from 2005, estimates show that by 2025:[6]

- Costs of treatment for OIs, health care and hospital admissions will rise to AUD21 million per annum
- Medical hospital capacity will be over 70% with AIDS patients
- Costs of anti-retroviral drugs will be over AUD28 million per annum
- Doctor to patient ratios will reach 1:260 (from 1:46 in 2005).

The absence of good epidemiological data and clinical and social research is a major constraint to providing Papua New Guinea with an accurate picture of the epidemic and its impact. Although surveillance activities are slowing increasing they are not yet to provide for accurate tracking of the epidemic to convey its extent. There is also dearth of information available on sexual behaviour, and the contextual factors contributing to spread of HIV.

3. Overview of the National Response

3.1 Advocacy, Public Policy and Legal Framework

This section highlights some of the key policy achievements in Papua New Guinea that set out the institutional framework for the response and scaling up responses to treatment, care, support and prevention.

At the national level, the National AIDS Council (NAC) and its secretariat, NACS, are responsible for the formulation, review and revision of the national policy for the prevention, control and management of HIV/AIDS and for monitoring and coordinating the implementation of the National Strategic Plan. At the provincial level, Provincial AIDS Committees (PACs) have been established in all 20 provinces

[6] ibid.

and are responsible for coordinating the implementation of provincial activities to address HIV and AIDS. District AIDS Committees have also been established in a small number of districts. The government framework for the response is shown at Annex 2.

The Government of PNG has been slow to demonstrate leadership and commitment to the HIV response. Recent initiatives suggest that there is some progress in this area. The decision to move NAC and NACS to the Department of Prime Minister and NEC is a major step forward in the government response, and in the 2006 budget the allocation for NACS was increased to K4.1 million. The appointment of a Special Minister for HIV/AIDS to assist the Prime Minster is also recognition that HIV is seen as a priority issue within government. A Parliamentary Special Committee on HIV/AIDS was established in 2003 and the government has endorsed HIV/AIDS as a key priority for *the Medium Term Development Strategy 2005-2010.*

Other key initiatives include the passage of the HIV/AIDS Management and Prevention Bill (HAMP) in 2003 which mandates counselling for HIV testing with provisions for confidentiality. Legislation addressing sexual assault has been passed and cases are increasingly being brought to the courts.

The media has become increasingly involved in promoting HIV and AIDS within PNG. There are daily reports in newspapers on activities within provinces and discussion of key issues. National campaigns have stimulated much of this discussion and promote community debate. Although studies of these campaigns show an increased level of awareness about HIV and AIDS, there are still high levels of HIV-related stigma evident within communities. There are a small number of politicians, church and community leaders who are regular advocates for HIV and AIDS, however there remains an important challenge to ensure that correct messages and information are conveyed.

Universal primary education remains a goal in PNG and although there are moves to reform the education system, much more commitment and resources are needed to achieve this goal.

The National Health Plan (2000-2010) also recognises the importance and impact of HIV and AIDS on the health sector. Its Medium Term Expenditure Framework has placed HIV/AIDS as a top order priority for funding over the next 3 years. A Strategic Plan was recently developed for the health sector for the period 2006-2008. One of the four public health strategic directions is to reduce the rate of increase in STI and HIV. This will be achieved through greater focus on STI management and service delivery, access to anti-retroviral treatment at level 1 and 2 hospitals, expansion of the Prevention of Mother to Child Transmission (PMTCT) Program to all hospitals, and supply and distribution of condoms at all facilities.

The PNG National Strategic Plan on HIV/AIDS 2006 - 2010 (NSP) was developed through a wide consultative process during 2004. It was finally approved by the government in late 2005. A Monitoring and Evaluation Framework for the NSP has now been developed and monitoring systems are being established.

PNG's commitment to HIV treatment is firmly outlined in the NSP. Commitment to and resourcing of treatment programs however have largely been the responsibility of donor agencies specifically World Health Organization (WHO) and the Asian Development Bank (ADB) through the 3x5 Initiative. The provision of ART is a key element of the Global Fund to fight AIDS, TB and Malaria (GFATM) agreement and GFATM will continue to be the primary agency to fund the supply of anti-retrovirals (ARVs) for PNG. WHO will remain the key agency in PNG to procure ARVs for the short to medium term. A small amount of procurement is also being handled by Catholic Health Services for their programs.

A review of patent and trade laws relating to TRIPS was undertaken in 2004 to identify legislative and administrative procedures that are needed for the government to comply with importing generic drugs. PNG has a National Drug Policy but it has yet to be reviewed to accommodate changes proposed for importation of ARVs. During 2005, 12 ARV drugs were added to the medical supplies catalogue of drugs that can be procured by PNG. The National Nutrition Policy will also need to be reviewed to take account of needs of people living with HIV and AIDS and specific nutritional support for those on ART.

While there is preparation and readiness for importation of ARVs, it is unlikely that the government will move to import these drugs while there is difficulty in financing, procuring and supplying basic drugs for health facilities.

3.2 Strategic Planning, alignment and harmonization

This section reviews the context for planning and implementation of the response to date against key focus areas of the National Strategic Plan. It includes targets that have been established through NSP and through GFATM and some of the progress that has been made in achieving these targets.

3.2.1 Epidemiology and surveillance

NSP Objectives:

- *To strengthen and maintain a comprehensive, efficient and a well resourced national surveillance system by establishing at least one surveillance site in all provinces by 2008.*
- *To increase the availability of accurate data about the risk of HIV infection for particular groups and how best to reduce these risks by expanding sentinel surveillance sites to five district hospitals by 2006 and ten by 2008.*

Targets for surveillance are:

At least two surveillance sites for antenatal cases (one urban and one rural) established in all provinces by 2010

Epidemiological data on the epidemic in Papua New Guinea is very limited due to underreporting, lack of testing sites providing data, difficulties with processing of test results. Sero-surveillance sites have been established in 14 provinces at 26 sites including 4 district sites. Most of these sites are at existing antenatal, STI and TB

clinics. In early 2006 it is proposed that a number of surveillance sites will be established up in community settings where High Risk Settings Strategy (HRSS) is being implemented. Behavioural surveillance is being undertaken in seven sites (4 STI clinics, 2 military sites and 1 prison in Port Moresby) and will be expanded to other military and prison establishments during 2006. Surveillance capacity overall remains limited and there are ongoing difficulties in establishing these systems within National Department of Health. A national surveillance group under NDoH has been established to oversee the development of surveillance activities and research and dissemination of epidemiological information.

Some headway has been made through the development of the NSP M&E Framework to link with NDoH information systems. However the challenge remains in implementation of these M&E systems, the establishment of surveillance sites, monitoring and management of data and reliable reporting.

Key Challenges for surveillance are:

- While NDoH has a well-established National Health Information System and has demonstrated capacity for surveillance in some diseases, it has not strengthened its approach to key areas of surveillance such as laboratory surveillance and sentinel surveillance sites for diseases of interest. NDoH maintained responsibility for surveillance of STI, when HIV surveillance was transferred to NACS in 1999. While NACS has retained the role of HIV surveillance this has been without strong technical capacity. The challenge now is to bring these areas together under NDoH. The transfer of these functions to NDoH, including the expansion and management of sentinel sites is proposed during 2006.
- National HIV/AIDS Support Project (NHASP) and PNG Institute of Medical Research (IMR) have been supporting serological and behavioural surveillance. This responsibility will need to begin to be managed by NDoH during 2006. WHO and ADB plan to support NDOH to build its capacity to do this. Developing and resourcing surveillance systems will take some time.
- The need to strengthen and sustain a national surveillance network to improve analysis of surveillance data and monitor surveillance sites. While there have been some moves to establish this network it will need commitment and resources to ensure that it works effectively.

3.2.2 Monitoring and evaluation

NSP Objective:

- *To develop a Monitoring and Evaluation framework to produce, collate, analyse and disseminate information on the national response to HIV, by 2004.*
- *To accumulate and disseminate data from all sources including provinces through the use of relevant indicators that will assist in the reporting on respective international milestones for example, UNGASS and the MDG by 2005.*
- *To measure the effectiveness and efficacy of the national response by undertaking a review of the NSP by 2008.*

A National M&E Framework has been developed to underpin the NSP. The Framework has 17 indicators and incorporates some of the GFATM and UNGASS indicators. In rolling this out there are likely to be substantial issues around the capacity of both government and NGO/CBO groups to provide relevant information that will enable the framework to operate as a planning and decision making tool.

Monitoring and evaluation skills, experience and systems across all groups are poor and reflect more long standing impacts of culture and education on critical analysis skills.
Key challenges for monitoring and evaluation are:

- Build the capacity of National AIDS Council to establish a functioning unit on M&E
- Strengthen monitoring capacity of provincial programs
- Build and resource capacity among civil society organizations.

3.2.3 Treatment Program

2.2.3.1 Anti-retrovial Therapy

NSP Objectives:

- *To make ARV treatment available and accessible to at least 10 per cent of people currently infected with HIV and AIDS throughout PNG by 2005 and 25 per cent by 2008.*

Government of Papua New Guinea and donor partners are committed to roll out of ART through the GFATM agreement. AusAID has also strengthened its commitment to support universal HIV treatment in the Pacific and PNG through its recent White Paper report.

Targets for treatment (GFATM):

- *To provide ART to 7000 people by 2010 (1500 by 2006; 3000 by 2007; 4500 by 2008; 6000 by 2009; 7000 by 2010).*
- *200 service providers trained in ARV treatment and monitoring by 2007*

Since 2004, as part of the 3x5 Initiative, WHO, ADB and NDoH have been supporting a pilot program to introduce ART in PNG. Known as the Heduru Clinic Project, this initiative set a target of 1500 people on ART by 2005. The provision of ART is currently confined to 2 sites at the major hospitals in Port Moresby and Lae. It is proposed to expand the program to Mt Hagen, Goroka and Rabaul during 2006 through Phase 1 of the ART scale up for GFATM.

In January 2006, 320 people have been given treatment through this program which represents 13% of that target. Another 677 are on the waiting list to receive treatment. A number of these people require adequate social support systems to be eligible to receive treatment. A recent assessment of people receiving treatment in Port Moresby showed that 80 people who have received treatment had not presented to Heduru Clinic in the past 6 months. The Clinic does not have the resources to follow up these people and contact details are often too vague to allow for follow up.

Treatment protocols for antiretroviral treatment for HIV infection have been developed and training has been provided for 52 prescribers for ART. Training was also recently provided for 26 health care workers on HIV comprehensive care management using IMAI approach. There has also been some preparation of teams to initiate ART in 6 more sites (3 public and 3 private). AusAID has been supporting the

operational and staffing support for Heduru Clinic and WHO is funding 3 technical advisers for ART.
While up to 78 doctors and nurses have been trained, only 8 are currently working in the Program. Many of these people have moved on to other positions and there are difficulties in relation to pay and incentives to do this work, among other issues. There are ongoing issues of staffing related to public sector staff freeze on positions and the hospital is unable to recruit suitable staff to the program. Donors have agreed to fund 15 staff to support the expansion of the program to additional 3 sites as an interim measure until the Department of Health is able to fill these positions.

A site readiness assessment was undertaken for the ART program in January 2006. This assessment looked at Heduru Clinic, and capacity of sites in Lae, Rabaul, Mt Hagen and Goroka to deliver and expand ART programs. Recommendations from this assessment are not yet available but some of the constraints identified through this consultation were:

- Limited staffing available at these sites
- Lack of medical and nursing staff to resource these sites
- Lack of good facilities for counselling and assessment
- Limited networks and referral processes for follow up outside of clinical settings within the community.

3.2.3.2 Prevention of Mother to Child Transmission

UNICEF is supporting the Prevention of Mother to Child Transmission (PMTCT) program in collaboration with WHO and Catholic Health Services in NCD, Simbu and East New Britain provinces since 2003. More recently this program has expanded to Milne Bay, Western and Eastern Highlands, East Sepik and Bougainville. This program is expected to expand significantly through the GFATM. Plans to expand this program include strengthening obstetric care and supervised delivery, the establishment of mobile clinics and outreach services through maternal and child health services, improving basic water and sanitation services and staff skills and knowledge. It is proposed to establish PMTCT services in established health centres providing antenatal care in a number of provinces.

UNICEF has set a target to establish PMTCT services in all 48 major health centres over the next five years. This will include training in VCCT, including primary prevention issues, clinical protocols, quality care and reducing stigma and discrimination. Funding to expand these programs will be needed, especially for training and testing supplies. It is intended that GFATM will support the supply of ARV drugs to expand these programs.

To date around 17,000 women have been counselled and 60% have tested for HIV. Since 2004, the Port Moresby General Hospital has tested over 8000 pregnant women. Around 100 have received prophylactic ART for prevention of mother to child transmission. The service is integrated with Heduru Clinic to facilitate treatment of mothers and their families.

Key constraints to rolling out PMTCT programs are:

- Low access to antenatal services in provinces (in 2004, 42% of women did not attend any antenatal clinics, particularly in rural areas)

- Lack of supervised delivery (in 2004, 39% of women had their babies delivered under supervision) ie. most babies are delivered outside of the health care system
- Lack of clinical outreach services, staffing and quality of care issues in most centres will inhibit the further development of antenatal care
- Most centres do not have access to rapid HIV testing kits
- Slow return of confirmatory test results – simplification of confirmatory test algorithm using non-laboratory based rapid tests
- Lack of sustained supply of ART – both prophylactic and therapeutic for both PMTCT and Paediatric AIDS treatment programs
- Counselling capacity is limited or unavailable in most health care facilities
- VDRL and other STI testing are unavailable for most district based services
- Lack of national policy on breastfeeding for HIV positive mothers.
- Lack of affordability, availability of infant formula and acceptance of use
- Lack of health care facilities support services (social work) in most hospitals reduces good long term compliance to clinical management and HIV transmission
- Slow/minimal integration of HIV/PMTCT data collection, monitoring and evaluation within the health care system.

UNICEF has launched its Global Campaign for Children which includes scaling up its prevention and care programs, including PMTCT Plus for women and their partners, and establishing a Paediatric Treatment and Care program. Eleven children have received ART through the program at Port Moresby General Hospital. It is intended to scale up this program over the next 12 months. UNICEF is looking to achieve universal access for HIV positive children by 2010.

Targets for PMTCT (GFATM):

- *600 HIV infected pregnant women receive ART by 2010 (180 HIV infected pregnant women receiving complete course of ART by 2007)*
- *100% of health facilities offering a minimum package of PMTCT by 2010 (10 health centres providing a minimum package of PMTCT by 2007)*
- *200 service providers trained in PMTCT by 2007*
- *20,000 IEC leaflets printed for PMTCT by 2007*

Key challenges to the effectiveness of ART (including PMTCT) programs are:

- The ability of health service providers to provide the necessary counselling, support and monitoring for those receiving treatment
- Follow up and tracking of patients on treatment outside of the clinic setting
- Adequate laboratory capacity to support the program
- Regular and reliable supplies of drugs and consumables
- Ongoing problems with logistics and distribution of ARVs to provinces and districts
- Development of criteria for ART that can maximize coverage, especially to rural areas
- The ability of patients to comply with treatment regimes because of difficulties in getting to health facilities and patient understanding of compliance requirements

- The ability of communities to support patient compliance
- Improving social support systems to enable people to be eligible to receive ART
- Difficulties in promoting treatment centres because of stigma associated with HIV
- Retaining trained staff to work on the Program
- Capacity of NDOH to monitor efficacy of treatment
- Capacity of NDoH to coordinate training and management of the HIV programs within the health care system.

3.2.3.3 Treatment for Opportunistic Infections

Treatment for opportunistic infections (OIs) in many settings, especially beyond urban clinics is not readily available and the efficacy of some drugs being used to treat certain AIDS-related infections has been questioned. Drug supply issues, lack of management regimens and staff skills are key constraints to implementation of effective programs beyond key centres. The diagnosis and management of AIDS related conditions is confined to larger hospitals and key STI clinics. Increasingly health care workers will be required to manage these conditions at the health centre level. Training for HIV case management has been undertaken at key facilities however needs to be expanded to district level.

GFATM proposes the procurement of drugs for treatment for OIs and the development of guidelines and training of health care workers for treatment of these infections.

Targets for OI treatment:

- *50 HCW trained in OIs by 2007*
- *10 health facilities capable of providing advanced interventions for prevention and medical treatment of HIV infected people*
- *OI drugs available in health facilities for 7000 patients*

3.2.3.4 Post-exposure Prophylaxis

It is proposed that GFATM will support the development of Post-exposure Prophylaxis (PEP) guidelines and fund PEP kits for health centres. PEP will provide ART to health care workers who have been exposed to HIV and also women who have been sexually assaulted. The policy for PEP and programs for implementation have yet to be developed. Health care services will need to work more closely with the police and village courts to provide training and devise processes for management and referral of these cases and to ensure timely intervention with ART.

Targets for PEP:

- *150 service providers trained in PEP by 2007*
- *100 people who could potentially receive PEP (HCW and rape cases*)

3.2.4 Sexually Transmitted Infections

NSP Objective:

To reduce incidence and rate of STIs in risk populations to 5% and the general population to 3% by 2008.

The management of STIs in PNG is focussed upon syndromic management, treatment protocols are well established, and health workers have been trained to the district levels in many provinces. There are currently 12 dedicated STI clinics in PNG, and another 38 are proposed for construction. Since STI clinics are the primary clinics providing access to testing and treatment, the roll out of these centres will substantially increase the availability of prevention programs, HIV treatment and management programs including ART. VCCT services and support for home based care is also likely to be strengthened through these facilities.

Key challenges for STI services:

- Difficulties of access to some centres, especially in rural areas
- Attitudes of staff, quality of clinic services and facilities
- Reliability of drug supplies and reagents to health centres and STI clinics
- The lack of data on STI prevalence. NDOH has responsibility to conduct monitoring and surveillance of STIs. While most clinics do record and report on STI data, NDOH has had limited resources to collate and monitor national prevalence data.
- The inability of NDOH to staff and provide adequate supervision of additional STI facilities.
- Lack of human resources in NDoH to provide adequate support to the STI program in the provinces.

3.2.5 Voluntary Confidential Counselling and Testing

NSP Objective:
To establish at least two sites for VCT services in each province that are easily accessible to people by 2008.

Although there are now around 60 nominated VCT sites in PNG. About one third of these are government centres, around half are church facilities and the rest are private or NGO clinics. Many of these non-clinical sites are not fully functional as testing sites and are not accredited for VCCT. Only 3 non-clinical sites have been accredited under guidelines established for accreditation of VCCT services in PNG. The accreditation process involves assessment of sites to meet service quality standards and guidelines. It is planned to complete the accreditation process by early 2006.

Targets for VCCT:

- *30 districts with VCT services by 2007*
- *100,000 people receiving VCT in 2007*
- *200 service deliverers trained in VCT by 2007*

A national VCCT Committee was established in 2005 and has approved national policies and guidelines, including minimum standards that form the basis of the accreditation program. VCCT curricula and materials have been developed, and up to 1000 counsellors have participated in a 3 week training course for VCT.

During 2004, 728 people accessed VCCT through NACS/NHASP supported sites. Up to October 2005, 1385 people accessed testing through the network of testing sites, showing a substantial increase in the number of people seeking testing. Around 10% of people accessing VCT tested positive for HIV.

Rapid testing is being introduced in some centres and will be expanded to most districts through GFATM.

Twenty three care centres have been established in 10 provinces and provide a focal point for home based care support, respite, day care, counselling and support to people living with HIV/AIDS. Training programs on home based care have been undertaken in many provinces.

Increasingly VCCT is being provided outside of health care settings, however there are only a few professionally trained counsellors to undertake counselling at these sites. These non-clinical settings are community care facilities which also provide other support services for people living with HIV and AIDS and offer a suitable alternative to clinical services. They are also an appropriate place for people to receive ongoing support, counselling and monitoring for treatment. However coordination between clinics providing ART and these care centres needs to be improved for this approach to work well. It also offers a way to streamline the provision of support to people who test positive at health centre clinics. Those who receive ART could be referred to community care centres for ongoing support and counselling rather than receiving this through health centre clinics. This would free up time and space in clinics for assessment of new patients and ongoing monitoring of those on ART.

Key challenges for VCCT are:

- Ongoing accreditation of VCCT centres to ensure quality and consistency in service provision, however this is a resource intensive exercise and requires support to assist in service development to meet standards
- While a large number of counsellors have been trained, few are equipped to meet the need and able to provide an adequate level of counselling support
- There is a lack of infrastructure to support trained counsellors in the field.
- Fragmentation of responsibility for VCCT programs - these are largely being managed through NHASP/NACS or church health services with little involvement of NDoH. GFATM is seeking to strengthen NDoH's role to support VCCT.
- Linkages and support of VCCT sites with ART programs - support for ART compliance
- Linkages between VCCT sites, day care centres and ART clinics for patient follow up and support – lack of referral pathways
- Involvement of communities and people living with HIV and AIDS with VCT and day care centres.

3.2.6 Prevention

NSP Objectives:

To provide 80 per cent of the country's population with relevant, accurate and comprehensive messages about prevention of HIV transmission by 2008.

To target interventions to groups at particular risk, using culturally acceptable methods, to keep HIV prevalence in these groups below 5 per cent by 2008

To increase safer sexual practices amongst the sexually active population, in particular the youth population.

Since 2001 a number of national social marketing campaigns have been undertaken that have resulted in increased awareness of HIV/AIDS and prevention measures in the general population. Research shows that there is a high level of awareness, around 90%, about HIV in PNG. The national campaigns have been supported with the development of a range of IEC materials, the establishment of a National Resource Centre, improved condom distribution and a variety of media and theatre activities funded through grants program.

Around 6 million male condoms and 1.8 million female condoms will be procured and distributed during 2006 through NACS, PACs, NGOs, private sector agencies, health centres and other community settings. In late 2005 NACS began rolling out condom vending machines to increase condom access in many provinces.

Targeted interventions include High Risk Settings Strategy (HRSS) funded through AusAID, and a peer education program through the European Union (EU). These are targeting populations and particular settings associated with high-risk activities, in many provinces around the country. Through these programs a number of community based initiatives and local partnerships are emerging to mobilize communities. In particular these include partnerships with private sector organisations to support and resource prevention activities. Around 1200 peer education trainers have been trained and more than 1400 peer educators are trained in provinces around the country. The number of active peer educators is not known.

HRSS is being implemented in 14 provinces in 33 sites. These include sites along transport routes and around mines, at urban settlements, at defence barracks and night clubs, at local markets and wharfs, and at local factories and shops. Many of the activities are being undertaken in conjunction with private sector industries such as retail industries, mining compaines and oil palm companies.

School based programs, including development of curricula for population and sexual health for elementary schools, life skills programs and specific youth initiatives have been implemented. Reform of the education system is underway and aims to provide basic education for all children up to 9 years, expand access to secondary and vocational education and improve teacher training. The Education Department has just released their HIV/AIDS Strategy and is mainstreaming HIV into their programs.

Programs focusing on sexual and domestic violence are also being implemented through local NGOs. National campaigns are underway and sporting personalities are being used to promote a reduction in domestic violence.

There have been some recent initiatives with sex workers to develop and strengthen networks among groups and individuals and begin to build the capacity for behaviour change and involvement in the response.

Leadership training and advocacy programs have been established and include initiatives that range from senior government to village leaders and the churches.
The private sector has begun to respond through prevention, HIV testing and community support initiatives, especially among the mining sector and oil palm industries.

Targets for Prevention:

- *200 teachers trained in HIV education by 2007*
- *100,000 HIV/AIDS related prevention brochures printed and distributed by 2007*
- *300 peer educators trained by 2007*
- *1 youth friendly centre established and operational by 2007*

Key challenges for prevention are:

- Moving beyond awareness to developing approaches that promote and sustain behaviour change
- Mobilising communities to develop locally based initiatives
- Getting consistency in messages among leaders at all levels
- Improving gender relations and reducing gender violence
- Identifying and targeting vulnerable populations and engagement of these groups
- Strengthening and building networks of people living with HIV and AIDS, sex workers
- Build capacity for all sectors - communities, churches and the private sector to respond.

3.2.7 Family and Community support

NSP Objective:
To increase access for people living with HIV throughout PNG to access STI/HIV community based care and support services
To develop a supportive environment for people living with HIV and their families through the establishment and/or training support and care groups in all provinces by 2008 and reduce discrimination and violence against them.
To ensure proper full recognition of human rights, including children's rights, in addressing the HIV epidemic, including respect for confidentiality, reduction of discrimination, and increased access to care and support.
To build capacity for community based organizations and groups to identify and provide support for orphans and vulnerable children.

Most PNG communities are unprepared for impact of HIV and AIDS. Community understanding of and their preparedness for the epidemic means they are mostly ill equipped to care for the sick and dying and for children left behind by the loss of their parents. High rates of HIV-related stigma, cultural practices and beliefs and lack of

basic resources to care for people who are ill contribute to difficulties in providing good community care.

There are also an increasing number of children affected by HIV and AIDS, either as orphans or as children living in affected families. There have been some estimates of children affected by HIV and AIDS however accurate data on the number of OVC is not available. UNICEF estimates that 17 percent of all children will be affected by HIV/AIDS by 2010, either as orphans or as children living in AIDS affected families. It clear however that many children will be affected by HIV and AIDS and will require substantial support in the future. There are already a number of church supported initiatives underway to target vulnerable children and assist communities to support families and children affected by HIV.

In rural areas, the churches and some community groups have initiated a number of community based responses, some are particularly innovative. Care centres established in many provinces are specifically providing a focal point for family and community support, with services for VCCT, counselling training and support to people living with HIV/AIDS, and home based care training.

Appropriate technology home-based care kits have been developed over recent years by a small NGO in Eastern Highlands Province to support community care capacity and reduce the burden on families. These are now produced commercially and are being distributed by local groups and Provincial AIDS Committees. This group also has plans to develop water technologies that aim to reduce the burden of water cartage on women and children. These innovations are significant but rely on local groups, Provincial AIDS Committees and government staff to inform people of their availability and to distribute them.

Support for *Igat Hope* as the National Association of People Living with HIV/AIDS will facilitate more effective representation for people living with HIV/AIDS at the national level and provides a valuable support network for positive people in PNG. This support will include strengthening the management and organisational capacity of *Igat Hope*, including financial management, governance, leadership skills as well as opportunities to improve income security and nutritional support.

Targets for community support**:**

- *30 support groups for PLWHA reached by 2007*
- *20 support groups for PLWHA trained by 2007*
- *30 civil society organizations reached by 2007*
- *30 civil society organizations delivering HIV/AIDS services by 2007*

Key challenges for expanding community support programs are:

- Engaging churches and NGO groups to take a lead in promoting and resourcing community care initiatives
- Building community competence and capacity to provide and resource local care and support initiatives, including care of vulnerable children
- Building skills and capacity of PLWHA networks and groups, particularly in the provinces

- Reducing HIV related stigma and discrimination at all levels
- Reducing gender violence and strengthening women's leadership roles
- Improving linkages and coordination of local community initiatives and activities
- Improving counselling referral networks and data bases in the provinces to enable better follow up in communities, better targeting of government services and the targeting of vulnerable children.

4. Structural and Systems constraints to the provision of an effective health response

The following sections highlight some of the key constraints in scaling up responses to HIV and AIDS. These primarily address health sector issues and capacities.

4.1 Human Resources

The lack of skilled and trained people to undertake technical and management responsibility for implementing the response is evident at all levels. Problems of management, supervision, low staff morale, lack of skills, high rates of absenteeism and complacency have been reported in relation to human resource performance across the health sector. Some of the contributing factors are: lack of management support, limited supervision and guidance, limited training opportunities, poor equipment, lack of supplies, run-down facilities and poor or the absence of quality housing for staff.

These issues are contributing to the decline in health worker performance along with low levels of funding, particularly among government services, especially at the district level. Church health services comprise around 50% of health services across the country and in general have higher staff morale, better management and supervisory support.

The shortage of staff is evident across all facilities. At the community level, aid posts have not been filled and across the country around 50% of these basic services are closed. Data from WHO show that there are 5 doctors and 53 nurses per 100,000 head of population in PNG. Projections for staff needed to manage treatment and care for AIDS related conditions show that the ratio of doctor to patient will need to increase from 1:46 to 1:260 by 2025 (1:78 by 2010).[7] While these figures show the required increase in medical staff, it is likely that nurses will need to assume greater responsibility for management of HIV and AIDS, including ART.

Another recent study looked at the number of nurses, doctors, laboratory technicians and pharmacists that would be required to scale up and manage services for ART. This study shows that to achieve full coverage immediately PNG would need. By 2010 this number would need to be increased to 18 doctors and nurses and 9 laboratory technicians and pharmacists.[8] To support VCT programs it was estimated that PNG would need 33 nurses and 17 laboratory assistants would be needed for full

[7] HEMI ibid.

[8] Abt Associates. Costing HIV and ST Services in PNG – report still to be released

coverage of 60,000 VCT patients. By 2010 this number would need to be increased to 49 and 34 respectively.

PNG will need to substantially increase the numbers being trained in these professions over the next few years, however to achieve coverage in the short term may need to redirect and reskill staff from other areas, which will also further exacerbate staffing shortages in other parts of the health system.

A number of reviews have highlighted the following issues that will need to be addressed in providing an adequate response to HIV treatment and care:

- Need for workforce planning in anticipation of workforce attrition due directly or indirectly to HIV
- Review of staffing and skill requirements to assist in the management of STIs and AIDS related conditions
- In-service training that directly responds to program needs (eg treatment protocols, counselling, infection control) and is delivered in ways that promotes better application in the workplace
- Management support including supervision, personnel policies, identification of training needs, and workforce development
- Implementation of policies to reduce risks to health workers that arise from inadequate infection control processes
- Support for health workers at all levels to gain understanding and skills in the management of STI and HIV
- Development and implementation of supervision guidelines.

Targets for training:

- *200 teachers trained in HIV education by 2007*
- *300 peer educators trained by 2007*
- *200 service deliverers trained in PEP by 2007*
- *20 service providers trained in blood screening by 2007*
- *200 service deliverers trained in VCT by 2007*
- *50 service providers trained in OIs by 2007*
- *200 service providers trained in ARV treatment and monitoring by 2007*
- *200 service providers trained in PMTCT by 2007*

4.2 Organization and Systems

4.2.1 Procurement and logistics

A strong and reliable supply system is critical for an expanded response to prevention, treatment and care, especially for condoms, ARV and OI drugs, test kits, reagents. Supply involves procurement, storage, distribution and dispensing and it relies on systems for assessment of need and management of stock.

The consequences of a poor supply system are well known and regularly experienced in PNG and the medical supply system in PNG has experienced many difficulties now for a number of years: These include:

- The collapse of a previously strong requisition system

- Poor coordination between central level with Medical Supplies Branch and Area Medical Stores
- Lack of staff for logistics and distribution of supplies
- Procurement planning is poor across the health sector and funds for procurement can be very slow, leading to delays
- Poor stock management, frequent 'stock-outs' of essential drugs, high level of wastage and ineffective monitoring of stock, including large quantities of expired stock in many centres.
- Poor management and supervision on procurement and distribution processes.

There has been some support within NDoH to build logistics capacity with Medical Supplies Branch and Area Medical Stores, however, the division of responsibility between national and provincial level is a major factor in following through on processes of supply. NDoH's responsibility ends with distribution to Provincial Stores and it has no control over distribution processes at the provincial level.

A short-term measure that was taken to improve supply and distribution of medical supplies has been the provision of health centre kits that are delivered directly to all health centres, bypassing the current system for distribution. This has ensured that all health centres has access to basic supplies, including condoms.

Donor support during the past 6 years has contributed to some improvement through supply of kits, training of staff and strengthening drug rationalisation and procurement procedures. Through the sector wide approach in health, donors are harmonising their approaches to procurement with National Department of Health and there is an increased emphasis on using and strengthening government systems, increasing staffing levels and building capacity. Within the Department there are moves to centralise procurement to improve efficiency and donors will support a program of capacity building, however further work will be needed to strengthen functions of provincial centres to manage and distribute supplies. Two key reviews of medical supplies undertaken by central agencies provide recommendations for reform in areas of contracting and supply management, through strengthening central supply processes, and increasing staffing to improve functions of NDOH in relation to medical supplies.

While the approach within the health sector is to use government procurement systems, it is agreed that the procurement of ARV and OI drugs, HIV test kits and reagents will be managed by WHO through a parallel system in the short to medium term. However, GFATM proposes to utilise the Medical Supply Branch distribution system to deliver drugs and supplies to the provincial level. There is a risk in doing this that the current weaknesses in the MSB system will have a detrimental impact on the roll out of these drugs and supplies to provincial centres. However, the procurement of supplies such as condoms, STI drugs, and goods and services such as training and IEC materials will be undertaken using NDoH systems.

Key challenges for effective procurement and distribution systems are:

- Timely processes for procurement and distribution of supplies for HIV and STI services through NDoH systems – some mitigation of this risk through processes being managed through HSIP Management Branch
- Implementation of reform processes across government agencies and support for streamlining of procurement functions within NDoH
- Finding ways to ensure the supervision of distribution processes beyond Area Medical Stores
- Improving the coordination of supply and distribution processes between national and provincial bodies
- Improving management capacity for procurement planning and supervision of procurement and distribution
- Improving practices for stock management and requisition at facility level.

4.2.2 Management

Numerous assessments of the PNG health sector have highlighted the issue of management capacity. These assessments refer to a culture of tolerance of poor performance and lack of management intervention. Managers are frequently in positions that are beyond their capacity, and processes that are in place for managing and appraising their performance are not often applied. Within NDoH the Senior Executive Management team has not been functioning well as a management group to address these issues.

Processes and skills for planning are reasonably well developed but skills for implementation, supervision and human resource management are still quite weak at all levels. There have been various programs and training support to build management capacity but without a strong internal culture of management and accountability, improved capacity has been difficult to achieve.

NDoH has begun to address some of these issues through its Strategic Plan 2006-2008, supported by donor partners in the SWAp. Changes are being proposed within NDoH to restructure branches and strengthen management processes.

As a part of this reorganisation the Disease Control Branch has been restructured to include several more positions to support HIV and STI program. Staffing capacity has been very low and consequently key functions such as surveillance and monitoring have not been undertaken. It is hoped that a reinvigorated branch may bring an increased response to HIV within the health sector, provide more direction to provincial health office and support for development of policies and guidelines for the sector on HIV and AIDS.

Key challenges to improve management in the health sector are:

- Strengthening the management capacity across the health sector - finding appropriate ways to make managers more accountable
- Capacity of staff in the Disease Control Branch in NDoH to develop and implement the HIV program within health sector
- Provincial management of health sector responses – adequate supervision to facility level

- Streamlining and improvement of hospital and provincial health functions to improve delivery of services at health centre level
- Developing linkages between government and non-government services for referral, patient care and training.

The NAC and its secretariat are responsible to oversee the implementation of the NSP and manage the coordination of the response. Two key reviews undertaken on role and function of NAC and NACS have been identified a number of issues relating to the way these bodies are operating:

- While NAC is seen by stakeholders as the key body to spearhead coordination, planning, monitoring and evaluation of national response it has not been operating effectively as a coordinating body, its members are unclear of the role and function of Council and lack a shared vision for how NAC may contribute towards an effective response.
- NAC members vary in terms of their level of authority and skills to participate effectively in decision-making.
- NGO representatives are unable to effectively represent the increasing number of non-governmental organisations. The lack of an umbrella organization or forum makes formalising this representation difficult and limits the feedback from Council to a broader group of NGOs.
- There is not a formal relationship between NAC and CCM (GFATM decision-making and coordination body) except through the current chair of these committees. Reporting, communication and accountability arrangements may need to be developed with these bodies.
- NACS is required to manage funding for NGOs under GFATM. Its capacity for financial management and monitoring is very limited and will need to be strengthened.
- NACS does not have strong organizational and management systems.

Non-governmental organizations are slowly growing and vary in their capacity to design and deliver programs. The gap in capacity largely exists between international NGOs and the local organizations. Many local NGOs lack the organisational and technical skills needed to support their activities. Few of these organizations have a clearly identified purpose or mission, and no strategic or operational plans. Those that are registered as NGOs still lack functioning governance systems, such as Boards of Management, and have poorly developed organisational systems for management of their resources including financial reporting. Paid staffing positions are low in most organizations and many operate through the goodwill of volunteers.

Many of the local NGOs are struggling to maintain their organisational base and are unable to make any longer term plans in relation to their activities. This lack of organisational capacity also limits their ability to secure longer-term partnerships and funding and therefore their viability. These are areas that will need strengthening to enable these organizations to be effective implementers in the response.

4.3 Infrastructure

A well functioning health system requires facilities that are adequately equipped to provide prevention or clinical programs to the community. Many health centre facilities across the country are run down. Community utilisation and access to these services is most often constrained by the facilities lack of cleanliness, lack of running water, poor or broken equipment, lack of privacy for history and medical examination, lack of request slips for referral, and the ability to transport specimens. While there are minimum standards for health centres at different levels there is little commitment to ensuring that these standards are being met.

Difficulties with transport and fuel are major constraints to provision of outreach services and extending care beyond the health centre. Limited operational funds at the provincial and district levels has led to fewer outreach and supervisory visits to health centres.

Roads in PNG are often poorly maintained making travelling to remote areas more difficult. Security concerns in some provinces have also restricted outreach visits.

Communication (usually by telephone or VHF radio) provides the capacity to support clinical management, provide collated service data, and support urgent supply matters, however in many centres phones and radios are not operational.

Laboratory equipment is broken and poorly maintained in most districts and laboratory workers have few supplies and reagents to undertake their work. Provincial and central laboratories lack the equipment needed to monitor ART (eg biochemistry analyser to monitor toxicity, or CD4 counts).

There have been some improvements in some provinces through a capital works program and funds to improve clinic facilities, however this often relies on the commitment of the provincial or district health offices to provide resources for this. Some communities have taken the initiative to rebuild their health centres through greater involvement with the management of local health services.

Across PNG the radio network is being expanded and strengthened to district level. Some gains have been made in hospitals and health centres with a program that provides training for health care workers in basic equipment maintenance.

Key challenges are:

- To stem the continuing decline of standards of care within health facilities through provincial and district funding and greater commitment by health managers and supervisors
- Improving hygiene standards, equipment and building maintenance
- Improving public infrastructure – roads, communication and transportation in rural areas
- Providing adequate supervisory support and resources to ensure minimum standards are applied
- Encouraging greater community ownership and health staff responsibility for maintaining local facilities.

5. Partnerships and Coordination

The government, churches, the private sector, NGOs, other donors and communities each have a role to play to help improve the response to HIV and AIDS and partnerships between these sectors are evident. Successful activities cannot be developed or sustained by any one group alone because the consequences of this epidemic are so widespread and reach so deeply into Papua New Guinea communities and families. The complex problem of reducing HIV requires many different approaches and solutions.

Although government agencies have a leading role in addressing HIV and AIDS, community, political and traditional leaders have an important role in strengthening the effectiveness of response initiatives at the community level. Church and community based organisations are very influential in Papua New Guinea communities. Their networks and leadership of country-wide activities have the potential to reach greater number of the target populations.

At the provincial level partnerships are developing between local communities and private sector industries to support prevention activities. Provincial AIDS Committees have played an important role in facilitating these partnerships.

Key agencies involved in the response are:

- Government sector – Prime Minister and NEC, members of parliament, government departments and agencies including the Departments of Health, Education, Community Development, Defence, Works, Transport, Agriculture, Correctional Service, Constabulary, Planning and Rural Development, Mining, Finance and Treasury, Personnel Management.
- Development partners – AusAID, UN agencies, Asian Development Bank, USAID, European Union, British High Commission, JICA, NZAID.
- International NGOs – Family Health International, Save the Children in PNG, Hope Worldwide, Red Cross, World Vision, VSO (UK), YWCA, Oxfam Australia.
- PNG NGOs – StopAIDS, ATechnologies, Help Resources, Friends Foundation, PNG Federation, Igat Hope, Humanity Foundation, Special Youth Project, Public Employees Association, Trade Union Congress, 3 Angels Care, Collaboration for Health
- Faith based organisations – the churches, including Catholic Health Services, Uniting Church, Anglican Church, ADRA, Salvation Army, Four Square Church
- Private Sector – business houses, PNG Chamber of Mines and Petroleum, Placer Dome, Ok Tedi, Lihir, Oil Search, CDC Oil Palm, PNG Chamber of Commerce and other industry organisation.

A more detailed description of donor funded program is attached at Annex 1.

With an increasing number of players looking to fund and initiate activities in response to HIV, coordination is becoming a critical issue. Duplication is evident, there is inconsistency in programmatic responses, fragmentation and despite having the NSP as the agreed plan for the response, and there is little direction from the government. While the NAC is the recognized body to coordinate the response, it has

not been operating in that way and mechanisms for coordination of the implementation of the NSP have yet to be developed.

Its secretariat, NACS, is poorly resourced to support the NAC's coordinating role. Staffing is limited and the technical and managerial capacity is not strong. Its structure, set up under the previous five-year plan, does not adequately support its role to coordinate the NSP and funds available from GoPNG have been extremely limited until this year.

At the Provincial level, PACs are responsible for coordinating the response, however they are operating variably. Many do not have the skills and resources to lead the response, have a limited mandate at this level and are not well linked with existing structures. Where these bodies are working well, there is good coordination of activities and regular meetings of stakeholders.

The UN Expanded Theme Group and the Country Coordinating Mechanism for GFATM have provided alternative opportunities for coordination. However their membership and focus is driven by donor priorities and external agency requirements. There is general agreement in the donor community that while these groups provide a level of coordination, they are not a substitute for a national coordinating body.

Recently a Donor Coordination Group was established to improve coordination and communication among donor agencies and to develop mechanisms for communication with the Government of PNG. There is greater willingness among donors for collaboration and to align their processes and systems more closely with each other and with Government of PNG.

A SWAp has been established within the health sector and will be fully operational this year. AusAID, ABD and NZAID are pooling their assistance through the Health Sector Improvement Program (HSIP). This is also the mechanism for managing GFATM funding. Within PNG, AusAID and other donors are increasing looking to channel its funding through sector programs, working within GoPNG systems and looking for greater alignment with other donors around funding and reporting mechanisms.

6. Way forward

Papua New Guinea is continuing to develop ways to respond to the growing threat that it is facing. While there are many constraints these are being addressed in a number of ways:

- Improved donor coordination is bringing more coherence to support for treatment, care and prevention programs. Within the health sector the SWAp enables many of the issues relating to health sector capacity to be identified, discussed and addressed through support to strengthening systems and structures. It also provides the means for funding to address shortfalls to respond more quickly when necessary and work in partnership with government to achieve longer-term change.
- In moving towards implementation of the "Three Ones", partners are increasingly aligning their processes and working to support the government program – strengthening of NAC and NACS to enhance its coordination and management

capacity; improvements in donor coordination; development of M&E framework and systems within NACS; and, endorsement of NSP as the national framework for the response.

- GFATM support has started to build some momentum for health sector response, including strengthening systems for delivery and human resource development programs, especially in NDoH.
- Specific activities are underway to support expansion of the treatment program. This includes the assessment of additional ART sites in preparation for increasing the number of sites offering ART. Funds for this roll out are available and commitment to ensure that the program is expanded to other provinces is high. Opportunities to improve staffing levels are being addressed.
- There is evidence of increased leadership at the national and provincial levels. The appointment of a senior minister to support the Prime Minister on HIV/AIDS and an active Parliamentary group has resulted in greater funding for HIV and AIDS being allocated from GoPNG budget for 2006.
- While NAC is still relatively weak, increased support is proposed to build its capacity for management and coordination of the response. Changes to the composition of the Council are proposed to make it a higher profile Committee.
- Technical assistance for monitoring and evaluation is starting to build M&E systems within NACS and over the next few months, capacity assessment will be undertaken to determine the areas for further support for the Secretariat. Mechanisms for coordination with stakeholders are being devised and it is expected that PNG will have structures in place by mid 2006.
- Many government agencies are beginning to mainstream HIV into their activities and look for opportunities to scale up their response through their programs.
- Support for *Igat Hope* is intended to strengthen that organizations viability and ability to be an effective partner with government, along with building skills and capacity of people living with HIV and AIDS.
- Leadership initiatives are underway across PNG and will be strengthened this year with a high level program working with politicians and senior bureaucrats.
- There is evidence that community based responses are moving from awareness programs to the use of approaches that build on community knowledge, networks and competencies to target behaviour change.
- During 2006 AusAID will commence its new program of support to the response working with government and civil society organizations to support the implementation of the NSP. This program will bring a significantly higher level of resources for the response.
- In early 2006, UNAIDS will hold a Prevention Summit to focus on ways to strengthen prevention efforts in PNG.

It is clear that meeting its targets for treatment, care and prevention will be a major challenge in PNG, however there is commitment, effort and resources available to achieve these. We know that the achievement of a scaled up response is not only dependent on the provision of financial resources but also on the capacity within PNG. Skilled and available human resources and infrastructure will be required to deliver effective programs and much more effort will be needed in these areas. Political leadership, community engagement and partnerships are critical elements to an effective response and while there have been some gains in these areas much more is needed. These elements are clearly developing in PNG and will take time to impact

on social and behaviour change.

ANNEX 1 Resources for the Response

The following table provides estimates of resources available for the response to 2010 (in USD). These amounts are based on current commitments and planned programs.

Donor	2006	2007	2008	2009	2010
AusAID	10,000,000	20,000,000*	20,000,000	20,000,000	20,000,000
UN agencies	3,000,000	3,000,000	4,000,000	4,000,000	4,000,000
GFATM	6,000,000	6,000,000	6,000,000	6,000,000	6,000,000
ADB	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000
Other (USAID, NZAID)	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
GoPNG	2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
Total	**26,000,000**	**36,000,000**	**37,000,000**	**37,000,000**	**37,000,000**

* Indicative annual amount for new AusAID Program – resources for Program still to be approved by Australian government.

AusAID

The Australian Government has been providing direct support for HIV and AIDS in PNG since 1995. In 2000 support through AusAID was significantly scaled up under the five-year National HIV/AIDS Support Project (NHASP) to support the implementation of Papua New Guinea's *HIV/AIDS Medium Term Plan.* With a budget of approximately AUD15 million per year this has positioned Australia as the largest donor supporting HIV program in PNG. This Project is due to end in late 2006. It has supported a wide range of activities including:

- management and technical support to NACS
- support to NDOH to strengthen laboratory services, health worker training, STI management, construction of STI clinics
- grants for civil society activities
- support for research and the development of social and community based research
- support for a the development and implementation of a High Risk Strategy Setting (HRSS)
- financial support and training for Provincial AIDS Council (PACS) staff
- development of Information, Education and Communications (IEC) materials and national campaigns
- social marketing of condoms
- development of counselling and VCT guidelines and training programs
- technical support for the development of national HIV/AIDS policy and protocols.

Within AusAID, an HIV mainstreaming program has been initiated across the agency and AusAID has been working with Government of PNG to facilitate mainstreaming activities within the government agencies. AusAID has also partnered with other

donors in a Leadership Support Initiative that aims to encourage greater engagement of politicians and bureaucrats in the response and is funding a number of health and HIV/AIDS activities undertaken by UNICEF. Through the Church Partnerships Program, Australian churches are receiving assistance to develop the response capacity of PNG churches.

AusAID has now completed the development of its new program of support for HIV and AIDS in PNG. This 7-year program will commence at the beginning of 2007 and a number of activities currently funded through NHASP will be transitioned to the new program during 2006, including activity and research grants scheme and support for the provincial response. There will also be an emphasis in this program on capacity building with government and non-government agencies, principally with NAC and NACS to strengthen its coordination capacity. The program will operate in partnership with Government of PNG and key donor agencies and will be based on an annual planning process developed from NSP. Resources for the new program are likely to be significantly higher than the current program.

Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)
GoPNG has received funding from the Global Fund to fight AIDS, Tuberculosis and Malaria for US$30 million over a five-year period. By 2009 it aims to:

- reduce HIV transmission among young people and create a supportive environment for PLWHA
- scale up Voluntary Confidential Counselling and Testing services in 20 provinces, and
- scale up anti-retroviral treatment and monitoring capacity through 30 public, private and Faith Based Organisation clinics.

The GFATM will support: IEC programs including school curricula and teacher training; programs for out-of-school youth, including youth peer education programs; training of health staff for HIV clinical management and treatment programs (Prevention of Mother to Child Transmission, ART and Post-exposure Prophylaxis); VCCT counselling training and establishment of VCCT sites; procurement of ART and OI drugs and testing supplies; upgrading of regional laboratories; development of a home care network, day care centres and training of volunteers; community leadership and PLWHA training; capacity building in NACS and support for strengthening NGO/CBO coordination and advocacy.

United Nations Agencies
The UN has developed a Joint Work Plan for its response to HIV and AIDS to guide the implementation of activities across its agencies. This Plan identifies five key result areas for its work:

- community mobilization to strengthen community capacity to respond to HIV and AIDS
- prevention and treatment- increasing access to treatment, including prevention of mother to children transmission, building community capacity for prevention, advocacy on gender, stigma and discrimination
- leadership - working with political leaders, people living with HIV/AIDS, youth and religious leaders
- monitoring and evaluation
- partnership building and donor coordination.

More specifically some of the activities being undertaken by the UN agencies include:

- UNAIDS is providing financial and technical support for a number of leadership activities – Asia Pacific Leadership Forum on HIV/AIDS and Parliamentary Special Committee on HIV/AIDS. It has a small amount of grant funding to target NGO capacity to support delivery of ART programs and the involvement of PNG leaders in advocacy activities. Advocacy initiatives towards achieving the "Three Ones" and coordination of the response have also been a focus of UNAIDS.
- UN Theme Group is providing financial and technical support to NACS for the development and implementation of a national M&E system.
- In preparation for the roll out of ART under the GFATM, WHO is providing technical support to strengthen the diagnostic capacity of laboratories, developing policy guidelines and protocols for ART and a pilot treatment program on ART. WHO will continue to provide technical support for treatment as this program is rolled out with GFATM funding. Additional funds from Japan through the UN Human Security Fund will support WHO in the scale up of treatment programs through strengthening infrastructure and community interventions.
- In line with its mandate UNICEF's program will maintain a focus on women and children, targeting pregnant HIV positive women to prevent mother to child transmission and supporting a Special Youth Project targeting prevention activities for out of school youth. UNICEF will use findings from knowledge, attitude and practice studies to develop training for community leaders through a community mobilization strategy. UNICEF has also completed an analysis of the social and policy environment affecting children orphaned by AIDS. Its recent Global Campaign for Children plans to increase the focus on treatment, human rights and protection for children.
- UNDP has funded a leadership development program, which has provided training for leaders from all levels of government and civil society. It has also supported development of the International Labour Organization Toolkit and the gender audit of the NSP.
- UNFPA is funding a number of activities targeting adolescent reproductive and sexual health - through Family Life Education, curricula development with Department of Education which incorporates HIV and AIDS, peer education training with university students at University of Papua New Guinea. UNFPA is also funding gender programs with girls and women through Leadership Empowerment Project, and support for work of Family and Sexual Violence Action Committee.

Asian Development Bank

ADB is proposing to implement a project within rural enclave developments from 2006 for 5 years. This project has three components: building public-private partnerships with rural economic operators to strengthen health infrastructure in rural areas and strengthen leadership advocacy; capacity development with civil society organizations for community behaviour change and a national social marketing of condoms program; and, strengthening and expanding the surveillance system. The project is funded through a grant from ADB for USD15 million. The remainder of the project is intended to be co-financed by Australian, New Zealand and PNG governments. Australian and New Zealand governments has committed USD3.5 each

million for social marketing project. GoPNG in the recent budget has committed K11 million.

Others International Donors

- World Bank has proposed a number of small projects implementing HIV activities within broader development activities, however these are currently on hold waiting a decision to proceed.
- The British High Commission is supporting HIV/AIDS leadership initiatives, activities targeting violence against women and deploying volunteers to support HIV activities in the provinces.
- The European Union has had a five-year program across 13 provinces to target vulnerable groups through peer education program. This program has aimed at strengthening the capacity of CSO groups to deliver prevention and care activities. This program will end in December 2006. The EU is looking to integrate its activities into other programs after this time.
- USAID is funding Family Health International to establish targeted interventions with sex workers and men who have sex with men. Recently USAID funded a local NGO, StopAIDS for some of its prevention work.

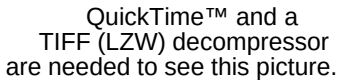
Civil Society Organizations

A number of FBOs, international and national NGOs and CBOs as well as some Trusts established by the mining industry, are supporting the implementing a range of projects that focus on preventing transmission, and provision of community care and counselling services. AusAID, the churches and international NGOs fund the majority of these programs.

Much of the work undertaken by churches has been funded by NHASP grants and Church Partnership Program. The Catholic Church has developed a network of coordinators in each diocese to support its work in a number of provinces. Care and counselling centres, VCCT and day care facilities have been established and will need ongoing funding to maintain the level and quality of these services at the district level. Anglican, ADRA and Uniting Church are also providing HIV awareness, counselling and care programs.

The mining sector has been playing a key role in developing an industry code and is encouraging and coordinating the response of the private sector through a coordinator position based in Chamber of Mining and Petroleum. The Trade Union Congress and the Public Employees Association are also involved in a range of awareness, policy development and advocacy activities with key trade union groups. Some private clinics are providing treatment and clinical services for PLWHA but this is currently limited to the National Capital District, around Port Moresby.

The Institute of Medical Research, the University of PNG and the National Research Institute are engaged in a number of research studies. These include behavioural surveillance surveys and KAP studies, research on molecular epidemiology and prevalence of HIV-1, and STI research.



ANNEX 2 FRAMEWORK FOR THE RESPONSE

ANNEX 3 TARGETS FOR SCALING UP TOWARDS UNIVERSAL ACCESS IN PAPUA NEW GUINEA

Focus Areas	Current Targets	Achievements against targets	Targets for 2010	Constraints and Challenges
		At 2006		
Treatment - ART	• To provide ART to 7000 people by 2010 (1500 by 2006; 3000 by 2007; 4500 by 2008; 6000 by 2009). • 200 service providers trained in ARV treatment and monitoring by 2007	320 people on ART 76 people trained	10000 people on ART* 20 doctors trained 1500 nurses trained	• Staffing shortages • Follow up and monitoring support from clinics • Community support for compliance and adherence • Staff training and management • Logistics and distribution of drugs and supplies • Inclusion of patients on ART seen in the Private clinics in the national data • NGO capacities and resources
Treatment - OI	• 50 HCW trained in OIs by 2007	No data available	100 doctors trained	• Supply and distribution of

* at 2010 it is estimated that there will be around 100,000 people with HIV and AIDS. If 100% of those people with late stage HIV and AIDS (about 20% of all those with HIV) were to receive ART, the target would be 20,000 people. The NSP target of 25% would put this number at 5000. In order to scale up toward universal access we will extend the NSP targets for 2010 to 50%. This would make the target number 10000 by 2010.

Focus Areas	Current Targets	Achievements against targets	Targets for 2010	Constraints and Challenges
	• 10 health facilities capable of providing advanced interventions for prevention and medical treatment of HIV infected people • OI drugs available in health facilities for 7000 patients		3500 nurses and health care workers trained OI drugs available in health facilities for 21,000 patients	drugs • Staff training and retention • Supervision of health centre staff • Access to prescription OI drugs by the NGO and the private sector in the national catalogue
PMTCT	• 600 HIV infected pregnant women receive ART by 2010 (180 HIV infected pregnant women receiving complete course of ART by 2007) • 100% of health facilities offering a minimum package of PMTCT by 2010 (10 health centres providing a minimum package of PMTCT by 2007) • 200 service providers trained in PMTCT by 2007 • 20,000 IEC leaflets printed for PMTCT by 2007	100 women receive ART	10000 HIV infected women have access to life line ART 6000 babies have access to ART 100% of health facilities offering PMTCT 3500 service providers trained in PMTCT	• Low access to antenatal services and supervised delivery • Lack of clinical outreach services • Limited counselling and support services available at health centres • Reliability of supply of ART • Affordability, acceptability of using infant formula • Community advocacy for access to the PMTCT program • Follow up of mothers on PMTCT • Testing policy for HIV positive mothers

Focus Areas	Current Targets	Achievements against targets	Targets for 2010	Constraints and Challenges
VCCT	To establish at least two sites for VCT services in each province that are easily accessible to people by 2008 • 30 districts with VCT services by 2007 • 100,000 people receiving VCT in 2007 • 200 service deliverers trained in VCT by 2007	All provinces have nominated sites Almost 2000 people have received VCT since 2004 > 1000 service providers trained	2 functioning and accredited VCCT sites in each of the 89 districts	• Accreditation of VCCT centres • Quality of counselling • Linkages between VCCT sites and ART programs • Reporting and monitoring of data across sites • Advocacy and promotion of VCCT sites • Retention of trained staff • Training of quality counsellors
STI	To reduce incidence and rate of STIs in risk populations to 5% and the general population to 3% by 2008		Reduction in STIs to 3% of general population	• Quality of clinic services and facilities • Reliability of drug supplies to health centres • Supervision and training of staff • Monitoring of STI data • Human resources capacity
PEP	• 150 service providers trained in PEP by 2007 • 100 people who could potentially receive PEP (HCW and rape cases)		3500 service providers trained in PEP National PEP policy developed	• Lack of policy and guidelines • Staff training • Linkages with police, village courts and other services

Focus Areas	Current Targets	Achievements against targets	Targets for 2010	Constraints and Challenges
Prevention	• 200 teachers trained in HIV education by 2007 • 100,000 HIV/AIDS related prevention brochures printed and distributed by 2007 • 300 peer educators trained by 2007 • 1 youth friendly centre established and operational by 2007	1200 trainers for peer education 1400 peer educators trained	20000 teachers trained 1,000,000 prevention brochures printed and distributed 3000 active peer educators 1 urban and 1 rural youth friendly centre in each province 50% increase in condom use among 15-29 year old	• Mobilising communities to develop local responses • Consistency of messages – false notion about condoms • Improving gender relations and reducing violence • Identifying and targeting vulnerable populations • Prevailing religious and traditional beliefs • Access of condoms in remote areas
Family and Community support	• 30 support groups for PLWHA reached by 2007 • 20 support groups for PLWHA trained by 2007 • 30 civil society organizations reached by 2007 • 30 civil society organizations delivering HIV/AIDS services by 2007		60 civil society organizations reached 60% of total HIV/AIDS programs delivered by civil society organizations	• Strengthening networks of people living with HIV and AIDS • Reducing stigma and discrimination • Engaging churches and NGOs to develop local initiatives • Strengthening local leadership

Focus Areas	Current Targets	Achievements against targets	Targets for 2010	Constraints and Challenges
				• Improving coordination of local activities • Community mobilization and support
Epidemiology and Surveillance	At least two surveillance sites for antenatal cases (one urban and one rural) established in all provinces by 2010	26 sites; 7 sentinel sites producing data	2 surveillance sites for antenatal cases in all provinces Behavioural Surveillance - at least 2 sites in each province	• Human resources capacity in NDoH for surveillance • Data management, analysis and dissemination • Development and maintenance of national surveillance system • Standardising reporting in line with UNGASS
Monitoring and Evaluation	• To develop a Monitoring and Evaluation framework to produce, collate, analyse and disseminate information on the national response to HIV, by 2004. • To accumulate and disseminate data from all sources including provinces through the use of relevant indicators that will assist in the reporting on respective international milestones for example,	M&E Framework developed	Functional unit within NACS CRIS established	• Capacity of NACS M&E Unit • Limited skills and M&E systems at provincial level • Limited capacity among civil society organizations

Focus Areas	Current Targets	Achievements against targets	Targets for 2010	Constraints and Challenges
	UNGASS and the MDG by 2005. • To measure the effectiveness and efficacy of the national response by undertaking a review of the NSP by 2008.			
Management			DCB is functioning as viable branch within NDoH NACS has in place mechanisms for coordination, planning and monitoring of the NSP	• Strengthening performance, leadership and management capacity in health sector • Building capacity within Disease Control Branch
Procurement			Reliable procurement and distribution system functioning to districts	• Timely processes for procurement and distribution through NDoH systems • Improving management capacity for planning and supervision • Improving stock management at facility level • Adequate storage and security for drugs