Papua New Guinea Report NCPI

NCPI Header

COUNTRY

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Describe the process used for NCPI data gathering and validation:
Sample Selection and Sample Size The GAR Core Working Group identified 65 stakeholders at a National level and 12 from the Provincial level as key in the implementation of the National HIV and AIDS Strategic Plan 2006-2010 and the National HIV and AIDS Strategy 2011 - 2015. Of these 51 were nominated to participate in the survey – 29 from the government sector and 22 from the CSOs, bi-lateral and UN organisations. Notice, invitation and consent The Director of the National AIDS Council (national coordinating body) sent out letters to the senior staff of each participating organisation in December 2011. The letter advised them of the purpose of the survey and encouraged/invited their organisation to be involved. Each interviewer was supplied with a copy of the letter of invitation and the interviewee was provided with a copy. Building capacity of interviewers The GAR Core Working Group conducted NCPI interviewer training over a three-day period in December 2011. For the first the participants were drawn from the recently appointed M& E officers in the Provincial government and Provincial AIDS Committee offices. For the majority this was the first time they had conducted a survey of this nature and more importantly, with senior staff and government officials of high standing. Of the 11 trained, only two were involved in the interviewing in 2010. Of the 11 trained two were unable to continue and a further two were recruited to replace them. Data Collection Fifty-three interviews were conducted 30 of the government sector and 23 from the CSOs, bi-lateral and UN organisations. This is 12 more than the 39 interviews in 2010 NCPI and 22 more than the 19 in the 2008 NCPI report. However one of the government sector data forms was duplicated/overwritten during transcribing with another so of the two, only one was entered. One CSO survey form and one government survey form arrived after the NCPI was completed so were not included. This NCPI is based on 28 government sector interviews and 22 from the CSOs, bi-lateral and UN organisations, a total of 50. Data Collection Methods Face to face interviews and two self-administered surveys. Of those that provided the time of interview the majority (27) were completed between 1 ½ and 3 hours, with the next cluster between ½ hour and 1 ½ hours (18). There were as one interview over 4 hours. Survey Implementation Period The survey was implemented between January and 16 March 2012. This NCPI included three provinces as well as national stakeholders. The provinces were: Western Highlands Province, Morobe Province and Central Province. Data Management The survey data was collected in hard copy and manually entered in a specially formatted Excel worksheet template of the survey. The 51 individual Excel sheets of data were then entered into one master file for analysis. Analysis was done using Excel and discussions with the Core Working Group. Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions: The format and quality of the raw data was discussed with the GAR Core Working Group on 14 March. The first draft NCPI was presented to the GCWG on 21 March where discussions were had on areas of the NCPI to gain consensus. The revised NCPI v2 was and then presented to the stakeholders in a 2 day Consensus Workshop, on 22 and 23rd March. The workshop recommendations for change were implemented and the final NCPI was entered into the on line tool between 26th and 30th March 2012. Regional/Provincial participants This is the first NCPI in PNG that interviewed Provincial stakeholders (three Provinces). A number of respondents were not familiar with national policies and strategies and tended to answer from the perspective of the Provincial issues. Percentages and Multiple Choice Consensus was more difficult where the questions asked respondents to provide a percentage without there being a range offered as a multiple choice. This resulted, in some cases, with over 15 different answers. The Core Working Group overrode the answers with the correct answer for the country. Entry error Two forms provided the exact same data where an error had occurred during transcribing from the handwritten forms. There was not time to re-enter the additional data. Investigation was undertaken to match the responses to the role and one was discarded. Overview of participation Whilst a number of surveys comprised very limited data, primarily just answering the binary questions and not providing any commentary, explanations or brief notes, overall respondents were conscientious in their participation and provided thoughtful and informed answers where they could. As this is the third NCPI for PNG, and the first including some of the Provinces, there is growing data sets for comparative analysis and trend analysis emerging for PNG.

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

questions:
The format and quality of the raw data was discussed with the GAR Core Working Group on 14 March. The first draft NCPI was presented to the GCWG on 21 March where discussions were had on areas of the NCPI to gain consensus. The revised NCPI v2 was and then presented to the stakeholders in a two-day Consensus Workshop, on 22 and 23rd March. The workshop recommendations for change were implemented..

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):
There were clearly some answers that indicated a poor understanding of the questions emphasis and syntax. It is important to note that whilst many of the respondents are fluent in English, the complexity and technical language of some of the questions posed some difficulty, particularly, when the comfort levels of some interviewers were not at an optimum level due to this being their first NCPI involvement. This was evident when interviewers and interviewees persevered with a question that actually had no sense in English. There was the one typo error in the survey template that was printed for interviewers use - AI 1.3 'IF NO explain how key populations were indentured?' however the actual word in the GAR guidelines document is identified. This question was thus rendered unusable and the answers, whilst well intentioned, did not relate to the question. High Level AIDS Review June 2011/Political Declaration on AIDS 2011. The High Level AIDS Review June 2011 has not been comprehensively followed up in PNG and as the NHS 2011-2015 was just into it's first year when the 2011 Declaration was made there were no changes made in 2011 to the NHS 2011-2015 or the budget allocation for 2012. The NCPI question assumed knowledge of the AIDS Review June 2011 rather than asking if the Declaration was known to the respondents. The majority answered that NHS 2011-2015 and the national HIV budget were changed accordingly. However, on enquiry, many assumed the question was bout the Declarations of Commitment on HIV/AIDS 2001 and Political Declaration on HIV/AIDS 2006.

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

Organization	Names/Positions	A.I	A.II	A.III	A.IV	A.V	A.VI
Central Province Administration- Community Development: Kwikila	Ms Tawa Gebia & Ms Rolyne Raka/No job title provided.	Yes	Yes	Yes	Yes	No	No
National Planning, Monitoring & Evaluation Department	Ms Amanda. Kikalia/ Senior Programme Officer	Yes	Yes	Yes	Yes	Yes	Yes
National AIDS Council Secretariat	Dr Moale Kariko/ Deputy Director – Care, Treatment & Support	Yes	Yes	Yes	Yes	Yes	No
PNG Christian Leaders Alliance on HIV (PNG Churches Alliance)	Mr Eddie Kekea/ National Coordinator	Yes	Yes	Yes	Yes	Yes	Yes
National Department of Finance	Mr Andrew Saige/ Assistant Secretary	Yes	Yes	Yes	Yes	Yes	Yes
National AIDS Council Secretariat	Ms Julie Airi/ Manager, Behaviour Research Information, Prevention Division	Yes	Yes	Yes	Yes	Yes	Yes
Central Province Administration – Health Division: Kwikila Hospital	Mr Richard Oaeke/ Officer in Charge-Health Sector	No	Yes	Yes	Yes	Yes	Yes
National AIDS Council Secretariat	Mr Moses Kaigu/ Manager Policy & Planning	Yes	Yes	Yes	Yes	No	No
Central Province Administration – District Administrator - Rigo	Mr Iobo Lalai/ Deputy Administrator	Yes	Yes	Yes	Yes	No	No
Rigo District Admin- Education Section	Mr Weseley Satu/ District Elementary Coordinator	Yes	Yes	Yes	Yes	Yes	Yes
NCD Provincial AIDS Council Secretariat	Doreen Nadile/ HIV Technical Officer	No	No	No	Yes	No	No
PNG Sexual Health Society	Dr John Millan/Director	Yes	Yes	Yes	Yes	Yes	Yes
National Department of Health	Dr Paison Dakulala/Deputy Secretary of Health- National Standards	Yes	Yes	No	No	Yes	No
National Central District - Provincial AIDS Council Secretariat	Mr Isu Aluvula/ HIV AIDS Response Coordinator	Yes	No	No	No	No	No
National Department of Health	Mr Sibank Vivaldo Bieb/Manager Disease Control & Surveillance	Yes	Yes	No	No	No	No
Morobe Provincial AIDS Council	Ms Joan Ganoka/ - HIV AIDS Response Coordinator	Yes	Yes	Yes	Yes	No	No

Morobe Province -Provincial Health Office- Division of Health	Mr Micah Yawin/Acting Provincial Health	Yes	Yes	Yes	Yes	Yes	Yes
Community Development Morobe Admin	Mr Kiun Kimbing/A/Provincial Program Advisor	Yes	Yes	Yes	Yes	Yes	Yes
National AIDS Council Secretariat	Mr Philip Tapo/ Deputy Director - Prevention	Yes	Yes	Yes	Yes	No	No
Port Moresby General Hospital - Heduru HIV Clinic	Sister Opina/ Sister in Charge	Yes	Yes	Yes	Yes	No	No
National AIDS Council Secretariat	Mr Valentine Tangoh/ Regional Manager - Momase	Yes	Yes	Yes	Yes	Yes	No
National AIDS Council Secretariat	Mr Wep Kanawi/ CSM. OBE Director	Yes	Yes	No	No	No	No
Western Highlands Province- Provincial Health Authority	Mr Philip Talpat/ Acting Director – Public Health	Yes	Yes	Yes	Yes	Yes	Yes
Western Highlands Province –Provincial Administration	Mr Pym Mamandi/ Deputy Administrator – Corporate Services	Yes	Yes	Yes	Yes	No	Yes
Western Highlands Province – Community Development	Mrs Regina Kanza/ Women's Coordinator: NGO, FBO & CBO Affairs	Yes	Yes	Yes	Yes	No	Yes
PNG Australia Law & Justice Partnership (PALJP	Ms Joanne Robinson/ L&J Sector Cross Cutting Issues Activity Management Team: Sector Coordinating Mechanism	Yes	Yes	Yes	Yes	Yes	Yes
National AIDS Council Secretariat	Ms Angelsula Jogamup/ Southern Region Manager	Yes	Yes	No	Yes	No	No
NDoH - HIV Prevention & Care in Rural Development	Kel Browne/ Deputy Project Manager	No	No	Yes	No	Yes	No

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	B.I	B.II	B.III	B.IV	B.V
FHI 360	Mr William Yeka/Senior Technical Officer - M&E	Yes	Yes	No	No	No
Advantage, Development and Relief Agency (ADRA) Seventh Day Adventists	Ms Becky Sambak/Project Manager	Yes	Yes	Yes	Yes	Yes
Hope Worldwide PNG	Mr Jonah Kuman/ HIV Programme Manager	Yes	Yes	Yes	Yes	Yes
Business Association against HIV and AIDS (BAHA)	Ms Carolyn Bunemiga/ Director	Yes	Yes	Yes	Yes	Yes
National Research Institute	Dr Holly Buchanan Haruwafu / Mr Ray Frank Associate Researcher Behaviourial Surveillance	Yes	Yes	Yes	Yes	Yes
Anglicare StopAIDS	Ms Heni Meke/National Director	Yes	Yes	Yes	Yes	Yes
PNG Sustainable Development Program Ltd	Ms Jennifer Krimbu & Ms Jacklyn Esseo/Senior Program Officer HIV & AIDS	Yes	Yes	Yes	Yes	Yes
PNG Alliance of Civil Society Organisations (PACSO)	Mr John Kerari/Chairman	Yes	Yes	Yes	Yes	Yes
Save The Children (Poro Sapot Project)	Ms Lydia Seta & Mr Jonathan Wala/ Acting Project Manager & M& E Officer	Yes	Yes	Yes	Yes	Yes
Japanese International Cooperation Agency/JICA	Mr Taniguchi/Program Officer	Yes	Yes	Yes	Yes	Yes
USAID	Ms Jennifer Erie/Health Officer	Yes	Yes	Yes	Yes	Yes
National Catholic AIDS Office	Sr Tarsicia Hunoff/Director	Yes	Yes	Yes	Yes	Yes
Baptist Union of PNG	Mr Michael Pasaga/HIV AIDS Project Manager	Yes	Yes	Yes	Yes	Yes
UNAIDS PNG	Dr Ali Feizzadeh/M&E Advisor	No	No	Yes	Yes	Yes
Sanap Wantaim: PNG Australian HIV						

Sanap Wantaim: PNG Australian HIV Programme (AusAID)	Dr Ninkama Moiya/ Medical Advisor	Yes	Yes	Yes	Yes	Yes
PNG: International Development Law Organisation (IDLO)	Lydia Karre/ Legal Officer	No	Yes	Yes	No	No
UNAIDS PNG	Maria Nepal/ Partnership Social Mobilisation Advisor	Yes	No	No	No	No
UNAIDS PNG	Stuart Watson/ Country Coordinator	No	Yes	Yes	No	No
UNICEF	Cristina Morf/Chief HIV/AIDS	Yes	Yes	Yes	Yes	Yes
Igat Hope (PNG) Incorporated	Annie McPherson/ Executive Director	Yes	Yes	No	No	No
World Vision	Lucy Jaro/Project Coordinator – HIV Section	Yes	Yes	Yes	Yes	No
WHO	Dr Fabian Ndenzako/HIV AIDS Programme Director	Yes	Yes	Yes	Yes	Yes

A - I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?
(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2):
Yes
IF YES, what was the period covered:
2011-2015
IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.:
YES: Summary of comments from respondents. • New one: multisectoral. Integration of services. Old one: Standalone & a multitude of strategies that did not work. • It is addressing all sectors of societies and aspects of development as a cross cutting issue ……….. It's a way forward for Multisectoral and Intersectoral participation. • The previous strategy was not clear in terms of developing plans and activity at community based level, however, the new NHS has clear priorities and can easily be aligned with community based organizations activities and programs • The new plan has three priority areas. Whilst the old one had seven (7) areas. • The new plan has a clear "10 Must Do" task and also has the M&E plan. It also has the Implementation Framework. • Having these Frameworks (M & E and Implementation) make it much easier to focus our resources and energy to specific areas of the new plan

1.1 Which government ministries or agencies

Name of government ministries or agencies [write in]:
National AIDS Council is the legally mandated authority to coordinate multi - sectorial strategy (NAC ACT 1997 amended 1999).

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

SECTORS

Included in Strategy	Earmarked Budget
Yes	Yes
Yes	Yes
Yes	Yes
Yes	Yes
Yes	No
Yes	Yes
Yes	Yes

Other [write in]:
Agriculture, Mining and Petroleum, Law & Justice, Trade & Commerce/BusinessThere was one sector where the majority of respondents reported a No.
IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specifc activities?:
There was one sector where the majority of respondents reported a No. Note: However the comments also provided information that suggested that the source of the Departments HIV specific budget for may, was not from the re-current budgets but from development budgets which were sourced from NACS or donor partners. Respondent's comment: • Transport is part of Govt service plan but it has no budget - its HIV is catered for under partnership arrangements. Agriculture, Trade and Industry fall under the same category. • When there is no adequate budget funding from the

Department’s own development budget, it is through grant applications to NACS or donor development partners. E.g. UNICEF . The national Department can also request funding from District Level Governments or other Departments such as Health. • Corporate sector departments have their own plans but HIV budgets are supported by National AIDS Council Secretariat (NACS), National Department of Health (NDoH) and DONOR partners to budget for implementation.

1.3. Does the multisectoral strategy address the following key populations, settings and cross-cutting issues?

Men who have sex with men:
Yes
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
Yes
People with disabilities:
No
People who inject drugs:
Yes
Sex workers:
Yes
Transgendered people:
No
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations:
Yes
Prisons:
Yes
Schools:
Yes
Workplace:
Yes
Addressing stigma and discrimination:
Yes
Gender empowerment and/or gender equality:
Yes
HIV and poverty:
No
Human rights protection:
Yes
Involvement of people living with HIV:
Yes

IF NO, explain how key populations were identifed?:
Note: There was a typo error in this question. Indentured not identified. The answers do not relate to the question re identification so cannot be used to inform how the key populations are identified. The answer/explanations related to the 1.3 table selections. Consensus comments on the 1.3 table selections: HIV and Poverty as a cross cutting issue is not in the NHS 2011-2015 despite the majority reporting that it was. The NHS 2011-2015 does refer to injecting drug use users as an identified MARP within ‘Injecting practices’. (PA.1. SO.1. Cluster 1.4). 8 respondents reported it does not. However the NHS 2011-2015 does not refer to disability as a Key Population yet 17 of 22 (77%) respondents reported it did. Only one expressly commented that is was absent. One respondent stated ‘these populations are not in PNG’ but then went on to correctly identify key affected populations for 1.4
1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]?:
Men and women aged 15 – 59 with concurrent sexual relationships and multiple partners, male & female sex workers; pregnant women – mother to child; TB clients; STI clients; adults & children living with HIV; young men & women; vulnerable children; health workers; MSM; transgender; people who practice penile modification, tattooing and scarification; injecting drug users; women who experience gender based family /sexual violence; in and out of school youth; uniformed services, prisoners, mobile populations - economic enclaves.
1.5. Does the multisectoral strategy include an operational plan?: Yes

1.6. Does the multisectoral strategy or operational plan include

a) Formal programme goals?:
Yes
b) Clear targets or milestones?:
Yes
c) Detailed costs for each programmatic area?:
Yes

d) An indication of funding sources to support programme implementation?:
Yes
e) A monitoring and evaluation framework?:
Yes

1.7

1.7. Has the country ensured “full involvement and participation” of civil society in the development of the multisectoral strategy?:
Active involvement
IF ACTIVE INVOLVEMENT, briefly explain how this was organised:
Respondents Comments • Led by NACS: Through multi-sectoral teams including (CSOs, FBOs and biltaerals) & grouped up in thematic areas. They met together & discussed how to implement the multi-sectoral plan. • Consultative meetings were conducted involving all partners including civil societies from NGOs, FBOs and government sectors involved with HIV programs • Much, much wider consultation with Civil Society and community as compared to NSP.

1.8. Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?:
Yes

1.9

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?:
Yes, all partners

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

2.1. IF YES, is support for HIV integrated in the following specifc development plans?

Common Country Assessment/UN Development Assistance Framework:
Yes
National Development Plan:
Yes
Poverty Reduction Strategy:
Yes
Sector-wide approach:
Yes
Other [write in]:
Health, Education, Mining, Transport, Defence, Provincial Extension Plan, Vision 2050

2.2. IF YES, are the following specifc HIV-related areas included in one or more of the development plans?

HIV impact alleviation:
No
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support:
Yes
Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support:
Yes
Reduction of stigma and discrimination:
Yes
Treatment, care, and support (including social security or other schemes):
No
Women’s economic empowerment (e.g. access to credit, access to land, training):
Yes
Other[write in below]:
Maternal and infants Health , Leadership, Community Development

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?:
No
4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?:
Yes
5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS?:
No
5.1. Have the national strategy and national HIV budget been revised accordingly?:
No

5.2. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?:
Estimates of Current and Future Needs
5.3. Is HIV programme coverage being monitored?:
No
5.4. Has the country developed a plan to strengthen health systems?:
No
Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:
Answers indicate that there is knowledge on how 'information' is used but not on how THIS information is used as it is not collected/monitored. Respondents Comment: Very useful for national and Provincial Development plans, the HIV, HEALTH and other sectoral plans to develop appropriate strategy and allocate resources wisely
6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in the HIV programmes in 2011?:
8
Since 2009, what have been key achievements in this area:
Respondents comments: • School children increasingly becoming aware of HIV/AIDS through school (curriculums). All schools receiving basic HIV education, • Community taking bigger role in preventing HIV from spreading in their communities • Access to ART increase: 70 – 80)% of PNGeans are on the ART: ART rollout to the most remote districts • Increase number of VCT sites and ART sites • Establishment of District AIDS committees in the country • Leadership Development Framework introduced. • Increased focus on gender equality. • Improvement in a the breakdown of stigma & discrimination – more people are coming to be tested • Development of the multi-sectoral NHS 2011-2015. The only country in South - East Asia who has developed a multi - sectoral strategy plan for HIV. • Aligning government plans - Improved planning process with stakeholders. • 2011 Annual planning for the NHS 2011-2015 - (there were two strategic planning workshops for the four regions (1 workshop conducted for two regions, 2 staff & key stakeholders involved) followed up by two strategic planning workshops to enable better written submissions for budget assistance through the Government of PNG budgetary system. • Round 10 Global Fund securing over $500 000 USD to support implementing the new NHS plans.
What challenges remain in this area:
Respondents comments: • The LNG boom – migrants, miners in enclaves • Older men with young women • Sex work explosion • Having to detect new HIV infections, challenges, re how people receive HIV information. • ART resistance/ treatment failure • Infrastructure, health care centres are run down, technology lacking e.g.; CD4 Count machine, sustaining this machines and replacing them. • Effective management and utilization of resources. Coordination because of too many stakeholder and monitoring and evaluation. • Implementation of policies and plans. To date the sector response has not been driven by a formal analysis of the needs and context. • No Impact Evaluation: The sector and its agencies do not have a comprehensive understanding of how HIV&AIDS, could be affecting the achievement of their goals, objectives and programmes. There is not a detailed understanding of how the work practices of the sector and agencies could be causing or contributing to the spread of HIV. • Very little recurrent budget is allocated to HIV & AIDS activities and programs, these are almost exclusively funded by development (donor) funds or externally sourced from organizations such as NACS. • Need to improve on the reporting + maintain government and donor partners confidence + support as well as our stakeholders. • Human Resources, replace ageing work force. Refresher courses for trained health staff • Medical Research - more research needed to drive clinical interventions on HIV/AIDS. E.g.: HIV or TB vice versa to be diagnosed properly and treated accordingly. • Better alignment of development & donor partner programs to the national response • HIV is shifting in towards the rural areas. The level of discrimination and stigma in the rural communities, families is high. Capacity building for the rural health sector including everybody (Community, Churches etc.) • Provinces don't see the importance in HIV programmes. There is a lack of commitment as they think it is just for the National AIDS Council to worry about. Ownership of response at local levels. Resourcing of local response by local authorities • Work still needs to be done on leadership & ownership of HIV/AIDS. Needs proactive advocacy from leaders on HIV/AIDS. Politicians need to be role models for cross-cutting issues (take responsibility e.g. politicians have one wife & not two or three wives). • Donor funders withdrawing. • Government to continue support for proactive prevention/investment from donor partners • Inconsistency between initial budget estimates and the actual allocation of resources. More equitable distribution of resources • There should be better policies in place for capacity development and transfer of knowledge to people engage in the national response.

A - II. POLITICAL SUPPORT AND LEADERSHIP

1. Do the following high offcials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year

A. Government ministers:
Yes
B. Other high offcials at sub-national level:
Yes

1.1

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.):
Yes

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

Respondents comments: Nationally • The current & past Ministers for Health have spoken that HIV/AIDS poses a development challenge for PNG and have all stated support for NACS • Minister for Health attended the United Nation's General Assembly meeting and gave a speech on HIV/AIDS. At the WAD 2011 the NDoH Secretary, Minister & staff participated wearing T' Shirts (zero tolerance) for HIV/AIDS. • Former Minister for Community Development speaking at the Nation Convention of Human Rights and at PNG National Parliament promoting the a Bill that decriminalises the sodomy and prostitution. • Special political leaders and parliament committees attended international conferences on HIV/AIDS to reaffirm HIV/AIDS as a developmental issue in PNG & the country's effort towards minimising impact towards HIV/AIDS. • We've had ministers taking part in most of our workshops and forums while giving speeches. Provinces. e.g. NCD Governor Mr Powes Parkop, the NCD Governor, talks about HIV on media, has taken an initiative to take an HIV test publicly, has allocated K500,00 for the NCD response to support Mobile VCT clinics and he visits the VCT clinics. Sector leadership e.g. Law and Justice The Chief Ombudsman hosted World AIDS day activities at the Ombudsman Commission 2010, 2011. The Ombudsman Commission has included HIV as a funded line item in the 2012 annual plan. The Ombudsman Commission funded one Commissioner and the Cross Cutting Issues Coordinator to attend the XVIII International AIDS Conference in Vienna 2010 and have committed to funding one commissioner, the Manager HR and the CCI Coordinator to attend the XIX International AIDS Conference in Washington 2012. The RPNGC Assistant Commissioner Human Resources hosted World AIDS day Activities at police head quarters, 2011. The RPNGC Assistant Commissioner Human Resources participated in the Asia and Pacific Regional Consultation on HIV and Sex Work in Thailand, October 2010.

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

Yes

2.1. IF YES, does the national multisectoral HIV coordination body

Have terms of reference?:

Yes

Have active government leadership and participation?:

Yes

Have an official chair person?:

Yes

IF YES, what is his/her name and position title?:

Sir Peter Barter (acting Chair of National AIDS Council)

Have a defined membership?:

Yes

IF YES, how many members?:

19

Include civil society representatives?:

Yes

IF YES, how many?:

3-4

Include people living with HIV?:

Yes

IF YES, how many?:

1

Include the private sector?:

Yes

Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?:

Yes

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

Yes

IF YES, briefly describe the main achievements:

Note: respondents comments were both on the mechanisms and the achievements. The mechanisms are: a) BAHA - Business Coalition against HIV. b) PACSO - For NGOs and CSOs c) Government sectors d) Provincial AIDs Committees (10 are for each province) e) Church Alliance. • Through the NAC membership which is multi-sectoral & includes representation from all sectors. Two of these NGO mechanisms are on the National AIDS Council and all of the key government sectors/departments. The achievements are: • Got NHS 2011-2015 2011-2015 in place • Increased number of stakeholders from 50 to 200 • Decentralized HIV response to provincial down to districts & LLGs • Increased HIV in schools including Sensitized teachers to teaching HIV/AIDS • Private enterprise is now putting in or implementing HIV workplace policies • Increase in HIV Budget from 2009

What challenges remain in this area:

Respondents comments: • There needs to be formal or consolidated linkages in terms of coordination between BAHA, PACSO, Church Leaders Alliance, Youth Alliance, Igat Hope Inc and Govt Sector coordination groups and NACS. NACS need to continue strengthening these umbrella corporations. Reason being so that their leaders would work with NACS. It helps filter the process of policy change/formulation and as well as providing resources down to the people. • Regularity of treatment & elimination of stock-outs of ART. • Funding and Duplication of activities/programmes. • Political & Leadership - consistency

regarding promises and commitment. E.g.: Politicians may talk one day about HIV and the next day they do not. • A greater involvement of the private sector in provinces & in economic enclaves by government officers. • Better alignment with aid donors & development partners

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

44%

5.

Capacity-building:

Yes

Coordination with other implementing partners:

Yes

Information on priority needs:

Yes

Procurement and distribution of medications or other supplies:

Yes

Technical guidance:

Yes

Other [write in below]:

Monitoring and Surveillance , Statistics and data, income generation, resource mobilisation, home based are, research capacity, alignment with UN, Province, NGO plans, planning and budgeting, logistics, Training, Information sharing.

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

Yes

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?:

Yes

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

This question poses problems by merging laws with policies. Some replied on the basis of the Laws = No and others on Policies = yes. Yes: • The recent National Education Plan has now captured HIV Curriculum in Education unlike the previous one. In the Schools: they have integrated HIV study into the curriculum. • Amendment to General Orders to amend HIV workplace policies. Developed templates for workplace policies for private enterprise No: • Changes to the laws on sodomy and prostitution were talked about and a Bill but it was not passed.

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

The comments relate to Laws that are inconsistent not so much on the policies. Respondents comments: • Old national laws being inconsistent with modern laws on human rights including HIV • Provincial policies being inconsistent with the HAMP ACT • Laws being inconsistent with the HAMP ACT (Women not expressly protected) • Laws not consistent with human rights (e.g. Laws on sodomy & prostitution)

7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the political support for the HIV programme in 2011?:

5

Since 2009, what have been key achievements in this area:

Respondents comments: • More government officials are beginning to vocally address the epidemic; • Most activities were funded by donors (1989 - 2006 b) All NACS funded activities funded by the Government (since 2010) d) Additional activities are funded by donors. • Improved infrastructure for the health facilities, • Capacity building in terms of training, • Logistics improvement in terms of vehicle delivery. • Political Leaders involved in the planning and development of NHS 2011-2015 • Improvement of HIV Reports and Forms for reporting from government departments

What challenges remain in this area:

Respondents comments: • The only active and visible support is provided by the Minister for Community Development in this period. Even the MP who is chair of the Special Parliamentary Committee for HIV has rarely made public statements. • Most departments executives are yet to provide a clear strategic direction for how the sector wishes to address HIV&AIDS. There is very little open or active support from CEO's or senior executives for HIV programs. Most CEO's and Executives do not consider HIV as a strategic priority or see HIV as part of their "core business". • Very limited progress in implementing their HIV&AIDS workplace policies. Most have not yet allocated resources to the implementation of workplace policies nor appointed a senior staff member to take responsibility for the implementation of the workplace policy. • Donor Agencies pulling out budgets and Government funding increase/decrease depending on who is in leadership. • Politicians not honouring their commitments. Political Leaders delivering their commitments through wantoks/friends and thus the FULL commitment is NOT DELIIVERED. Need for a political champions. • Need to reconstitute the NAC to have traditional leaders in the Council. • Need for provincial, political leadership to provide resources to provincial programs. • Taking ownership of HIV at all levels. Develop policies geared towards, targeting population, specific catchment area- LLG, Wards.

A - III. HUMAN RIGHTS

1.1

People living with HIV:

Yes

Men who have sex with men:
No
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
Yes
People with disabilities:
Yes
People who inject drugs:
No
Prison inmates:
Yes
Sex workers:
No
Transgendered people:
No
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations [write in]:
-

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:
Yes
IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:
a) The Constitution (S55) guarantees all citizens the same rights, privileges, obligations and duties irrespective of sex. However, freedom from discrimination is not a guaranteed right as the constitution provides that Customary law is part of the underlying law of PNG. The following is the correct legal situation but other comments made it clear that MSM and sex workers do not believe they are protected by the Constitution. There is no legal guarantee of non discrimination on the grounds of sex. The Constitution provides that citizens have the right to freedom of assembly which theoretically would include associations of MSM, sex workers, and transgendered people. The Constitution provides that citizens have the right to freedom of movement which would theoretically apply to MSM, sex workers and transgendered people. b) The Discriminatory Practices Act 1963 prohibits discrimination on the basis of colour, race or ethnic, tribal or national origin. c) The Lukautim Pikinini Act protects and promotes the rights and wellbeing of all children regardless of gender and protects children from all forms of violence, abuse, neglect, exploitation and discrimination. d) Criminal Code (Sexual Offences and Crimes Against Children) Act 2003. e) The Juvenile Court Act 1997, specifically provides human rights protection for young offenders aged between 10 and 18 years old. f) The Police Juvenile Policy and Protocols provide a tool for dealing with juveniles in conflict with the law. g) The Correctional Services Act 1975 sets out the legal requirements for duty of care to prisoners.
Briefly explain what mechanisms are in place to ensure these laws are implemented:
There are the following formal complaints processes using the following mechanisms however the Consensus Workshop noted that this information is not common knowledge and that there are many obstacles to accessing these mechanisms for those experiencing discrimination: a) through the Village Court System, b) The Office of the Public Solicitor and the PNG Development Law Association provide legal aid services, c) the National Court Human Rights Track which provides a fast track process for redressing human rights violations and allows people to submit complaints related to human rights violations including HIV&AIDS directly to the national court without having to go through the police or engage lawyers. d) If the discrimination has been caused by the police, complaints can be made to The Commissioner, The RPNGC Internal Investigation Unit or the Ombudsman Commission e) For employment related discrimination complaints can be lodged with Department of Labour & Industrial Relations, Public services commission or the PNG Trade Union Congress f) complaints related to discrimination by public figures, politicians, leaders and LLG leaders can be lodged with the Ombudsman Commission g) The Ombudsman Commission is mandated to monitor places of detention h) Within the Law & Justice Sector all organizations with the exception of the OPP and OPS have endorsed HIV&AIDS Workplace policies which prohibit discrimination on the basis of perceived or actual HIV status. i) Within the Law & Justice sector all organizations with the exception of OPP and OPS have endorsed EEO Policies which prohibit discrimination on the basis of gender. Some organizations such as NJS and RPNGC specifically prohibit discrimination on the basis of sexual orientation, religion and gender. j) The RPNGC HIV/AIDS workplace policy acknowledges women, children, young people, drug users, sex workers, men who have sex with men, workers in the informal economy, people with disabilities and highly mobile workers as groups particularly vulnerable to HIV with which the police come into frequent contact. The policy commits the police to service as positive role models to these groups, promote understanding and provide information related to HIV. k) The Correctional Services HIV/AIDS workplace policy covers all CS personnel, their dependants and all prisoners. It commits to banning mandatory testing, encouraging voluntary testing, providing HIV education and awareness programs, VCT, treatment and care services and condoms being available to all staff and prisoners.
Briefly comment on the degree to which they are currently implemented:
Most of the answers related to HIV and very few on human rights or anti discrimination against MARPs. The Consensus workshop noted that whether HIV based or discrimination experienced by MARPs or women the reality is accessing the correct process is very difficult due to the obstacles. Respondents comments: • The National Court Human Rights Track was launched in July 2011. • For Human Rights - Currently difficult to implement and enforce, because the HAMP ACT was

implemented with little involvement of law enforcement agencies. • Some agencies are not familiar with HAMP ACT or current legislation that protects human rights and they have not applied them appropriately to date.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:
Yes

IF YES, for which subpopulations?

People living with HIV:
No
Men who have sex with men:
Yes
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
No
People with disabilities:
No
People who inject drugs :
Yes
Prison inmates:
Yes
Sex workers:
Yes
Transgendered people:
Yes
Women and girls:
Yes
Young women/young men:
No
Other specific vulnerable subpopulations [write in below]:
-

Briefly describe the content of these laws, regulations or policies:
The Criminal Code sections 210, 212 retain the offences of sodomy and indecent dealings between males. The Summary Offences Act makes it illegal to solicit or live off the earnings of prostitution. Living off the earnings of prostitution also applies to the sex worker.
Briefly comment on how they pose barriers:
• The discriminatory Laws and policies devalues the human rights of FSW & MSM.They go underground, they cannot access care, services and commodities such as condoms. • Enforcing the laws on the key affected population such as the MSM, PLHIV, and FSW will provide obstacles to effective implementation of HIV programs and drive the affected population underground making them hard to reach. Health concern - HIV work with concerned populations as such can be compromised and seen as legally breaking the law. • Police brutality/Extra – judicial action by police, • Harassment of perpetrators & those who care for them • Health concern - HIV work with concerned populations as such can be compromised and seen as legally breaking the law. • Fight fee and need for police report for survivors of rape are obstacles for women and girls

A - IV. PREVENTION

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

IF YES, what key messages are explicitly promoted?

Abstain from injecting drugs:
No
Avoid commercial sex:
No
Avoid inter-generational sex:
Yes
Be faithful:
Yes
Be sexually abstinent:
Yes
Delay sexual debut:
Yes
Engage in safe(r) sex:
Yes
Fight against violence against women:

Yes
Greater acceptance and involvement of people living with HIV:
Yes
Greater involvement of men in reproductive health programmes:
Yes
Know your HIV status:
Yes
Males to get circumcised under medical supervision:
No
Prevent mother-to-child transmission of HIV:
Yes
Promote greater equality between men and women:
Yes
Reduce the number of sexual partners:
Yes
Use clean needles and syringes:
No
Use condoms consistently:
Yes
Other [write in below]:
-

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?:
Yes
2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?:
Yes

2.1. Is HIV education part of the curriculum in

Primary schools?:
Yes
Secondary schools?:
Yes
Teacher training?:
Yes

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?:
Yes
2.3. Does the country have an HIV education strategy for out-of-school young people?:
Yes
3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations?:
Yes
Briefly describe the content of this policy or strategy:
As in the NHS 2011-2015. Strategic priority 1: Reduce the risks of HIV transmission 1.1: Sexual transmission of HIV and other STIs 1.2: Prevention of parent to child transmission of HIV 1.3: Transmission of HIV in health care settings 1.4: Injecting practices, penile modification and other emerging transmission routes Strategic priority 2: Address factors that contribute to HIV vulnerability 2.1: Gender-related vulnerability 2.2: Vulnerability of young people 2.3: Vulnerability of children 2.4: Vulnerability of more-at-risk populations 2.5: Drugs and alcohol Strategic priority 3: Create supportive and safe environments for HIV prevention 3.1: National and local social and cultural events 3.2: HIV prevention in the workplace and in economic enclaves

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

IDU	MSM	Sex workers	Customers of Sex Workers	Prison inmates	Other populations
No	Yes	Yes	Yes	Yes	Youth
No	No	No	No	No	-
No	Yes	Yes	Yes	Yes	Youth
No	No	No	No	No	-
No	Yes	Yes	Yes	Yes	Youth
No	Yes	Yes	Yes	Yes	Yough
No	Yes	Yes	Yes	Yes	Youth
No	No	No	No	No	-

3.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate policy efforts in support of HIV prevention in 2011?:
8
Since 2009, what have been key achievements in this area:
Respondents comments: • Most significant has been the development of the NHS, and the development of the Implementation Framework and the M&E framework. • Almost 80% of people who need treatment have access to facilities. • In 2011, as a result of the NHS 2011-2015 focus - Greater emphasis on gender equality, addressing gender based violence and making men and boys to be responsible partners. • Increase in condoms distributed. • More integration of HIV & STIs. • There's been a scale - up of prevention efforts for specified target groups including all of the sub - populations (PLHIV, FSW, MSM, TG, Prisoners, women, girls and youths)
What challenges remain in this area:
Respondents comments: • Challenge in educating people in rural areas, especially in the young population. • Main streaming of gender equality. • Advocacy for increased use of both male and female condom. • Discussion and decision on male circumcision as a national preventative measure. • Realistic inclusion of key affected population in preventative efforts. • Geographical constraints prevent delivering these messages, • Cultural Barriers to reaching MARPs. Need to strengthen MARPs groups. • Strengthen the Monitoring and Evaluation of HIV programs. • Lack of quality assurance processes -needs to be strengthened through M&E.
4. Has the country identified specifc needs for HIV prevention programmes?:
Yes
IF YES, how were these specific needs determined?:
Note, the majority of respondents referred to consultations and workshops as the means for identifying the needs for HIV prevention programmes. Through the bio behavioural surveys, and other means of research and from experience, lessons learnt and international best practice the country utilised these sources to develop the National HIV Strategy and prioritise prevention.

4.1. To what extent has HIV prevention been implemented?

Blood safety:
Agree
Condom promotion:
Agree
Harm reduction for people who inject drugs:
Strongly Disagree
HIV prevention for out-of-school young people:
Agree
HIV prevention in the workplace:
Agree
HIV testing and counseling:
Agree
IEC on risk reduction:
Agree
IEC on stigma and discrimination reduction:
Agree
Prevention of mother-to-child transmission of HIV:
Agree
Prevention for people living with HIV:
Agree
Reproductive health services including sexually transmitted infections prevention and treatment:
Disagree
Risk reduction for intimate partners of key populations:
Disagree
Risk reduction for men who have sex with men:
Disagree
Risk reduction for sex workers:
Disagree
School-based HIV education for young people:
Agree
Universal precautions in health care settings:
Agree
Other[write in]:
-

5. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in implementation of HIV prevention programmes in 2011?:
6

A - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?:
Yes
If YES, Briefly identify the elements and what has been prioritized:
Respondents comments: • HIV counselling and testing should be made available where possible in the districts, provinces and wards. • Upgrading and increasing the number of testing sites. • Integration of HIV, STIs and TB testing and treatment. • There is a continuum of care from the home through to provincial hospital with the use and engagement of auxiliary staff, volunteers and organisations such as churches, community care providers, Pastors and Priests, community herbalist so that there is a range of treatment from the house to the hospital for person living with HIV/AIDS. • Ensure a continuous procurement and supply of OI - Opportunist infections and ARV medications
Briefly identify how HIV treatment, care and support services are being scaled-up?:
Respondents comments: • Training conducted to health officers on ART and PICT. • Improvement of facilities to do PICT, storage of blood sample and improved filing system. • Increased funding and improvement to care and support centres to take in HIV positive persons for psychosocial care and support.

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

Antiretroviral therapy:
Agree
ART for TB patients:
Agree
Cotrimoxazole prophylaxis in people living with HIV:
Strongly Agree
Early infant diagnosis:
Agree
HIV care and support in the workplace (including alternative working arrangements):
Disagree
HIV testing and counselling for people with TB:
Agree
HIV treatment services in the workplace or treatment referral systems through the workplace:
Agree
Nutritional care:
Agree
Paediatric AIDS treatment:
Agree
Post-delivery ART provision to women:
Agree
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):
Agree
Post-exposure prophylaxis for occupational exposures to HIV:
Agree
Psychosocial support for people living with HIV and their families:
Agree
Sexually transmitted infection management:
Agree
TB infection control in HIV treatment and care facilities:
Agree
TB preventive therapy for people living with HIV:
Agree
TB screening for people living with HIV:
Strongly Agree
Treatment of common HIV-related infections:
Agree
Other [write in]:
Improving loving standards Reducing Poverty

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?:
No
Please clarify which social and economic support is provided:
Government does not provide social & economic support for PLHIV. Respondents comments: • Social & economic support is given by charity organizations & churches. • NACS has small grants for FBOs and NGOs to assist HIV people or (HIV related work) with Services.
3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?:
No
4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?:

No
5. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2011?:
7
Since 2009, what have been key achievements in this area:
Respondents comments: • Introduction of PICT (Provider, initiated, counselling and testing) • TB nurse or nurse at STI clinic can offer their clients pre - counselling, then do HIV test. • Upscale of PPTCT and treatment of children (less than 12 years old) with paediatric ARV. • Maintaining and getting new ART supplies and trying to do this on a regular basis (maintain continuous supply). More ART prescribers • Maintaining, stabilization procurement and supply of condoms • Greater network and Participation, Development of the National HIV treatment, care and support strategy 2011 - 2015, • Increased funding, • More support from government institutions. • Private sectors increased their capacity to provide VCT at workplace or make referrals using established organizations such as Business coalition Against HIV and AIDS (BAHA).
What challenges remain in this area:
Respondents comments: • Increased ARV resistance • Limited access to TB prophylaxis for PLHIV • PEP and allocating funds to improve VCT services & sustain ART. • Expand & strengthen nutritional care for PLHIV. • Expand integrated approach to treating HIV, TB & STI. • Delay in Confirmatory tests from Health Department. • The quality of testing, reporting & monitoring • The logistics & distribution of commodities. Commodity supply issues – test kits to sites. ART stockouts – regular • The geographical location (culture & language issues) • Capacity of care givers (health officers) • Discrimination poses threat to those seeking treatments. • Procurement services very low, scale up is only concentrated in urban and semi urban areas. Majority of people live in rural areas and remote can’t be reached. Roll out of ART to rural majority • Data/surveillance not being prepared on time from the Health Department.
6. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?:
Yes
IF YES, is there an operational definition for orphans and vulnerable children in the country?:
Yes
IF YES, does the country have a national action plan specifically for orphans and vulnerable children?:
Yes
IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?:
No
IF YES, what percentage of orphans and vulnerable children is being reached? :
-
7. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?:
4
Since 2009, what have been key achievements in this area:
Respondents comments: • Development of the Lakautim Pikinini Act. Communities now know needs of orphans & vulnerable young children. • National Social Protection Task Force has been set up to deal with vulnerable children/orphans. NGOs handle the orphans. Just a testing, treatment has been improved
What challenges remain in this area:
Respondents comments: • NACS needs to strengthen partnership with Dept of Communication Development in four areas: Gender, Women and Children, Orphans and Vulnerable Children, the law, HIV and special populations (CSW, Trans - gender etc.) . • Vulnerable children populations increasing yearly so there is need for more awareness on HIV done to protect orphans and other young children. No real focus at this time, a lot of adhoc activities (activities for vulnerable children) • Could be missing out on real data for number of vulnerable children. Government should improve existing Acts [e.g.: Lakautim Pikinini Act] to cater for orphaned children under current development strategies. • Government to support organizations which are dealing with orphanage issues in the country.

A - VI. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?:
Yes
Briefly describe any challenges in development or implementation:
No challenges described in the development of the NHS 2011-2015 M & E Plan. Respondents comments: Challenges in implementation: • Capacity to monitor and establishing good monitoring systems. • Strengthen coordination at all levels. • Capacity building. • Training. • Collection of data and processing of data needs improvement • Data dissemination. National & Sub - National Databases • Surveys and Surveillance • HIV Evaluation and Research.
1.1 IF YES, years covered:
2011-2015
1.2 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?:
Yes, all partners
Briefly describe what the issues are:
Not clear from responses if respondents were aware of the key partners having their own M & E requirements. Answers are more on what is needed for PNG to scale up M & E Respondents comments: • More training in order to align organizational plans to National HIV Strategy under each Priority Area for proper monitoring and evaluation, • Building capacity to M&E

officers at all levels in terms of knowledge and resources to coordinate and manage M&E processes

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy:
Yes
Behavioural surveys:
Yes
Evaluation / research studies:
Yes
HIV Drug resistance surveillance:
Yes
HIV surveillance:
Yes
Routine programme monitoring:
Yes
A data analysis strategy:
Yes
A data dissemination and use strategy:
Yes
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate):
Yes
Guidelines on tools for data collection:
Yes

3. Is there a budget for implementation of the M&E plan?:
Yes
3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities? :
8%
4. Is there a functional national M&E Unit?:
Yes
Briefly describe any obstacles:
Respondents comments: • Lack of coordination therefore, it seems dysfunctional. • Lack of a shared understanding of the M&E framework and a capacity to implement. • Lack of resources to backup and support in collating and collecting HIV and other related information. • No proper coordination • Needs major improvement

4.1. Where is the national M&E Unit based?

In the Ministry of Health?:
No
In the National HIV Commission (or equivalent)?:
Yes
Elsewhere [write in]?:
-

Permanent Staff [Add as many as needed]

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
M&E Manager	Yes	-	2004
M&E Officer	Yes	-	2004
Data Officer	Yes	-	2004
Surveillance Officer	Yes	-	2004
Surveillance Officer	Yes	-	2004
Surveillance Officer	Yes	-	2004

Temporary Staff [Add as many as needed]

POSITION [write in position titles in spaces below]	Fulltime	Part time	Since when?
-	-	-	-

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?:
Yes
Briefly describe the data-sharing mechanisms:
National Oversight Committee at National AIDS Council (NAC) and National Department of Health (NDoH) oversee all M&E operations . Respondents comments: • The NACS M&E unit coordinate the programs data whilst NDoH surveillance unit is

responsible for surveillance information. • All Program and Surveillance information in each province are compiled and validated during the Provincial Monitoring, Evaluation & Surveillance Team (ProMEST) Meetings and sent to NACS M&E unit for data aggregation by province and later to National Oversight Committee for validation and approval for use. • This information is then disseminated through the same process to be distributed in the province for use.

What are the major challenges in this area:

Respondents comments: • The issue of organisations redefining of National Indicators to suite their Program level Indicators. • Fine tuning of data collection tools • More training to health and non-health multi-sectoral organizations to correctly report and follow reporting process. • Both the international and national organizations must follow the three ones principle and report to NACS as the legitimate body mandated with the task to coordinate the national HIV response. • Effective coordination and management of M&E programs, training of M&E officers as part of capacity building to effectively manage.

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

Yes

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

Yes

IF YES, briefly describe the national database and who manages it.:

National database is managed by NDOH and there is where all the data goes. NACS manages the HIV data (program data) and NDOH manages the clinical data.

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?:

Yes, but only some of the above

IF YES, but only some of the above, which aspects does it include?:

Of the 6 who said 'Yes' to No.6 question - no-one gave a response to this question. Comment from someone who gave a 'No' answer It includes the organization, geographical coverage and sex disaggregate

6.2. Is there a functional Health Information System?

At national level:

Yes

At subnational level:

Yes

IF YES, at what level(s)?:

It is based at the national level, data comes from facility, data is mostly used at national and provincial level

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

Yes

8. How are M&E data used?

For programme improvement?:

Yes

In developing / revising the national HIV response?:

Yes

For resource allocation?:

Yes

Other [write in]:

M&E data are used for planning, decision making, policy formulation, prioritising activities, making projections, allocation of resources and study the impacts of projects

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:

-

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

At national level?:

Yes

IF YES, what was the number trained:

30

At subnational level?:

Yes

IF YES, what was the number trained:

30

At service delivery level including civil society?:

Yes

IF YES, how many?:

50

9.1. Were other M&E capacity-building activities conducted` other than training?:

Yes

IF YES, describe what types of activities:

Respondents comments: • Awareness & issuing of condoms and demonstration on how to use condoms. • Setting up of HIV Monitoring and Evaluation position in the government structure at National and Provincial level. • NCPI interviewer training

10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?:
6
Since 2009, what have been key achievements in this area:
Respondents comments: • The completion of M&E framework and toolkit • Completion of NHS and M&E framework recruitment and induction of 20 provincial M&E officers and 5 National officers. • Greater network and Participation, National AIDS Council to play coordination role, Provincial AIDS Committee in place.
What challenges remain in this area:
Respondents comments: • Lack of leadership on M&E and surveillance • Need for better communication between M&E and programme • Skill development for new M&E officers • Data management is still a challenge • No separate budget for M&E • The surveillance unit at NDoH in under-staffed and suffered a loss in budgets and staff in 2011 • Lack of coordination between M&E staff and Provincial Health Officers at provinces • Difficulty in communication between provinces and national level

B - I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?:
4
Comments and examples:
Respondents comments: • Civil Societies have been instrumental in formulation and policies on: children's rights, women and girls, most vulnerable population such as transgender, men who have sex with men and female sex workers. • Though political commitments have not yet resulted in policies and laws for MSM and FSW, gender based violence policies (The Family Protection Bill and the National Family and Sexual Violence strategy) are all still in draft there has been increased debate in the public as a result. • Private businesses are a strong factor in contributing to the response – (e.g. Steamships, RH, OK Tedi) a) Through Sponsorship b) Moving Condoms c) Funding. • Every time there is a review on National HIV Strategy (NHS), civil society is well presented & gives inputs into the review process. • Civil Society has contributed a lot to the contribution to strengthening the political commitments of top leaders • The civil society organizations have being very engaged in the response. They have umbrella organization responsible for coordination. e.g. PACSO which is the member of CCM in PNG. Apart from that, there are other organizations involved in influencing policies from different sectors including PLWH, the CBOs and Churches. They are involved in strategic planning process and hence influence the policies. They also do advocacy for services e.g. IGAT hope. • An example of where civil society has been influential in national law reform is the NEC reference to review the Summary Offences Act and the Criminal Code Act as it relates to sex work and sodomy. FYI although this started as an attempt to decriminalise sex work and sex work it ended up being a request to review rather than decriminalise.
2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?:
4
Comments and examples:
Respondents comments: • Civil Societies have contributed to the formulation of the NSP. This organization worked on developing sections in the NSP on most at risk populations (MARPS) in the current NHS 2011-2015, which were absent in the previous NSP. • CSOs involved in Activity Planning = 4/higher. CSOs involvement in Budgeting given a low 1. The influence of Civil Society's representatives individual in planning and budgeting for NHS very small. • CSO has played a key role, They are the eyes & ears of marginalised groups played a vital role in planning & budgeting. Igat Hope successfully lobbied NACS to give recognition to the stigma & discriminations' component in NHS. • They have participated in preparations for the National HIV Strategy and they have been involved in development of proposals for resource mobilization e.g. GFATM. They are also developing proposals to donors- AusAID to support implementation of programmes. • It has been extremely challenging to develop a budget for the NHS 2011-2015. A costing exercise was started with civil society involved but never completed. CSO are concerned that the NHS 2011-2015 does not have a budgeted annual cost.

3.

a. The national HIV strategy?:
5
b. The national HIV budget?:
2
c. The national HIV reports?:
3
Comments and examples:
Respondents comments: • Civil Society provides services in prevention, treatment, care and support which are then reported in reports such as UNGASS (now GAR). • Community awareness is mostly done by NGOs, FBOs etc. while some of the civil society organizations provide services in HCT and STI such as Catholic Health, Anglicare, Hope World Wide. The same is true for treatment of PLHIV and care and support. • National reports include the annual HIV surveillance report, the Universal Access report • Timing of reports is a big issue. They are always released far to late to be of any use in program planning

4.

a. Developing the national M&E plan?:

4

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

4

c. Participate in using data for decision-making?:

3

Comments and examples:

Respondents comments: • The M&E Committee is a small working group which has representation from NGO's • NGOs such as FHI 360, CHAI, PST and Anglicare and others have been actively engaged by NACS in developing M&E plans, e.g. Developing national indicators for general population and MARPS. Not too sure about the use of data for decision-making. • The national M & E structure is weak & needs to be strengthened. Some organisations do not have an M&E system in place and are working all over place. One weakness is channels of communication breakdown. So organisations are not working together. • No proper data being collected. No data profile being kept in most organisations - data management is poor. No coherent data is available for decision making. • Most organisations do not have a qualified person to manage data so that up to date data is used for progams & planning. • The nation has a M&E framework in National HIV Strategy but do not have a M&E plan thus resulting in Civil Society distrusting the data collected. The "distrust" is not because of the lack of an M&E plan but relates to the quality of the data. • The STI/HIV unit in the M&E division in the NDoH is very fluid - meaning an absence of M&E officers to work when work is there and laying off workers when there is no work. • M&E currently focussing on how to get the data from where it is being collected, through the PACS to NACS, it does not really focus very much on the quality of the data that is collected.

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?:

4

Comments and examples:

Respondents comments: • The involvement of the marginalized groups is better than previously UNGASS period, less adhoc, and less tokenistic and more meaningful • Civil Societies are at the forefront in HIV efforts in being inclusive of diverse organisations. Its organisations like FHI 360 and Save The Children initiating interventions for PLHIV, FSW and MSM in PNG and are continuing to do so. • Some of the national committees such as RAC, NAC and CCM have diverse organisations as members. • Many PLHIV organizations are established but not many are involved in planning. These organizations do not have skilled people to manage their orgs. They tend to continue to work in isolation to each other. • CPP-Church partnership programs with each other recognizes the diversity in approaches. BUPNG is part of the CCP including the seven main line churches of PNG-Lutheran, catholic and SDA, salvation army, united and Anglican o Example: BUPNG Baptist union of PNG works in collaboration with two groups • True Friends (Positive women) and True Warriors (PLHIV): Both groups advocate as service providers

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access

a. Adequate financial support to implement its HIV activities?:

3

b. Adequate technical support to implement its HIV activities?:

3

Comments and examples:

Respondents comments: • Annual plans are being requested but are not financially supported or are given at low level & many activities are cut back to skeleton level. Igat Hope's 26 networks in PNG need a budget that can support capacity work & network activities. Because of low level of funding, CSOs struggle and therefore have a tendency to rely on Foreign Aid and Technical Support. • Accessing funding is not easy. Funding depends on evaluation on programs/activities done. IF reports are good & there exists a need for more work in HIV then funding is usually accessed otherwise it is difficult. • HR is a problem. High staff turnover & many people move from one organisation to another organisation in the CSOS. So its not easy to implement work without qualified people. CSOS get technical support through partnering in meetings and consultations, also through trainings.(for capacity building). • Financial support provided by NACS is limited. However, most civil society get funding from donors such as AUSAID and Global fund. They do not often get what they ask for. Technical support is limited. Those who partner INGOs like FHI 360 do get good technical support but others do not get from the parent NGOs. This is one area that needs to be improved • Because of capacity issues (structures, systems, scale within the staff, M&E for reporting) they do not get funding. Sometimes the needs of organizations are not seen by funders or NACS & link is not there so funding is not given • Lots of technical assistance is given. Heaps of technical advise given by donors, unilateral/bilateral but should work closely with organizations to address issues in the organization. • There has been an increase in technical assistance at national level but there is an emerging need for technical assistance at provincial level which is not so easy to get funding for. • There is currently a lost opportunity to share available technical assistance between NGO partners.

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

People living with HIV:

>75%

Men who have sex with men:

>75%

People who inject drugs:

-
Sex workers:
>75%
Transgendered people:
>75%
Testing and Counselling:
51-75%
Reduction of Stigma and Discrimination:
>75%
Clinical services (ART/OI)*:
51-75%
Home-based care:
>75%
Programmes for OVC:**
>75%

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2011?:
6
Since 2009, what have been key achievements in this area:
Respondents comments: • Seeking wider consultation from Civil Societies prior to drawing up strategies by the government, e.g., NSP (2011 - 2015) • Over past three years, the number of NGOs, CBOs working on HIV and AIDS has increased. The environment has increased. A few more NGOs now support Sex workers. Legal support and home based care have emerged as well • NGO forums which are bringing together CSOs info & sharing to exchange activities, sharing the 'know how', working in partnership & not isolation, to avoid duplication. Also educating CSOs to focus on their strengths and weaknesses, and work with each other to carry out activities.
What challenges remain in this area:
Respondents comments: • NGO's and CBO's seem to be more worried about doing organizational activities. They are not so much involved in mobilizing society/other NGOs to stand for the rights of the people. • Most organisations fight for their own organisation's needs/requirements and not for focus of Whole Civil Society's participation. • Need improved coordination of funded programs. The government and in this case NACS and NDOH need to improve their coordination of the NGO/CSOs responding to the epidemic HIV. `Civil Society organizations can go off on a tangent and waste resources if they are not managed and coordinated properly'. • That means it is not properly coordinated as a result of less contributions coming in from larger international NGO's, resulting in less information/awareness within Civil Society Organisations in local communities. There are also challenges of logistics. • However, their full potential has not been realised by the Government. Many times the capacities in these organizations are lacking and this prevents their effective engagement • (Staff turnover huge) - Improve salary + benefits to retain staff in organisation. • Communication improved so CSOS participation is high. • Increase financial support to encourage more participation for CSOS. • Legal environment which is prohibitive for some risk populations, limited resources, unsupportive policy framework

B - II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?:
Yes
IF YES, describe some examples of when and how this has happened:
Note: A mixture of examples showing some minority views that government hadn't been as involving of people as others reported. Respondents comments: • PLWHA were involved in design of the NHS, in the CCM for the GFATM, and in programme implementation in many programmes. However, these areas can also be greatly strengthened so that the involvement is more meaningful and highly appreciated. • The GoPNG through CDC has arranged forums for key population groups to start dialogue on legal issues that hinder the involvement of CAP. • However working with the KAPs such as CSW and MSM/TG are difficult still due to prohibitive laws in PNG. • In legal reforms there has been an improved & increased partnering of marginal populations - with partners & stakeholders to provide legal assistance for PLHIV issues. NO • Absolutely No. Igat Hope has pushed the Parliamentary AIDS Committee to have a PLHIV as committee member or to partner with Igat Hope but did not get any response. • The department of development through Lady Kidu has attempted to enact laws de - criminalizing prostitution and same sex behaviour but is yet to get the support of Parliament.

B - III. HUMAN RIGHTS

1.1.
People living with HIV:
Yes
Men who have sex with men:
No
Migrants/mobile populations:
No

Orphans and other vulnerable children:
Yes
People with disabilities:
Yes
People who inject drugs:
No
Prison inmates:
Yes
Sex workers:
No
Transgendered people:
No
Women and girls:
Yes
Young women/young men:
Yes
Other specific vulnerable subpopulations [write in]:
Refugees

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?:
Yes
If YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
Note: Confusion represented by the majority referring to the non HIV specific law as the HAMP ACT. Respondents comments: • The Constitution has Human Rights embedded. Example: Protecting the rights of women. 1) The Constitution supports Human Rights, and especially on the principle democratic rights and freedom. 2) The Country also supports most of UN and other organizations that strongly support Human Rights issues. The country's constitution provides for freedom & equal treatment for all people in PNG. • However some laws are prohibitive because it considers MSM & CSW as criminal acts. • Constitution is the overall law that protects everyone's rights but actually/takes away rights of the key affected populations by not expressly including them. • HAMP ACT attempts to protect PLHIV in the workplace & public places but inconsistent with minimal laws for sodomy & prostitution. • The Discriminatory Practices Act 1963 makes it illegal to discriminate on the grounds of ethnicity, race, religion. It does not say anything about PLHIV.
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
Respondents comments: • Laws are in place but the problem still remains in the policing of those laws. The role of the CSO in PNG today is struggling to put this in order as they create pressure within the government departments and the sectors especially Justice and police. • There are other laws that protect rights of women and children against abuse but implementation is a challenge since many implementers such as police are NOT properly trained to uphold such laws. • There is some training with police and other law & justice sector personnel on the relevant laws and their roles and responsibilities in implementing these however within the police and court system there are currently few or no consequences for officers who do not implement the laws.
Briefly comment on the degree to which they are currently implemented:
Respondents comments: • Laws to stop violence against women, to protect women. These laws are implemented differently at rural and urban areas. • Discrimination is seen against women if suspected of sorcery and are beaten. More effort is needed to be put in awareness of children's rights to reduce abuse of children. • The Police and Court System are putting in a lot of effort to ensure protection of its citizen's rights. • Police now have 7 operational Family and Sexual Violence Units. • Magisterial Services (District Courts) are now issuing Interim Protection orders.
2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?:
Yes

2.1. IF YES, for which sub-populations?

People living with HIV:
No
Men who have sex with men:
Yes
Migrants/mobile populations:
Yes
Orphans and other vulnerable children:
No
People with disabilities:
No
People who inject drugs:
Yes
Prison inmates:
No
Sex workers:
Yes
Transgendered people:
Yes

Women and girls:
No
Young women/young men:
No
Other specific vulnerable subpopulations [write in]:
-

Briefly describe the content of these laws, regulations or policies:
Respondents comments: • Sex Work, MSM, Transgender IDUs are unable to access HIV services as the nature of their activities are forbidden under our Country's laws. • Law Against drugs under the criminal code for people who inject drugs. • Sodomy law in the Criminal Code Act 210 & 212 - Offense for sodomy & indecent acts between males. • Summary Offense act 1977 living off earnings room prostitutions is illegal. • Criminal code on trafficking, Summary Offenses Act & Crimes Act are all impediments to HIV treatment, care & support. • There were major efforts in 2011 to decriminalize consensual sex between adults but the proposal did not progress, however significant advocacy around the issue was a good first step in the right direction as it identified major barriers where more advocacy will be required to pass the law when it is re-tabled.
Briefly comment on how they pose barriers:
Respondents comments: • Main obstacle in implementing law is the culture of PNG. Customs are accepted in society & are applied by legal systems. Customary Law frequently takes precedence over Statutory Law. • Because of the nature of their activities, they cannot come out openly and seek HIV services as they are afraid of prosecution and criminalisation etc. • If peoples' sexual behaviour is criminalized, they will not go to get services & products for prevention, care & support. MSM and Sex workers may be reluctant to disclose risky behaviours and therefore would not be given the correct risk reduction information. • Some health care workers may deny treatment if they felt the patient was breaking the law.
3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?:
Yes
Briefly describe the content of the policy, law or regulation and the populations included:
Respondents comments: • Laws that exist are not being enforced well. • There are laws governing assault that prosecute people who hit other people. Summaries Offences Act covering assault. Laws against violence on women. Criminal Code also includes sexual assault, rape, grievous bodily harm, aggravated assault • Laws that attempt to side with polygamy (where customary), bride price & dowry - women may face discrimination when at fault. Ownership rights (customary law) - men who treat women like objects (women have no rights). • There is widespread advocacy to reduce gender based violence but there is a long way to go for the realization of the crime as the act is so widespread. E.g. GoPNG have implemented a policy that exempts people experiencing family, sexual and gender based violence from paying the 'Fight fee' • There are provisions in the Matrimonial Act relating to rape within marriage • The Family Protection Bill is currently being drafted. • There is a draft National Strategy for Family and Sexual Violence.
4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?:
Yes
IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
Respondents comments: • Protection of human rights mentioned in NHS 2011-2015, Medium Term Development Plan & National Gender Equality Policy 2011-2015. • International obligations, conventions: CEDAW, UNGASS, and Universal Access Declaration also mention human rights related to HIV. • HAMP ACT 2003, Protects and promotes the rights of those living with HIV AIDS and the Laukitim Pikinini Act.
5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and/or other vulnerable sub-populations?:
Yes
IF YES, briefly describe this mechanism:
Respondents comments: • No Human Rights Commission in PNG to record, document & address cases of discrimination. There has been pressure on PNG to have a Human Rights Commission to assist people whose rights have been violated. The enabling legislation that would allow the establishment of PNG's Human Rights commission has been drafted. • The court system is expensive & time consuming. • PNG IDLO currently providing legal assistance for PLHIV & key affected populations. Takes first discrimination case on HIV to court in May 2012. The PNG IDLO does community awareness for human rights • Other cases on abuse if women have been represented in court already • The court system is expensive & time consuming. • Each organisation has their monitoring facilities to capture discrimination cases. Clinics drop-in-centres (Anglicare-StopAids, World Vision, Catholic Services, Hope Worldwide) record cases of discrimination. Discrimination cases also recorded through home based care • There are several mechanisms available, the main problem is people don't know about them or don't know how to access them. See Part A for details.

6. Does the country have a policy or strategy of free services for the following?

Provided free-of-charge to all people in the country	Provided free-of-charge to some people in the country	Provided, but only at a cost
Yes	-	-
Yes	-	-
Yes	-	-

If applicable, which populations have been identified as priority, and for which services?:

Respondents comments: • PLHIV are priority. More HIV Prevention Services to be given to them in order to reduce transmission of HIV. • a) MSM b) Sex Workers c) Working in pop based d) Mining (fly in, fly out) e) Young pops entering workforce. • Special considerations must be made to children living with the virus because of their vulnerability • Pregnant mothers have to be treated the same as the children. • ART is provided to those who are assess as eligible by a medical officer. • HIV Prevention services are provided to everyone but some specialized services are for KAPs such as MSM/CSW. • Some NGOs/CBOS provide home base care for those affected and infected by HIV. (although poorly supported)

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

Yes

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

Yes

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?:

Yes

IF YES, Briefly describe the content of this policy/strategy and the populations included:

HAMP Act is the law that not only covers people with the virus but also people who are affected by virus & promotes human rights and the National HIV Strategic Plan 2011 – 2015. Both documents supports those affected by HIV. Respondents comments: • The NHS has and emphasis on having in place user-friendly services accessible by all the KAPs including gender sensitive services. The NHS identifies strategies for risk populations including women and most vulnerable children.

8.1

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?:

Yes

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

Respondents comments: • One approach cannot encourage people to participate so different approaches to ensure equal access for treatment and care are used. • All stakeholders' plans are encouraged and amended to be aligned with the NHS. This is so services provided by the NGO/CBO and even government entities are accessible to all groups of KAP (Key Affected Populations) • E.g.: Training of PLHIV to treat PLHIV. MSM/TG people to be trained to reach out to others.

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

Yes

IF YES, briefly describe the content of the policy or law:

Respondents comments: • The HAMP Act and all other workplace policies developed by both private and government sectors do not allow for HIV testing prior to employment. • HAMP Act but employers are doing it and nobody is saying anything. Government is going against their own laws. • Immigration (HIV Screening). There is certainly a perception that immigration requires an HIV test but actually they do not require on for the issuance of a work visa. It is required that there is an HIV test for people who intend to migrate to PNG. • It is the policy of the PNG Defence Force to test all recruits for HIV and in the past there have been cases where a positive test result meant the person would not be recruited. This policy is in contravention to the HAMP Act. If potential recruits wished they could take legal action against the military on the basis of mandatory testing and if they were not recruited on the basis of returning a positive result they could take action for discrimination.

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

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

Yes

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

No

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

Note: Respondents expressed low levels of knowledge on what exists Respondents comments: • Law And Justice Sector, Ombudsman Commission monitor and enforce human rights issues. • Ombudsman Commission and also is supposed to ensure that performance indicators for the protection of the Constitutional rights are in place.

11. In the last 2 years, have there been the following training and/or capacity-building activities

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?:

Yes

b. Programmes for members of the judiciary and law enforcement on HIV and human rights issues that may come up in the context of their work?:

Yes

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

a. Legal aid systems for HIV casework:

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

13. Are there programmes in place to reduce HIV-related stigma and discrimination?:
Yes
IF YES, what types of programmes?
Programmes for health care workers:
Yes
Programmes for the media:
Yes
Programmes in the work place:
Yes
Other [write in]:
Sports, Civil Society, Churches & FBOs

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?:
5
Since 2009, what have been key achievements in this area:
Respondents comments: • Many organizations, both Private and Public sectors are coming up with policies and regulations on HIV discrimination within their working environment. • A Major achievement is the breakdown of discrimination and stigma enabling more people to come out as PLHIV, clearly as a result of more awareness. • Attempt to change laws particularly in the Criminal Code. • Developed workplace policies for resource entities, • National conversations/dialogue on legal reforms for KAPS. • Developed workplace policies for resource entities, converse dialogue as legal reforms for KAPS. • A growing number of the affected populations know their rights for protection. Populations like MSM, TG and Sex workers. • Increasing numbers of people from affected populations accessing HIV services. • Family support centers have been established to provide care of victims. These are generally based in hospitals and are supported mostly through Dept of Community Development. • RPNGC has established 7 units specifically to respond to Family and Sexual Violence. • Hospitals and other NGOs are providing the PEP for survivors of sexual assault. • The major advocacy achieved in trying to pass the law to decriminalise consensual sex between same sex. It helped to make well known the stigma and discrimination faced by MSM, Sex Workers and transgender people in PNG. • IDLO has now given legal assistance to PLHIV who for example have been fired from work. • The Office of the Public Solicitor has provided legal aid to PLHIV • The Village Courts are dealing with increasing numbers of cases related to HIV, but only those that fall into the proscribed offences under the Village Courts Act as they have no jurisdiction under the HAMP Act.
What challenges remain in this area:
Respondents comments: • Actual implementation of the policies and laws that are in place and whether the end results are achieved (Protection of Human Rights). • Change attitudes of people towards affected populations through sensitisation programs, awareness programmes and Human Rights programmes. • Information on the HAMP Act .Simplify legal terms (policies/legislations) so that key population understand what is for them so that they can easily access services. • Increase manpower for Human Rights Service Providers to help affected populations. • The weak law enforcement agencies need strengthening to assist key affected populations whose rights have been violated. • More Political will and Leadership engagements
15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?:
4
Since 2009, what have been key achievements in this area:
Respondents comments: • More Human Rights abuse cases been reported to appropriate authorities. • More awareness on human rights by Law and Justice for general population. • More Stakeholders 2011 involved in improving legal rights – CSO in working group to organise the National Dialogue on HIV, Law and Human Rights organised in 2011
What challenges remain in this area:
Respondents comments: • To educate more Papua New Guineans on Human, civil and legal Rights so that they can change their behaviour towards protecting the rights of others • Cultural belief system that still exist with communities in the midst of churches • Political willpower in making firm decisions - this is lacking today. MPs not making 100% personal commitment. • More resources and efforts needs to be put into developing human rights policies.

B - IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?:
Yes
IF YES, how were these specific needs determined?:
Respondents comments: • Yes but big caveats. PNG has developed NSP which was incorporated into NHS; however, there are specific needs for specific populations - not enough biological evidence to support key affected groups. Example: Past 3 year's only one biological study among high risk population sex workers in PNG. • Data were collected and not analyzed properly to give information on specific needs for key affected populations • What's identified is not what is implemented. •

HIV prevention programmes are scaled - up by identifying needs of the communities. FBO's, CBO's, Private Sectors working with Communities. Some comments suggested respondents were not sure on how evidence based programmes are designed. • Through reports provided by stakeholders and natural forums for HIV trends in PNG. It is also determined at national data collectors workshops. • Lack of prevention programs that specifically target MARPS/KAP's • Recognise there has not been sufficient data in the past to inform prevention programs but it has improved over the last 2 years • There has been a shift away from NACS designed prevention programs to more programs designed at local level and by CSOs

1.1 To what extent has HIV prevention been implemented?

Blood safety:
Strongly Agree
Condom promotion:
Agree
Harm reduction for people who inject drugs:
N/A
HIV prevention for out-of-school young people:
Agree
HIV prevention in the workplace:
Agree
HIV testing and counseling:
Strongly Agree
IEC on risk reduction:
Agree
IEC on stigma and discrimination reduction:
Agree
Prevention of mother-to-child transmission of HIV:
Strongly Agree
Prevention for people living with HIV:
Agree
Reproductive health services including sexually transmitted infections prevention and treatment:
Agree
Risk reduction for intimate partners of key populations:
Agree
Risk reduction for men who have sex with men:
Agree
Risk reduction for sex workers:
Agree
School-based HIV education for young people:
Strongly Agree
Universal precautions in health care settings:
Agree
Other [write in]:
-

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?:
8
Since 2009, what have been key achievements in this area:
Respondents comments: • Scaled up accessibility of ART, testing and counselling , • Condom promotion and blood safety, • Increase in HIV prevention in workplace and youths out school. • Increase in number of people using VCTs • Increase awareness leading to Health Seeking behaviour • Increased knowledge HIV. • Networking with other Stakeholders which helps strengthening the Referral Systems. • More sites for counselling and testing have been made available, rapid testing were introduced. • Curriculum for HIV prevention for out of school youth was implemented for the first time in 2011. Condom promotion and social marketing was apparent. • The PPTCT Operational Plan was launched and the training curricula were developed
What challenges remain in this area:
Respondents comments: • Focus HIV programs to most affected population (high risk groups). • Provide evidence for HIV programs. Evidence should come from biological and behavioral studies. • More needs to be done for the MARPS populations, also targeting couples instead of individuals to go for VCT to assist further with safe disclosure. • More emphasis is needed on reducing risks in the vulnerable youth populations. • PPTCT roll out has been hampered by the many vacant posts within NDOH during the restructure exercise in 2011, 2012 should prove to be much more productive with more staff on the ground to support and the extra assistance being funded by GFATM Round 10 for PPTCT and Paed AIDS.

B - V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV and AIDS treatment, care and support services?:
Yes

IF YES, Briefly identify the elements and what has been prioritized:
Yes, the NHS has a section dedicated to the Testing, treatment care and support services. Within that point of care rapid testing with an emphasis on PICT, STI and TB services; and increased access for adult and paediatric ART and OI/TB management at the district and local level in high prevalence provinces. Respondents comments: • Treatment of STI effectively, • ART with good adherence • Treatment of opportunistic infections • Engagement of PLHIV to treat/care for PLHIV • Accessible services provision-user friendly and non stigmatizing treatment sites.
Briefly identify how HIV treatment, care and support services are being scaled-up?:
Respondents comments: • The number of ART proscribing sites has increased in past 2 years to 80. • Number of people started on ART has increased • Point of care testing, revised treatment guidelines, more sites referring for PCR testing. • More facilities meeting the national standards • Improved collaboration with other stakeholders or partners • Many HBC and family support centers being established by stakeholders-some not funded but initiated by communities.

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

Antiretroviral therapy:
Strongly Agree
ART for TB patients:
Agree
Cotrimoxazole prophylaxis in people living with HIV:
Strongly Agree
Early infant diagnosis:
Agree
HIV care and support in the workplace (including alternative working arrangements):
Agree
HIV testing and counselling for people with TB:
Agree
HIV treatment services in the workplace or treatment referral systems through the workplace:
Agree
Nutritional care:
Agree
Paediatric AIDS treatment:
Agree
Post-delivery ART provision to women:
Agree
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault):
Agree
Post-exposure prophylaxis for occupational exposures to HIV:
Strongly Agree
Psychosocial support for people living with HIV and their families:
Agree
Sexually transmitted infection management:
Agree
TB infection control in HIV treatment and care facilities:
Agree
TB preventive therapy for people living with HIV:
Agree
TB screening for people living with HIV:
Strongly Agree
Treatment of common HIV-related infections:
Strongly Agree
Other [write in]:
Palliative care, Hospice care for terminally ill

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011?:
7
Since 2009, what have been key achievements in this area:
Respondents comments: • More cases registered for ART. • Health seeking behaviour has increased. • People have adequate information on HIV so can look after themselves. • Partners of sex workers coming to get HIV Service (Partner referral). • ART access has improved (with all provinces with sites), • PICT has also strengthened, • VCT access is also improved. • The care and treatment guidelines updated. • Scaling up Provider initiated testing and counselling.
What challenges remain in this area:
Respondents comments: • Quality of ART service especially linking ART & TB services. • Treatment and care for terminally ill people. • PPTCT has had minimal progress since 2009. • HIV M& E and surveillance capacity has weakened. • Issues with improving/supporting - Treatment adherence, treatment retention, treatment access. i.e. adequate Drug supply. • Limited technical capacity of service providers to fully utilise, mix and match available ARV's for effective treatment • Need to scale up treatment support to community level. More community based care management services (FHI 360 examples) • HR capacity in NDOH is not sufficient to ensure stock outs do not continue-hopefully this will be addressed in 2012. • More training on PEP

is required to ensure implementation. • Drug stock outs reported. Issues of drug movement, supply chain, procurement systems.

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

Yes

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?:

Yes

2.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children?:

Yes

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

No

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

-

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011?":

7

Since 2009, what have been key achievements in this area:

Note: Answers referred back to Question 2. Not 3. Respondents comments: • The training on the Lukautim Pikinini Act is underway and some training roll out for churches working at community level has progressed to try and guide communities on their role in care protection and support of any vulnerable child. • NHS includes a section on programming to reduce the vulnerabilities of children affected/infected by HIV. • See answers to 1.2

What challenges remain in this area:

Respondents comments: • System strengthening around second-generation surveillance systems will also help guide HIV treatment. However, overall program has being stagnant for past year due to reforms within health sector, the reduced funding from donors- Global Fund Orphans/Vulnerable children • Policy is unclear and identification of orphans remains challenges. Less partners working in this area • Requires more work to ensure HIV partners are aware of the national strategy and policy so that proper referrals can be made. Not enough partners working specifically to protect children and information management is weak. • Paediatric wards, ANC's , Schools, and churches (places where children may be assessed) are important partners to ensure their roles and responsibilities to the child are well known.

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