

Papua New Guinea Report NCPI

NCPI Header

is indicator/topic relevant?: Yes

is data available?: Yes

Data measurement tool / source: NCPI

Other measurement tool / source:

From date: 01/01/2013

To date: 12/31/2013

Additional information related to entered data. e.g. reference to primary data source, methodological concerns::

Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source:: Interview with 50+ stakeholders have been conducted for the 2013 NCPI. The National AIDS Council Secretariat has not yet completed entering or analyzing the data. The NCPI section of PNG's 2014 GARPR will be added when it is completed.

Data measurement tool / source: GARPR

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any: Ms Agnes Gege, Data Centre Officer, National AIDS Council, Papua New Guinea

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Describe the process used for NCPI data gathering and validation: The GAR Core Working Group identified stakeholders at a National level and from the Provincial level as key in the implementation of the National HIV and AIDS Strategy 2011 - 2015. Almost all questionnaires were completed by stakeholders based in Port Moresby at national level with only 5 out of the 47 questionnaires being completed by staff based at provincial level. The two provinces who participated were Morobe and Central. Due to financial constraints, time and in the interests of sustainability, only 4 additional casual staff were hired as interviewers who assisted the coordinator to implement the survey. This year it was decided to trial the NCPI as a self-administered questionnaire for those who had participated in previous NCPI's. For those who were new to NCPI or felt unable to complete the questionnaire without assistance, members of the survey team were available to assist. Unfortunately provincially based M&E officers who were trained on how to implement the NCPI survey in their respective provinces were all unable to report this period, except for Morobe and Central provinces. It is hoped that for the next NCPI provincially based M&E officer will be fully engaged in facilitating NCPI questionnaires with the full range of stakeholders in their province. Preparations for the NCPI survey started in November 2014 but actual implementation was between January and 16th March.

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 and a wider stakeholder consultation consensus workshop was held on 20th March. Data under each of the key areas was presented as it was, based on respondent's perspectives but where queries or disagreement raised, discussions were held and final consensus were reached on the final answers. These comments are regarded as final answers.

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 seems very clear that respondents were very well informed regarding policy, strategy and regulations in the specific area of the response that they are working in or supporting, but there are only a very small number of stakeholders who are well informed and have up to date knowledge on policy, strategy and regulations across all areas of PNG's HIV response. PNG undertook an assessment of Progress Toward Achieving the Targets & Commitments of the 2011 UN Political Declaration on HIV/AIDS in June 2013. During that time it was noted that very few people, including senior NACS and

NDoH staff were aware of the Political declaration and the commitments made by the GoPNG to its targets. The National HIV&AIDS Strategy 2011 – 2015 has not been reviewed or revised against either the 2011 UN Political Declaration on HIV/AIDS or the findings of the progress report.

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

Organization	Names/Positions	Respondents to Part A
National AIDS Council Secretariat	Ms Angesula Jogamup-Regional Manager Southern	A1,A2,A3,A4
National AIDS Council Secretariat	Ms Doreen Mandari	A1,A2,A3,A4,A5,A6
National AIDS Council Secretariat	Mr Philip Tapo- Deputy Director	A1,A2,A3,A4,A5
National AIDS Council Secretariat	Ms Julie Airi- Research Unit Manager	A1,A2,A3,A4
National AIDS Council Secretariat	Ms Doreen Nadile - HIV - Technical Officer	A1,A2,A4,A5
Department of Education	Mr Eddie Sarufa - National Coordinator,HIV/Gender	A1,A2,A3,A4,A5,A6
National Department of Health	Mr Namarola Lote, ART Database Manager	A1,A2,A3,A4,A5,A6
Department of Education	Mr Daniel Isaac - HIV Officer -Department of Education	A1,A2,A4
Department of National Planning(Monitoring & Evaluation)	Ms Amanda Kikala-Senior AID Coordinator World Bank	A1,A2,A3,A4,A5,A6
National AIDS Council Secretariat	Mr Moses Kaigu	A1,A2,A3,A4,A5,A6
National AIDS Council Secretariat	Ms Agnes Gege	A1,A3,A5
National AIDS Council Secretariat	Mr Ishmael Robert	A1,A2,A3,A4
Morobe PAC		A1,A3,A5
Morobe PAC	Ms Joanne Ganoka	A1,A2,A3,A4,A5,A6
Morobe PAC		A1,A2,A3,A4,A5,A6
Morobe PAC	EJ	A1,A2,A3,A4,A5,A6
Central PAC	Mr Lester Bisibisora	A2,A4,A5,A6
National AIDS Council Secretariat	Mr Marcel Burro	A1,A2,A3,A4,A5,A6
National AIDS Council Secretariat	Ms Freda Taimbari	A1,A2,A3,A4,A5
National AIDS Council Secretariat	Dr Moale Kariko, Deputy Director	A1,A2,A3,A5
National AIDS Council Secretariat	Ms Margaret Munjin	A3

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

Organization	Names/Positions	Respondents to Part B
Anglicare	Ms Heni Meke, Director	B1,B2,B3,B4,B5
Oil Search Health Foundation	Mr Kevin Miles, Director HIV programs	B1,B2,B3,B4,B5
Clinton Health Access Initiative(CHAI)	Dr Mombuno Kiromat, Director	B1,B2,B3,B4,B5
Health & HIV Implementation Service Provider	Dr Ninkama Moiya	B1,B2,B3,B4,B5
Church leaders/Church Alliance	Mr Andrew Hamma	B1,B2,B3,B4,B5
Population Services International		B1,B2,B3,B4,B5
National HIV&AIDS Training Unit / International Education Association	Mr Thomas Lisenia	B1,B2,B3,B4,B5
UNICEF	Dr Justine Nankinga	B1,B2,B3,B4,B5
Australian Government/DFAT	Dr Priscilla Nad	B1,B2,B3,B4,B5
PNG Association of Community Service organizations (PACSO)	Ms Monica Arua	B1,B2,B3,B4,B5
Hope Worldwide	Mr Timothy Tony - ART Prescriber	B1,B2,B3,B4,B5
Hope Worldwide	Ms Jane Tropu - VCT Counsellor	B1,B2,B3,B4,B5
Business Against HIV&AIDS	Ms Caroline Bunemiga	B1,B2,B3,B4,B5
Catholic HIV&AIDS Service	Sr. Tarsicia Hunoff	B1,B2,B3,B4,B5
Catholic HIV&AIDS Service	Mr Grahame Apain	B1,B2,B3,B4,B5
WHO	Dr Fabian Ndenzako	B1,B2,B3,B4,B5
Divine Word University	Mr Clement Manning	B1,B2,B3,B4,B5
UN Women	Ms Julie Bukikin	B1,B2
Friends Frangipani	Ms Cathy Ketapa	B1,B2,B3
Tingim Laip	Ms Jennifer Miller	B1,B2,B3,B4,B5
USAID	Dr. Pankaja Panda	B1,B2,B3,B4,B5
Save the Children - Poro Sapot	Ms Lydia Seta	B1,B2,B3,B4,B5
Save the Children - Poro Sapot	Mr Johnathan Wala	B1,B2,B3,B4,B5
CDC	Mr Steve Terrell-Perica	B1,B2,B3,B4,B5
Health & HIV Implementation Service provider	Mr Abraham Opito	B1,B2,B3,B4,B5
Marie Stopes	Mr Tom Ellum	B1,B2,B3,B4,B5
JICA	Mr Yoshikazu Taniguchi	B1,B2,B3,B4,B5
UNAIDS	Mr Stuart Watson	B1,B2,B3,B4,B5
World Vision	Sr. Binanke Gibilen - Nurse Counsellor	B1,B2,B3,B4,B5

A.I Strategic plan

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

IF YES, what is 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.: Summary of Respondent Comments. • Key developments/modifications are: (1) Focus of MARPS clearly given prominence (2) More detailed or technically sound (much better) M&E framework of the NHS (2011-2015). • The new plan has three priority areas whilst the old one has 7 priority areas. The new plan has clear 10 must do areas and also has Monitoring and Evaluation plus the Implementation framework. Having this framework makes it easier to focus our resources and energy to specific areas of the new plan. • Focuses more on Human Rights. 2. Increase Access to VCT. 3. Increase Education and Awareness on target population. 4. Collaboration amongst public sector and private sector. • This one is more multisectoral & founded on clear priorities such as scaling up on the response and identifies top 10 interventions • More comprehensive in coverage and targets, but is user friendly with implementers guidelines and many stakeholders find it easy to understand and use it.

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

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?: This question was not well understood by respondents. Although most respondents recognized that the National AIDS Council had a role in the development and implementation of the National HIV&AIDS Strategy no respondent recognized that the National AIDS Council is the legally mandated authority to coordinate the multi - sectorial HIV strategy (NAC ACT 1997 amended 1999). The current National AIDS Council has the following membership: Chairman and representatives from Women's Interest; Special parliamentary Committee on HIV&AIDS; Commercial & Industrial Organizations; Universities & Research Institutions; Social Research; PLHIV; Enclave Industries; CBO's; Health Workers; Global Agencies; Bilateral Aid Partners; NACS, Churches; NGO's; Education Sector;

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

Education:

Included in Strategy: Yes

Earmarked Budget: Yes

Health:

Included in Strategy: Yes

Earmarked Budget: Yes

Labour:

Included in Strategy: Yes

Earmarked Budget: No

Military/Police:

Included in Strategy: Yes

Earmarked Budget: Yes

Social Welfare:

Included in Strategy: Yes

Earmarked Budget: Yes

Transportation:

Included in Strategy: Yes

Earmarked Budget: Yes

Women:

Included in Strategy: Yes

Earmarked Budget: Yes

Young People:

Included in Strategy: Yes

Earmarked Budget: Yes

Other:

Included in Strategy: No

Earmarked Budget: No

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

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

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS:

Discordant couples: No

Elderly persons: No

Men who have sex with men: Yes

Migrants/mobile populations: No

Orphans and other vulnerable children: Yes

People with disabilities: No

People who inject drugs: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations: No

SETTINGS:

Prisons: Yes

Schools: Yes

Workplace: Yes

CROSS-CUTTING ISSUES:

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 identified?:

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country?

People living with HIV: Yes

Men who have sex with men: Yes

Migrants/mobile populations: No

Orphans and other vulnerable children: Yes

People with disabilities: No

People who inject drugs: Yes

Prison inmates: Yes

Sex workers: Yes

Transgender people: Yes

Women and girls: Yes

Young women/young men: No

Other specific key populations/vulnerable subpopulations [write in]::

: No

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

1.6. Does the multisectoral strategy include an operational plan?: Yes

1.7. Does the multisectoral strategy or operational plan include:

a) Formal programme goals?: Yes

b) Clear targets or milestones?: No

c) Detailed costs for each programmatic area?: No

d) An indication of funding sources to support programme implementation?: No

e) A monitoring and evaluation framework?: Yes

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

IF ACTIVE INVOLVEMENT, briefly explain how this was organised.: Respondents comments included: • Yes, there have been active involvement-CSO, groups brought to POM for several consultations • All civil society organisations thought to be involved or implementing HIV/AIDS programs were invited (through letters from the Director, NACS) to participate in focus group discussions on the Thematic Areas of NHS (2011-2015). Their contributions were captured by Group Rapporteurs who later consolidated all responses. A draft was presented back to all stakeholders for validation & finalization.

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

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

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

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:
Respondent’s comments on this question were not really related to whether or not development partners had aligned and harmonized their HIV related programs to the NHS, indicating that perhaps the questions was not well understood.

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS:

Common Country Assessment/UN Development Assistance Framework: Yes

National Development Plan: Yes

Poverty Reduction Strategy: No

National Social Protection Strategic Plan: No

Sector-wide approach: Yes

Other [write in]:

:

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

HIV-RELATED AREA INCLUDED IN PLAN(S):

Elimination of punitive laws: No

HIV impact alleviation (including palliative care for adults and children): 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: No

Reduction of stigma and discrimination: Yes

Treatment, care, and support (including social protection or other schemes): Yes

Women's economic empowerment (e.g. access to credit, access to land, training): No

Other [write in]:

:

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?: No

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?: 1

4. Does the country have a plan to strengthen health systems?: Yes

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications and children: Respondents comments: • Much talked about but yet to be materialized • Upgrading of infrastructure and other renovations have improved in re opening some health facilities for HIV Testing and treatment.

5. Are health facilities providing HIV services integrated with other health services?

a) HIV Counselling & Testing with Sexual & Reproductive Health: Few

b) HIV Counselling & Testing and Tuberculosis: Few

c) HIV Counselling & Testing and general outpatient care: None

d) HIV Counselling & Testing and chronic Non-Communicable Diseases: None

e) ART and Tuberculosis: Few

f) ART and general outpatient care: None

g) ART and chronic Non-Communicable Diseases: None

h) PMTCT with Antenatal Care/Maternal & Child Health: Many

i) Other comments on HIV integration :

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 your country's HIV programmes in 2013?: 3

Since 2011, what have been key achievements in this area: 13 respondents answered this question, with a score range of 3-10, the majority scoring 3. Respondents comments include: • No stockout of 'ARVs, 2. Scale up of HCT and IMAI Trainings, Report Coverage from facilities improve greatly. • Much motivation replying amongst individuals and groups to advocate and raise awareness • Leadership Development Framework. • Development of National HIV Strategy. • Increase in Scope of multilateral programs regarding HIV/AIDS. • Regional and Provincial sector wide consultations with key stakeholders and Development partners in participation for development of the HIV & AIDS strategic plan.

What challenges remain in this area: Respondents comments include: • Challenges of funding to support training needs for the education workforce, teacher training and student learning materials. • Training to all Health facilities doing HCT and ART, • Communication problems due to geographical locations of sites, Personnel to concentrate only to do M&E and logistics for major sites (sites with >200 clients) • Access to reliable data • M&E of Government sector program implementations. Until now National Coordination Body (NACS) can't measure the output from Government sectors who have been implementing certain strategies of the NHS. M&E is very poor. • The greatest challenge now is actual implementation of well described, developed, documented strategy, • Effective Utilization of allocated resources.

A.II Political support and leadership

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

A. Government ministers: Yes

B. Other high officials at sub-national level: Yes

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?: No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership: Respondents comments include: • Senior Education Officials have been continuously speaking about the issues surrounding HIV in their activities/conferences etc. • Dedicated a ministry solely for addressing HIV and health issues in the country. • Lady Carol Kidu , Dr. Bunare Bun, former MP used to be Ministers who provided the leadership & were vocal on the issue. Current Ministers for Community Development Lujaiya Toni needs to be more vocal. • NCD Governor, Hon Powes Parkop personally taken the initiatives to support the HIV Response in NCD • We've had Ministers taking part in most of our workshops and forum who gives speeches. The same applies to few departmental heads and administrators of provinces including their governors • The NCD governors support for PLHIV & referral pathways. • Big forums and World Aids Day Events, where leaders are invited to speak, advocate for leadership and political commitment. • Funding provided through PACs by governors • We have seen leadership support demonstrated through the Provincial Engagement Framework signing with provinces such as East New Britain and West New Britain. In East New Britain, funding to support HIV Response at the 4 districts has been boosted through the JDBPC allocation. In West New Britain, plans are underway to include the Provincial AIDS Committee Secretariat into the provincial structure.

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

IF NO, briefly explain why not and how HIV programmes are being managed::

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?: Dr Banare Bun, Chairman National Aids Council

Have a defined membership?: Yes

IF YES, how many members?: Respondents answered 15-22, the correct answer is 19

Include civil society representatives?: Yes

IF YES, how many?: Respondents answered 1 to 8. There are currently 4. PLHIV rep x 1, CSO rep x 1, NGO rep x 1 and Church rep x 1.

Include people living with HIV?: Yes

IF YES, how many?: There is 1 PLHIV rep

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 coordination between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?: Yes

IF YES, briefly describe the main achievements:: There are following comments : • NACS has to coordinate mechanisms effectively. NACS is the body that bridges the CSO plus Govt and other private partners. Planning process that happens annually. - Stakeholder forums and meeting. - NGO Partner forums. BAHA, YAHA, PACSO, NJCC. - PAC establishment in provinces (PAC Committees). • Quarterly Council Meetings; Quarterly Council's Committee (e.g.: Finance, HR, etc..) Meetings; Multi-sectoral Annual Planning Exercise; Development Partners Forum; Monitoring and Evaluation • We work through PLASSMA to reach out to all government departments. We have PACSO who is taking charge of civil society organization and BAHA looking after business houses, YAHA to coordinate all youth programs on HIV; Igat Hope for all positive networks; PNG Church Alliance for churches response to HIV. All leaders of these organizations are members of our NAC committees which information is our shared and used.

What challenges remain in this area:: • Commitment to resource the plan and monitor & report on achievement after planned period. • The main challenge is to have a mechanism in place to coordinate the public sector response. The second issue is capacity of this organizations need to be strengthened so they can effectively manage and coordinate the response within the sectors they represent. At the moment, organizations that are effectively functioning are BAHA and Igat Hope. We still experiencing problem with PACSO and PNGCA while there has been some improvement with YAHA. • More Networking roles and responsibilities and ensuring that it all happens and that reporting is dependable • Flow of information and service to the districts and back at the national level • Not much commitment from Government, • Leadership at NACS to lead/facilitate the multi-sectoral planning exercise and Development Partners Forum • NACS need to continue strengthening these umbrella organizations like : BAHA, PACSO, Youth Alliance, Church Alliance and Igat Hope so that their leaders would work with NACS. It helps filter the process of policy change/formulation and as well as providing services down to the people. • Getting right down to the LLG through the Political Leadership • Continuity in resource allocation and project program execution, 2. • Reporting of success stories through strong M& E, 3. • Unclear outputs and outcomes. • Ownership of PACs by provincial administrations and report correctly ever thing that being implemented.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?: 46

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

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]:

: No

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?: No

IF YES, name and describe how the policies / laws were amended: Most respondents answered yes to this question but did not / could not provide any examples of policies or laws that had been amended. The most common comments were: • Need to review the HAMP ACT, Review HAMP • Work on decriminalization has lost momentum, Decriminalization of HIV,

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:: • A few respondents reported that the Criminal Code which makes same sex relationships between men illegal needed to be reviewed. • No respondents mentioned the Summary Offences Act which makes sex work illegal needed to be reviewed. • No respondents mentioned the Migration Act which places restrictions on entry, stay and residence to PNG on the basis of HIV status alone. • Some respondent said there are labour laws that discriminate against PLHIV but did not say which laws these were (to the best of our knowledge there are no labour laws in PNG which discriminate on the basis of HIV). • One respondent said that the HAMP ACT-controls confidentiality but maintaining confidentiality can lead to persons continually infecting others without knowing, so this should be reviewed. • Although many respondents said the HIV & AIDS Management & Prevention Act needed to be reviewed they did not say which aspects of the ACT needed to be reviewed nor did they identify how this ACT was inconsistent with the National HIV&AIDS Strategy.

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 2013?: 1

Since 2011, what have been key achievements in this area:: There are following comments • In Education we have developed our DOE HIV policies based on our National Education Plan (NEP) 2005 - 2015. 2. Develop teacher training courses P/D Curriculum that contains HIV lessons. • There is a Special Parliamentary Committee for HIV but they are not active. • HIV has a portfolio and a minister • Main confidence/consolidation of Govt support/donor support. • Slowly Provincial Government taking responsibility-Progressing. • Political Commitment in funding, especially to cover the full cost of ARV's • Advocacy has increased; Few provinces have establish district & LLG response office • Funding and resource support have been boosted for provinces. NCD, East New Britain, West New Britain and Bougainville. ENB and WNB have signed their MOAs implementation of the Provincial Engagement Framework (PEF).

What challenges remain in this area: There are the comments : • Politicians need to be more vocal and provide VCT in their electorates. • Leaders need to be sensitized on HIV AIDS. • The challenge is to have support coming from 109 members of parliament instead of few active ones. • Lack of understanding commitment to support the HIV resourcing by political leaders. • Good leadership & direction from chairman • Link between gender and HIV to be included in the training and curriculum content. This should also be rights based. • Honoring commitments. • Consistency in resources and clear evidence of outcome after a period of time. • Changes in government leadership can affect support towards HIV response in the provinces. No respondents mentioned or appeared to be aware of the recommendations from PNG's last Universal Periodic Review which were rejected by the GoPNG: • Put in place legislation ensuring the equality of men and women and prohibiting discrimination against women • Review its national legislation so as to repeal all laws giving rise to discrimination against women and girls, with the aim of bringing the domestic system into line with the commitments made at the international level • Eliminate any legislation that has discriminatory effects against women in family and public life, in line with CEDAW, by, inter alia, including "gender" as a prohibited ground of discrimination in its Constitution • Decriminalize sexual relations between consenting adults of the same sex • Amend national legislation to include "sexual orientation" and "gender" as prohibited grounds for discrimination • Withdraw support from the proposed amendment that would curtail the power of the Ombudsman Commission, especially its ability to investigate independently human rights violations

A.III Human rights

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Select yes if the policy specifies any of the following key populations and vulnerable groups:

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

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]:

: No

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:: Nearly all respondents answered yes to this question; however the majority that answered “yes” cited the HIV & AIDS Management & Prevention Act (HAMP) as being a generalized law on non-discrimination which is incorrect. • One respondent reported the National Disability Policy • A small number reported that the PNG Constitution speaks to general non-discrimination in its preamble – “all citizens have the same rights, privileges, obligation and duties irrespective of race, tribe, place or origin, political opinion, colour, creed, religion or sex”. No respondents mentioned the • Defamation Act (1962) which makes it illegal to make insulting or slanderous suggestions about a person, or a member of his family, whether living or dead, which could lead to a) the reputation of that person is likely to be injured; or b) he is likely to be injured in his profession or trade; or c) other persons are likely to be induced to shun, avoid, ridicule or despise him. insulting or slanderous suggestions cannot be made by a) by spoken words or audible sounds; or b) by words intended to be read by sight or touch; or c) by signs, signals, gestures or visible representations, • Discriminatory Practices Act (1963) which makes it illegal for a person or a group of persons to discriminate either positively or negatively against or in favour of another person or group of persons for reasons only of colour, race or ethnic, tribal or national origin,

Briefly explain what mechanisms are in place to ensure these laws are implemented:: Very few respondents were aware of the mechanisms available in PNG. Many mentioned the broad areas of Police, Village Courts, District and National Courts. There are the following formal complaints processes using the following mechanisms this information is not common knowledge and that there are many obstacles to accessing these mechanisms for those experiencing discrimination: • through the Village Court System, • The Office of the Public Solicitor and the PNG Development Law Association provide legal aid services, • 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. Those who have experienced a violation to their human rights can request a “Human Rights enforcement application” make a “Statement of alleged or suspected breach of human Rights” or “Request for matter to placed on human rights list”. Any Judge or officer of the Court or any member of the Court staff or any other person, body or authority, including any member of the public, may bring any instance of alleged or suspected breach of human rights or freedoms to the attention of the Court by completing a statement of Alleged or Suspected Breach of Human Rights, • 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 • For employment related discrimination complaints can be lodged with Department of Labour & Industrial Relations, Public services commission or the PNG Trade Union Congress • complaints related to discrimination by public figures, politicians, leaders and LLG leaders can be lodged with the Ombudsman

Commission • The Ombudsman Commission is mandated to monitor places of detention

Briefly comment on the degree to which they are currently implemented: Comments include: • In Education the laws are taught through training education and inclusive in the learning curriculum contents for schools. • Laws against discrimination are in the National Constitution and subsequent laws e.g. HAMP Act however, they are not implemented or exercised.

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

IF YES, for which key populations and vulnerable groups?:

People living with HIV: No

Elderly persons: 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

Transgender people: Yes

Women and girls: No

Young women/young men: No

Other specific vulnerable populations [write in]::

: No

Briefly describe the content of these laws, regulations or policies: Many participants cite the Criminal Code and the Summary Offences Act as being barriers to effective HIV prevention, treatment, care and support for Sex Workers, MSM and Transgendered Individuals because they criminalise sex work and male to male sex, but none provided any explanation or description about how these laws pose barriers.

Briefly comment on how they pose barriers: Respondents' comments include: • Laws are there but are not being implemented/exercised. Lack of evidence of people going to court relating to HIV related incidences. • Law enforcing agencies continue to harass and abuse those sex workers and MSM. • The criminal code/Summary offences Act make it more difficult for -MSM, Sex workers, transgendered individuals to access health and STI/HIV services for fear of arrest and harassment. • A few respondents were in support of these laws saying MSM & Transgender I think is against Christian Beliefs.

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?:

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]::

: No

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?: No

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

a) age-appropriate sexual and reproductive health elements?: Yes

b) 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: Most respondents did not answer this question correctly, they mostly referred to policies and strategies in their own organizations or areas of work, but did not mention anything specifically targeting MARPS groups with one exception. One respondent referred to a MARPS policy currently being written, it is in fact a MARPS Communication Strategy. • In the national education system, we have the national education plan, that lights HIV as a priority in Goal 5. As such the department of education has strategized implementation of HIV issues in teacher education and curriculum (life skills) training/curriculum • Yes, workplace policy • The national department of Education has included HIV into its entire curriculum. NDOE has also written a policy for its employees/workplace. • There is a policy in place for out- of -school -youths, including possible activities for them as a way of educating them. • Policy for MARPS is being written now. Still in its draft form. The NHS 2011 – 2015 contains the following: 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?

People who inject drugs:

Men who have sex with men: Condom promotion, HIV testing and counseling, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education

Sex workers: Condom promotion, HIV testing and counseling, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education

Customers of sex workers:

Prison inmates: Condom promotion, HIV testing and counseling, Reproductive health, including sexually transmitted infections prevention and treatment, Stigma and discrimination reduction, Targeted information on risk reduction and HIV education

Other populations [write in]::

:

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 2013?: 4

Since 2011, what have been key achievements in this area: Respondents comments include: • First DOE HIV Policy was introduced/received education was distributed in 2012. Teaching and learning on HIV has taken place in all primary, secondary VET and teacher education institutes. • Tingim Laip Program has been very strategic and targeted activities centred on KAPS. • NHS (2011-2015) Capturing as much as possible all the key or vulnerability populations in its strategies. • Yes, we have targeted prevention intervention program targeting these segments of our populations. • HIV Testing & Counselling improved. More people accessing VCT sites. • More training on Sexual, Reproductive Health Programs, • Increase of VCT facilities, • ART roll out to main centres in the provinces, • Roll-out of new algorithm blood testing (confirmation tests). • PMTCT services have increased clinics doing testing. • General population prevention with condom use. • General Awareness changed to targeted intervention. • School/University debates have been encouraged • More groups to be formed to create Awareness amongst peers. • Condom use-marginalised group

What challenges remain in this area: Respondents comments include: • Need more training to many teachers who have not undertaken HIV training. Policy Implementation has only been done in central locations. Revised curriculum content on HIV and related issues need to be mapped out. • Need to address current challenges • Public Awareness and education amongst the rural population and urban areas. • More coverage and wider areas have to be covered. • MARPS population size, MARPS communication strategy, Leadership in implementing MARPS BCC activities (by NACS) • Strengthen, monitoring & evaluation of HIV programmes, • Lack of quality assurance - needs to be strengthened through monitoring & evaluation. • More work to be done in the area of targeted interventions (MARPS). More awareness on gender-based-violence. Campaigns need to be rolled out over certain time period to ensure people have really grasped the idea/knowledge on such issues. • Political will and Support. Policy development and the support to implement these policies at all levels effectively

4. Has the country identified specific needs for HIV prevention programmes?: Yes

IF YES, how were these specific needs determined?: Respondents comments include: • For the department of Education, we were to provide awareness to all education officials at the National, Provincial and District levels. • Through evidence based research (quantitative & qualitative) (2) • Using program data from provinces, surveillance & M&E reports, GAR Reports • Through M&E and research • MARPS- Specific needs to create awareness in this population groups. It has been identified that the virus prevalence rate is high among specific target population. The needs were found through various surveys. • Review and Evaluation of programme • Through studies and surveys/research conducted on different need specifics to determine interventions and programs pertaining to the needs.

IF YES, what are these specific needs? :

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to...:

Blood safety: Strongly agree

Condom promotion: Strongly agree

Economic support e.g. cash transfers: N/A

Harm reduction for people who inject drugs: N/A

HIV prevention for out-of-school young people: Disagree

HIV prevention in the workplace: Strongly agree

HIV testing and counseling: Strongly agree

IEC on risk reduction: Strongly agree

IEC on stigma and discrimination reduction: Strongly agree

Prevention of mother-to-child transmission of HIV: Strongly agree

Prevention for people living with HIV: Strongly agree

Reproductive health services including sexually transmitted infections prevention and treatment: Strongly agree

Risk reduction for intimate partners of key populations: Strongly agree

Risk reduction for men who have sex with men: Strongly agree

Risk reduction for sex workers: Strongly agree

Reduction of gender based violence: Strongly agree

School-based HIV education for young people: Strongly agree

Treatment as prevention: Strongly disagree

Universal precautions in health care settings: Strongly 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 2013?: 8

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:: Respondent comments include: • Yes for most living in the urban areas, No for those that are in the remote rural areas. • Large information, education and awareness have been made. • At education have advocated condoms to be made available to institutions for young sexual activities. • Care and treatment must be made accessible to any person tested HIV positive. • Yes, care & counselling (VCT) ART supplies • Through programs such as PICT, PPTCT,

Briefly identify how HIV treatment, care and support services are being scaled-up?: Respondents comments include: • Since 2011 more than 10 IMAI trainings were done covering approximately 20 participants per training. Hence we have adequate trained personnel who can confidently counsel, prescribe and initiate any person tested HIV positive. • Major improvement in the coverage of scale up and expansion with District health facilities. • Through integration of HCT sites at each district. • In education, teaching and learning of care and support is implemented. There are issues of female students leaving school to take care and provide support to their sick families. Teaching learning in our education system embarks on everyone's business in care and support. • Scaled up by the works of civil society organisations like churches for instances • It doesn't work in Central Province as most people access services at NCDC. Very few attend the Rural Health Services for counselling and initial testing but do not have access to treatment and further support.

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

The majority of people in need have access to...:

Antiretroviral therapy: Strongly agree

ART for TB patients: Strongly agree

Cotrimoxazole prophylaxis in people living with HIV: Strongly agree

Early infant diagnosis: Agree

Economic support: Strongly disagree

Family based care and support: Strongly 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: Strongly disagree

Paediatric AIDS treatment: Strongly agree

Palliative care for children and adults Palliative care for children and adults: Strongly disagree

Post-delivery ART provision to women: Strongly 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: Strongly disagree

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: Agree

Treatment of common HIV-related infections: Agree

Other [write in]::

:

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: There is no social and economic support available to people infected / affected by HIV in PNG, although respondents were unclear on this: • Not sure • No specific Policy or Strategy in place. • All HCT, care and treatment services are free of charge. • Not directly by NACS but we can refer our client to Strongim People Strongim Nation for financial assistance. • Done by very few people on Charity basis to care for others. • ART drugs provided are supplied free • Condom distributed freely & are freely sold at shops, 3Life skills training through community development

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

IF YES, for which commodities?: The majority of the answers were actually 'Yes' which is incorrect and indicate strongly that respondents don't know what a regional procurement mechanism is or that PNG does not have one.

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 2013?: 7

Since 2011, what have been key achievements in this area:: Comments included: • Established network between NAC - Provinces (PAC) the government departments and private organisations. • More than 200 personnel trained for IMAl,. • No ARV stock outs • Establishment of care and treatment centres • Management of STI, Counselling and Care & Testing • Increase number of VCT and HIV testing sites, has increase new cases that has enabled ART treatment to be scaled up and expanded. • Accessibility for all ART drugs; accessibility for all type of condoms

What challenges remain in this area:: Comments included: • Need to advocate and make Papua New Guineans really change their mind sets. Papua New Guineans with money have bigger problems in their decision making. • Facilities accessibility in rural areas as transport costs is a hindrance, • Monitoring of ART patients moving from one site to another is a problem • Need for more care and treatment centres • Clear ,strategic referral pathways, • Defaulters in ART, poor infrastructure, high turnover of trained staff.

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?:
Yes

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

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

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 2013?: 4

Since 2011, what have been key achievements in this area:: Respondents comments: • only Friends Foundation works in this area • Not much progress has been made in implementing the policy by Govt, but NGOs, FBOs are taking the lead in implementing them.

What challenges remain in this area:: There the following comments : • Data for orphan and vulnerable children need to be made/ established. • Need for strategy/policy for HIV related needs of orphans and other vulnerable children. • No social welfare plan. Lack of support and resources. • How best to address orphans as most Papua New Guineans treats orphans as a responsibility of relatives that will continue to support these orphans.

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:: Respondents did not mention any challenges related to the development of the M&E framework, all comments related to its implementation. • The challenge currently faced is in the implementation. There are major challenges in ensuring all big organisations work closely with PACs. Many due to their resources simply by-pass and report to funders. Until the government give strict requirements, the real impact will remain vague. • Country needs continues research in STI and HIV to compliment the routine surveillance • IT services, the communications in rural areas affect record keep of data. Lack of reliable data. • Too many indicators for data collection. M&E officers @ sub-national levels are not reporting • Program coverage data for non-clinical programs is lacking. Impact evaluation not clearly captured. • We have in the past 6 yrs advocate on three one principle. Slowly reports are coming in from provinces, accuracy of data remains doubtful. • There needs to be more collaboration with NACS and Health Department • Major challenges are, M&E framework not fully adopted by stakeholders; Implementation is poor, Timely reporting and Funding. • Some stakeholders not reporting to one M&E reporting framework. • Resourcing the M&E framework. Capacity issue. Consistency in adequately supporting the process. • Other key government departments beside NACS and & NDOH implementing HIV strategies M&E are in total absence.

1.1. IF YES, years covered: 2011 - 2015

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indi-cators) with the national M&E plan?: Yes, some partners

Briefly describe what the issues are:: Comments did not suggest that respondents were aware of key partners and stakeholders having their own M&E requirements and different donors having different M&E requirements. • Getting all partners to report on activities that are being implemented and reporting on the indicators. • Limited/Lacking Understanding in the process

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy: Yes

IF YES, does it address::

Behavioural surveys: Yes

Evaluation / research studies: Yes

HIV Drug resistance surveillance: Yes

HIV surveillance: No

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?: 12.5

4. Is there a functional national M&E Unit?: Yes

Briefly describe any obstacles:: Respondent comments include:: • M&E unit is part of the Prevention Section in NACS, it receives funding from some donor partners such as UNDP but mostly the GoPNG, and we have officers both at NACS level and Provincial level. • Capacity in surveillance and monitoring at National Health Dept. is very limited. Therefore, reporting is usually delayed. • Dysfunctional/lack of coordination • M&E Officers not performing required tasks. • Poor data Analysis of Non-Clinical Program

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

In the Ministry of Health?: Yes

In the National HIV Commission (or equivalent)?: Yes

Elsewhere?: No

If elsewhere, please specify:

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles]	Fulltime or Part-time?	Since when?
M & E Manager, NACS, not yet at NDoH	Full-time	2010
M & E Officer, NACS, not yet at NDoH		2010
Data Officer at NACS and NDoH	Full-time	2010
Surveillance Officer at NACS & NDoH	Full-time	2007
Surveillance Officer at NACS & NDoH	Full-time	2013
Surveillance Officer at NACS & NDoH	Full-time	2013

POSITION [write in position titles]	Fulltime or 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:: Respondents comments: • All surveillance reporting forms are in triplicates; a copy for each for National Department of Health, provincial health information officer and facility itself. • NGOs and partners are encouraged to make copies for their organisations. • A data vetting workshop is held before the data are disseminated for public consumption • Overall data collection and feedback mechanism in PNG • Strategic Information Technical Working Group (SITWG) • Service providers submit their report to the PACS-then elaborated at the PROMEST level before they are sent to NACS. At NACS level information are pass on to the M&E TWG and to NOC-NAC • Data Collection and Consensus Workshop

What are the major challenges in this area:: Respondents comments include:: • Reports not produced on time • Incomplete data received from stakeholders, • Reporting pathways in place, still not clear too many stakeholders. • Effective Coordination & Reporting of information collected

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.: There are the following comments: 3 National databases; 1 for ART, 1 For Testing and 1 for confirmed HIV cases. It is managed by the ART Data Manager at NDOH NACS also has databases for i. Stakeholders Database – list of stakeholders by organization type, program areas and target populations. ii. Stakeholder Reporting Database – List of reports provided by stakeholders iii. Condom & IEC Database – Numbers of condoms distributed by province iv. HIV/AIDS Reports Database list of reports received by implementing agencies v. HIV/AIDS Training Database – All HIV related trainings undertaken disaggregated by type of training and the target population. vi. Research database – a list of all research approved by the NACS research Advisory Committee,

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?: No, none of the above

IF YES, but only some of the above, which aspects does it include?: Although the majority of respondents said “yes all of the above” the NDoH & NACS national HIV databases do not include information about the content, key populations and geographical coverage of HIV services, or their implementing organizations?

6.2. Is there a functional Health Information System?

At national level: Yes

At subnational level: Yes

IF YES, at what level(s)?: The comments: • At NDOH, we have National Health Information System. At provincial level, we have provincial health information system. • Data that is not captures in the provincial or national health information systems includes: NACS (prevention) program, The condom promotion/family health, Life skills training (other department AAP), Some faith- based organisations (churches)

7.1. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?:

7.2. Is HIV programme coverage being monitored?: No

(a) IF YES, is coverage monitored by sex (male, female)?: No

(b) IF YES, is coverage monitored by population groups?: No

IF YES, for which population groups?:

Briefly explain how this information is used::

(c) Is coverage monitored by geographical area?: No

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

Briefly explain how this information is used::

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

9. 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]::

: No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:: Respondents comments include: • For Education it is used to improve our plan for improving teaching and learning on HIV and related issues in our schools and institutions. • To see trend of HIV in the country, • To do estimation and projection exercise every 2nd year to get national prevalence, • ARV and test kits forecasting • Key challenge here is most reports produced are produced very late, therefore data used is mostly outdated for making informed decisions in resource mobilization, evidence based planning, identifying gaps, trends, practices.

10. 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

10.1. Were other M&E capacity-building activities conducted other than training?: Yes

IF YES, describe what types of activities: Respondents comments include: • In house lockdown to do data analysis and report write ups. • Key Officers receiving training overseas. • Workshops conducted for stakeholders on reporting and stakeholder mapping

11. 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 2013?: 6

Since 2011, what have been key achievements in this area: Respondents comments include: • Data quality has improved a lot. • Report coverage from almost 60 ART sites and 320 HCT sites • We have M&E officers in all provinces and reports are coming,

What challenges remain in this area: Respondents comments include: • Monitoring and reporting of deaths and defaulters from ART programs is poor • Communication breakdown with facilities causing report delays • Man power capacity in terms of technical knowledge still poor; • Some stakeholders not reporting.; • The M&E systems are still using approaches & methods that are useful in a generalized epidemic but there has been no change to realign M&E systems to those that are required for a concentrated epidemic.

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?: 3

Comments and examples: 24 responses received ranging in scores from 1 to 4. Respondents comments were quite varied and included: • Political commitment has been strengthened over the last 2 years. • Respondent commented that Civil society organizations like Igat Hope, Kapul Champion, Friends Frangipani have advocated on behalf of PLHIV, MSM/TG and FSW/MSW thereby creating awareness in PNG of these populations and filling a niche where the GoPNG has limited programming for Key Populations. • The civil society and individual PLHIV activist have contributed to strengthening political commitment but more and sustained advocacy is required. • More tangible support is required for PACSO to better enable policy development at the national level and more effort needed to be put in, in sensitization of leaders and invitation of civil society to involve in formulations of strategy and policy. • Lots of effort has been put in place, but the results have not been as satisfactory as they could be. • There does not seem to be very much commitment or leadership in the national HIV response from politicians or leaders at all. We have not heard anything at all from the Special Parliamentary Committee on HIV&AIDS since the last Government elections. If anything political commitment has declined in the last 2 years. • That is a weak area. CSO need to carry out more awareness and raise their voices in order to be recognised and contribute meaningfully especially to National Strategy/policy formations. The political visibility and representation of minority groups such as PLHIV, MSM, TG is poor and there is no activism compared to other groups of this nature across the region. • In the last 2 years since the last report in 2012, political will has weaken dramatically, since the election there is no real champion for change in parliament. The national original dialogue on law reform in 2011 has not been progressed.

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)?: 3

Comments and examples: 24 responses with a score range of 1 to 5. Respondents comments included: • Representation isn't the issue rather it's tabling their activities for appropriate distribution and recognition. The coordination in this sector has been very poor and civil society should have been a more pro-active partner of the NDoH. • Involvement of civil society in planning and budgeting has been extremely good in the past; however, in the past three years this has waned. There has not been one planning and budgeting meeting called of all civil societies involved in HIV for the last three years and this has become a concern. Resource allocation for programs implemented by civil society is a decision made by NACS and its donor partners with little or no involvement of civil society. Some organisations are actively engaged compared to other NGOs this would depend on the capacity of the NGO, times, distance and sometimes some planned urgent meetings are missed. This should also be used as a performance assessment to help struggling NGOs with perhaps governance issues • Civil Society were very involved in the development of the last National Strategic Plan on HIV/AIDS 2011 – 2015, but not involved in the development of annual activity plans or annual reviews of the NHS. Another respondent noted involvement CSO at the recent mid-term review of the NHS included every stakeholder working in HIV/AIDS.

3. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?: 5

b. The national HIV budget?: 3

c. The national HIV reports?: 3

Comments and examples: 3.a -23 responses ranging in score from 2 to 5. The most common score was 5. 3.b- 19 responses ranging in score from 0 to 5. The most common score was 3. 3.c - 24 responses ranging in score from 1 to 5. The most common score was 3. Respondents comments included: • A significant portion of NGO, FBO activities is not captured through PAC/ NACS provincial reporting system. Confusion still exists amongst civil society agencies and PAC on correct use of reporting templates. • Many NGOs are not reporting through the established system of reporting such as ProMEST, although they are using public funding and are part of the planning cycle of Government. • A big proportion of NGOs funded health facilities do not report regularly to government and therefore their results are not reflected in the national reports. • In terms of reporting major civil society partners are consulted to collect essential data and information relating to HIV and AIDS and the Global reports on HIV and AIDS for PNG is contributed to by Civil Society Organizations participating in the response.

4. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society included in the monitoring and evaluation (M&E) of the HIV response?

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?: 2

Comments and examples: Respondents comments included: • There is No M&E plan for the country. • NGOs are not being fed the information analysed by the various technical committees to use the information in their future plans. • Utilisation of data for decision making is generally very low in the country and accordingly CSO have not contributed much: • Civil society was actively involved in the recent exercise for revision of the HIV and AIDS monitoring tools and reporting forms. They are invited to regular to M and E trainings when these occur and to the annual GAR/UA reporting exercises at national level; M & E and the likelihood of an effective application of a national framework is still challenging in that not all NGOs tend to report on all activities given that, there are competing priorities from Donor agencies and Global Fund apart from the national Dept. of Health impeding timely reporting of information to National Reports to guide inform and best guide programming. • The nation has an M&E framework in National HIV Strategy but do not have an M&E plan thus resulting in Civil Society distrusting the data collected. • 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; Very little is communicated from the M&E Committee on progress, reporting or issues that are being addressed by the Committee and what data exists is not uniformly distributed or easily accessible in a timely manner.

5. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, community based organisations , and faith-based organizations)?: 4

Comments and examples: 23 responses, ranging in score from 1 to 5. The most common score was 4. Respondents comments included: • 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. • There is still a long way to go before MARPS are meaningfully included. What involvement there is still very tokenistic, invited last minute and not often given opportunity to speak or get involved in decision- making. • The language and pace of meetings are also not inclusive of people with English as their second language or no level of English and different levels of literacy. • FBOs particularly have a long way to go before really working well with or accepting MARP orgs due to their religious beliefs. • Almost all services for Key Populations are provided by NGOs – FHI360 (Salvation Army, Four Square church, People Living with Higher Aims in Madang) , Save the Children, Tingim Laip, PSI, HWW, Anglicare and Baptist Union. • Representation is much more diverse in Port Moresby, Lae and Goroka where the Save the Children's Poro Sapot project has been active; Inclusion of youth groups, worker organisation remain limited; Participation of MSM, PLHIV groups and Sex workers hampered by legal impediments and stigma and discrimination.

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:: 6.a. 21 responses, scoring in range from 0-5. The most common score was 3. Respondents comments included: • There appears to be no real shortage of funds, but the ability to mobilise these funds productively is limited. • Previously financial support was available through NACS, but now AusAID funds go directly from AusAID to the civil society service providers. If the civil society proposed program of activities does not fit within donor priorities it is unlikely they will get any funding. 6.b. -24 responses scoring in range of 0-5. The most common score was 3. Respondents comments included: • The technical support is not to the level a few years ago under Sanap Wantaim Project. • It is extremely difficult to mobilise funding and technical assistance for civil society organizations for HIV activities. • 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. • Financial support provided by NACS is limited. • 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.

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

Prevention for key-populations:

People living with HIV: 25-50%

Men who have sex with men: <25%

People who inject drugs:

Sex workers: >75%

Transgender people: >75%

Palliative care : >75%

Testing and Counselling: 51-75%

Know your Rights/ Legal services: >75%

Reduction of Stigma and Discrimination:

Clinical services (ART/OI): 25-50%

Home-based care: 25-50%

Programmes for OVC: <25%

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 2013?: 6

Since 2011, what have been key achievements in this area: 22 responses, the most common score was 6. Respondents comments included: • Didn't see any major significant effort in 2013 to increase CSO's participations however, in 2014, we will be recruiting PLHIVs as casuals to do data entry in ART sites in the 9 high burden province. This is in response to the Mid-Term Review recommendations to have a greater involvement of PLHIVs. • There is high advocacy from bilateral agencies and the UN for government to support the civil society since it contributes greatly to health service delivery in all areas including HIV and AIDS. CSO receive significant financial support from development partners. The government also contributes to running and maintenance of NGO health facilities. From 2014, the government will be funding salaries of FBO staff to bring them at the same level as government employed health workers. • They have been increased as part of Sub-recipient to the Global Fund, 2. Private sectors have been promoted and supported by most donors,3.More training is targeting the CSOs and promoting their engagement • Civil Society Organizations have generally refocused their HIV programs from a general population approach to try and target those more at risk of HIV infection.

What challenges remain in this area: The comments are: • Things are becoming more technical, more health oriented (i.e. counselling). Capacity issues in this area (people on the job have to be trained, to understand these changes). • Poor visibility of CSOs at national level. Poor mobilisation of minority groups, such as TG/AMS/PLHIV/SW to become political activists and/or community development agents. Mobilization of local NGOs to be involved at local/community level and arranging funding system for such undertaking. • Non faith based CSOs (PLWHIV, Sex workers and MSM) are not well organized,2.Unsupportive legal environment for the MARPs organizations,3.Limited funds and technical know-how,4. High levels of stigma and discriminations. • The challenge that remains is adequate resourcing for the civil society to implement their planned activities. • 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'. • The organizational capacity of many civil society Organizations remains limited and there needs to be a focus on developing the organizational capacity so the CSO's can deliver better services. Most of the emphasis seems to be on getting the CSO's to deliver the services before they have the organizational capacity to do so.

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: 22 participants answered this question, 64% responded yes and 36% responded no. Comments from respondents who answered yes include: • 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. Comments from respondents who answered no include: • 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. • "Although sex work and same sex relationships are illegal in PNG the govt. has not stopped programing in these areas. Recently the Minister of Health and HIV/AIDS inaugurated the opening of Kapul Champion a MSM NGO. • Govt. funds do not support any programs for key populations directly, although several church based health programs receive govt. funding to operate and also serve key populations with donor funding support. • Igat Hope the NGO that supports PLHIV receives AusAID funding with the endorsement of the govt. The govt. also supports several ART sites around the country that serve PLHIV and pays for all ART medications in PNG. However more needs to be done like hiring PLHIV as peer educators and outreach volunteers."

B.III Human rights

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

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

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]:

: No

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:: As with respondents from government organisations Nearly all respondents answered yes to this question, however the majority that answered "yes" cited the HIV & AIDS Management & Prevention Act (HAMP) as being a generalized law on non-discrimination which is incorrect. There appears to be a very strong feeling from both Civil Society and Government Organizations responding to this questionnaire that the HAMP Act provides specific protections against discrimination for sex workers, MSM and transgendered individuals, which it does not. • No respondents mentioned the Discriminatory Practices Act 1963, The Defamation Act, the National Disability Policy, the Family Protections Bill which criminalizes domestic violence was passed by parliament on 19 September 2013 as of April 2014, this legislation has yet to be gazetted and thus is not yet enforceable. No respondents mentioned or seemed to be aware of the recommendations made in response to PNG's last Universal Periodic Review but were rejected by the GoPNG: • Put in place legislation ensuring the equality of men and women and prohibiting discrimination against women • Review its national legislation so as to repeal all laws giving rise to discrimination against women and girls, with the aim of bringing the domestic system into line with the commitments made at the international level • Eliminate any legislation that has discriminatory effects against women in family and public life, in line with CEDAW, by, inter alia, including "gender" as a prohibited ground of discrimination in its Constitution • Decriminalize sexual relations between consenting adults of the same sex • Amend national legislation to include "sexual orientation" and "gender" as prohibited grounds for discrimination • Withdraw support from the proposed amendment that would curtail the power of the Ombudsman Commission, especially its ability to investigate independently human rights violations

Briefly explain what mechanisms are in place to ensure that these laws are implemented:: There are the following formal complaints processes using the following mechanisms this information is not common knowledge and that there are many obstacles to accessing these mechanisms for those experiencing discrimination: • through the Village Court System, • The Office of the Public Solicitor and the PNG Development Law Association provide legal aid services, • 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. Those who have experienced a violation to their human rights can request a "Human Rights enforcement application" make a "Statement of alleged or suspected breach of human Rights" or "Request for matter to placed on human rights list". Any Judge or officer of the Court or any member of the Court staff or any other person, body or

authority, including any member of the public, may bring any instance of alleged or suspected breach of human rights or freedoms to the attention of the Court by completing a statement of Alleged or Suspected Breach of Human Rights, • 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 • For employment related discrimination complaints can be lodged with Department of Labour & Industrial Relations, Public services commission or the PNG Trade Union Congress • complaints related to discrimination by public figures, politicians, leaders and LLG leaders can be lodged with the Ombudsman Commission • The Ombudsman Commission is mandated to monitor places of detention

Briefly comment on the degree to which they are currently implemented: Many respondents said they were unsure on the degree to which these laws were implemented. Other comments include: • Non Discrimination laws are generally very poorly implemented. The general population and the populations more vulnerable to HIV have very limited knowledge about non-discriminatory laws that are already in place and even less knowledge about how to access and use the justice system if they should need to. Many of the police and court officials also have limited knowledge and understanding related to these laws. • Varying degrees from excellent efforts such as FSVAC, VAW, to law and justice sector or family protection issue through Australian AID. • Currently, I think people will not want to go through the long process of seeking justice so most times they will just let the matter to rest. • The CEDAW convention is adopted as law in PNG and government is responsible for its implementation. It is slow but gradual. The pace of the progress of most laws are usually slow but picks up when international pressure is place on the country to implement. • A poor rate • Implementation is very weak

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?

KEY POPULATIONS and VULNERABLE 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: No

Sex workers: Yes

Transgender people: Yes

Women and girls: No

Young women/young men: No

Other specific vulnerable populations [write in]::

: No

Briefly describe the content of these laws, regulations or policies: The number of respondents who answered yes and the number who answered no to “Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for women and girls” was equal, although no specific examples were provided of

these laws, regulations or policies • Sex workers and same sex relationships are criminalized. PNG failed to decriminalize homosexuality when it had the opportunity several years ago. • Same sex practice is illegal and regarded as criminal in PNG. This makes it difficult to work with them (MSM). Similarly sex workers are in the same category. • The HAMP law basically covers HIV Prevention and Discrimination and particularly protects the rights of persons infected or perceived to be infected with HIV and AIDS. Some provisions of the law tend to pose obstacles in redressing HIV issues, for example the law does not cover those who may get infected while providing services and therefore may not willing provide these services. The current laws on sex work and same sex activities are major obstacles in effective undertaking HIV prevention work. These laws make it extremely difficult to reach out to populations who are most at risk. • I think it is truly unfortunate that we have laws that protect the identity of PLHIV. I think those laws should be modified to protect only those genuine PLHIV (those who are not known to engage in risky sexual behavior especially multiple sex partnering) instead of all PLHIV. When the laws protect those PLHIV who engage in multiple sex partnering, the non-infected women and girls and young men and women are left vulnerable. Our laws should be directed at protecting the vulnerable (non infected) women and girls and young men and women. Current laws appears to be contradicting what we mean by 'prevention'

Briefly comment on how they pose barriers:: Respondents comments include: • Any organization working with MSM or CSW group will be seen as getting involved in illegal activities. (There is quite a common perception in PNG that because living off the earnings of prostitution and male to male sex is illegal, that it is also illegal to work with and provide services for men and women who sell and exchange sex or MSM and TG - THIS IS NOT CORRECT) • As these group are not legally accepted, it is hard to reach them with interventions for prevention, care and treatment • There is a lot of confusion around interpretation and enforcement of existing laws, in particular those around sodomy and living off earnings from prostitution. For example, in most cases it is women who are charged with living off earnings from prostitution - but never pimps. • Criminalizing these behaviors adds to stigma and discrimination that MSM, TG and FSW/MSW already face in the community thereby preventing them from accessing prevention, care and treatment services. Often the law enforcement agencies arrest and incarcerate these populations and subject them to additional physical and sexual violence. • Sex work & gay man illegal in PNG. Example if a transgender is raped & goes to the police for help, police will arrest the man instead of helping the man. • In PNG it is widely thought that criminalization of male to male sex and sex work impedes ability to access health services. It remains unclear what impact criminalization of male to male sex and sex work has on ability to access health services, or whether access is mainly hindered by the moral judgments that are made about sex workers and MSM. • 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.; • 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 include: • The Family Protection Law intends to address any form of violence against women and children and this included sexual assault. Violence and discrimination against women who are infected with HIV is also covered under this law as well as other laws like the HAMP. Respondents do not seem to be aware that although the Family Protections Bill has been passed it has not yet been gazetted and is therefore not yet enforceable. • I understand they is a policy for treatment of GBV survivors and all perpetrators can be charged in the court of law • Stop domestic violence against women. It is now a crime/criminal offence to commit the simplest form of domestic violence. • 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; There are provisions in the Matrimonial Act which make rape within marriage illegal; Note: The following recommendations were made in response to PNG's last Universal Periodic Review but were rejected by the GoPNG: • Put in place legislation ensuring the equality of men and women and prohibiting discrimination against women • Review its national legislation so as to repeal all laws giving rise to discrimination against women and girls, with the aim of bringing the domestic system into line with the commitments made at the international level • Eliminate any legislation that has discriminatory effects against women in family and public life, in line with CEDAW, by, inter alia, including "gender" as a prohibited ground of discrimination in its Constitution

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 include: • Respect for Human Rights is a guiding Principle of the NHS 2011 - 2015; • Protection of human rights mentioned in 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. • The HAMP act explicitly mentions the need to respect human rights. It is everybody's right to protect themselves from HIV. Intentional HIV transmission is an offence. Stigma and discrimination for PLHIV is an offence. The act provides guidance on where to seek legal help in cases of stigma or discrimination. • The HAMP Act 2003 provides for promotion and the protection of the rights of PLHIV

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?: Yes

IF YES, briefly describe this mechanism: It seems that almost all respondents are unaware of the mechanisms that are currently available in PNG. Respondent comments included: • Doubt this though it maybe be in place verbally by some CSO's or NGO's • Not sure with government but with civil society records and document are kept to monitor on regular basis on PLWHIVS in their communities feedbacks are collected and counseling is done with families and communities. • No routine mechanism of recording these practices. • Not that I am aware of. Since these activities are illegal it is doubtful that discrimination against these populations is recorded or addressed • With Poro Sapot, if MSM or TGs are stigmatized in public, an occurrence form is filled & record given to M & E. For physical assault a MSM or TGs cases are referred to police. The following mechanisms are currently available in PNG: • The Office of the Public Solicitor in Port Moresby has established a Human Rights unit which specializes in cases relating to HIV, GBV • The PNG Development Law Association in Port Moresby provides a free legal aid services for PLHOIV and people experiencing GBV • The National Courts Human Rights Track offers an opportunity to report discrimination if it fall into the category of denying human rights • The HAMP Act makes discrimination on the basis of HIV illegal; therefore any alleged discrimination can theoretically be reported to the police. • The Ombudsman Commission can investigate alleged discrimination on the basis of HIV if it involves a public official or public institution.

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).

Antiretroviral treatment:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: Yes

Provided, but only at a cost: No

HIV prevention services:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV-related care and support interventions:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

If applicable, which populations have been identified as priority, and for which services?: Respondents comments include: • All PLHIV are currently eligible for ART treatment if they present with CD4 < 350 • HIV positive pregnant women, patients co-infected with TB & HIV and children under 24 months are eligible for ART regardless of the CD4 count. • Men and women who sell and / or exchange sex ; men and women who have multiple concurrent sexual partners and men and women who have unprotected anal sex have been recognised as priority groups for HIV Prevention services. • Antiretroviral treatment is provided for all who are infected and needing to be on treatment. • The government provides HIV testing, antiretroviral drugs and drugs for treatment of opportunistic infections free of charge to all. But patients attending private clinic will pay for other HIV related services for example blood tests and consultation. • PLHIV are priority, however there are not enough services (ART) to meet the needs of all people currently living with HIV. In last year there has been a large shift in focus from general to key affected populations for all services. This has had an impact on programming and donor allocation of funding. PNG does have a policy to provide free ART, HCT and care for all, however in reality some clinics still charge a user fee.

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:: Most respondents answered "yes" to this question, however, PNG does not currently 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. Key populations are specifically mentioned in the NHS and a Communication strategy for MARPS is currently in development.

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?: No

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

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:: The HAMP Act prohibits the requiring or forcing of an HIV test for the purposes of employment, although not all respondents seemed aware of this as evidenced by their comments: • HIV testing can only be requested if the requesting entity is able to provide some service if this test is +ve • Yes - But at some places - this is not being implemented there are still discrimination within workplaces such as promotions. • There is a work place policy baring employers from screening for HIV and discriminating against PLHIV. • I haven't seen one yet and I have seen employers request HIV testing as part of their employees' medical examination for employment • Yes, HAMP ACT but very weakly implemented, many work places still insist on HIV screening prior to employment;

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:: PNG currently has: • Ombudsman Commission, • the Human Rights Track of the National Court, • the Constitutional Law reform Commission • PNG does not yet have a Human Rights Commission. • PNG last completed a Universal periodic review in 2011. • Human rights monitoring indicators monitoring framework for the NHS and the UNDAF e.g. monitoring the stigma index through regular surveys among PLHIV, monitoring reforms or to legislation that reduce the vulnerability, stigma and discrimination of ex workers, and same sex practices; monitoring legal processes initiated for HIV related stigma and discrimination

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 enforcement⁴⁶ 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: No

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]::

: No

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 2013?: 4

Since 2011, what have been key achievements in this area:: Out 19 responses provided for this question the most common score was 4. Respondents comments include: • Very little achieved in the past 2 years. • Broad policy/legislation for PLHIV but not for MARPs. Not strong and specific and detailed to appropriately capture and outline the targeted sub population. They all over arching laws and policies. • A national dialogue was held at parliament house to raise the issue of CSS/MSM being illegal in PNG but there has been no follow up and no further action. • There are Human Rights legal Instruments in place, however human rights legal information for HIV needs to be further disseminate and that the they affected population need to know and claim their rights as well as take legal actions against perpetrators. • The policies are still at infancy stage and not many actors; leave alone the PLWHIV who know them. The awareness efforts are needed to ensure the policies are well known • Tingim Laip is collaborating with PNG IDLA to support training in human rights policies, laws and regulations for members of key affected populations, relevant stakeholders (including police) and service providers in each of the locations it works. • Many of the affected populations know their rights for protection. Populations like MSM, TG, and Sex workers.; More people from affected populations accessing HIV services. • A lot of people are becoming aware of these laws and regulations and human rights abuses are being reported and debated more regularly then before. • There has been no major achievement in this time, but the landmark court case was won in Lae, a sex worker anti-discrimination case was won for sex workers who were discriminated against; • One achievement has been the case of a young transgendered individual who was arrested and put into prison in the male section. On appeal to the judge was moved and allowed to remain in the female section of the prison.

What challenges remain in this area:: Responses include: • Cultural barriers & beliefs. Illiteracy • Leadership at all levels-especially at National and church level are not willing to discuss it openly and look at options. • The challenge is the need to quickly establish the PNG National Human Rights Organization to effectively address human rights issues in PNG. • Resource allocation by national government to sustain the successful inventions by CS'O to encourage private sector support for National effort of HIV. • Advocacy and awareness that such policies exist. Most people are unaware of policies and laws in those areas. • Not many people know the services;. They are not widely available except in Moresby; Funding is limited, • There is widespread confusion and inconsistency around interpretation and application of laws. There is not accessible manner to hold individuals, including police accountable for behavior that does not comply with polices, laws and regulations. • Change attitudes of people towards affected populations through sensitization programs, awareness program, human rights. • Reforms to remove punitive laws to criminalize same sex relationship and sex worker; • Review of the HAMP Act 2013.

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 2013?: 3

Since 2011, what have been key achievements in this area:: 18 responses with a score range of 2 - 7. The most common score was 3. Respondents comments include: • HAMP ACT, testing is everywhere, success rate of treatment, in provincial & district levels. • Nothing that visible in the mainstream apart from annual WAD activities. • PNGDLA is established

and funded to address the legal views for HIV in the work place + stigma. • Development and existence of the HAMP Act and the Human Rights Rules as the National Govt. • In the area of awareness of HIV discrimination some things are done mostly in community and families. • Increased awareness of the contribution factors to HIV transmission • Establishment of legal services/NGO for PLWHA • More people are becoming aware of their rights and human beings • There has been a strong effort from civil society but no effort or interest from the government.

What challenges remain in this area: Comments include: • All the law enforcing agencies needs to be scrutinized, starting at the leadership levels. • People both in the urban and rural areas need to be educated about their rights and how to benefit from their rights. The other challenge is to effectively address the PNG Culture on the stereotype attitudes of better men & women seeing men as the authority even when rights of women are being violated. • More advocacies in that area and a legal AID System set up for the workplace policy. PLWHIV have been discriminated at workplace. Making it difficult for them to earn a living. • To contribute support from Government and private sector. • Current structures and implementing bodies should be properly identified. • To reach people in the rural areas in taking awareness on Human Rights to them. • The challenge of enforcing the laws and regulations is yet again pending • Nothing changes; Actual implementation of the policies and laws that are in place and whether the end results are achieved (Protection of Human Rights). Increasing the knowledge of the general public and groups more at risk of HIV about their legal and civil rights & responsibilities.

B.IV Prevention

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

IF YES, how were these specific needs determined?: 10 respondents answered this question and 7 of them answered yes. Respondents comments include: • It was identified through the NHS MTR- to focus more on specific interventions on MARPs/ICAPs population groups. • PNG has benefitted from an external midterm review of the national HIV strategy recently and is work in progress given key recommendations have helped provide clarity to the overall HIV strategic direction for the country. • The NHS identifies a need to scale up responses in a targeted manner, and this has been reinforced in recent years by NACS and donors. • Publication of several studies in recent years (NRI, IMR primarily) has confirmed concentrated epidemic amongst key affected populations, in particular women engaged in sex work, men who have sex with other men and mobile men with money (however current emphasis does not include MMM). • The IBBS still hasn't been done and PNG is lacking a much needed reliable biological baseline for its epidemic. • Current prevention programs are largely based on the consultations undertaken for the development of the 2011 – 2015 NHS. The groups defined “more at risk of HIV” are much too broad and include almost every population sub group in PNG. • Recently there has been a lot more discussion about the need to have a targeted focus on men and women who sell and / or exchange sex ; men and women who have multiple concurrent sexual partners and men and women who have unprotected anal sex have been recognised as priority groups for HIV Prevention services and particular geographical locations that continue to report ANC HIV prevalence at above 1%, however PNG has still not been able to undertake a mapping or size estimation of “more at risk groups” to enable this targeted approach.

IF YES, what are these specific needs? : Respondents comments: • Papua New Guinea has been implementing HIV prevention programmes using models for a generalised epidemic. However, there is growing evidence that the country may be dealing with a concentrated epidemic. • According to the average HIV prevalence of 0.6% PNG has a low level epidemic but also has some pockets where HIV prevalence is higher than 1%. • More research is needed to identify the drivers of the epidemic. Self -reported information among people testing HIV positive indicate that over 85% of HIV infected individuals acquire the infection through heterosexual transmission. • A few bio-behavioural surveys have been done but this focus on small geographical areas and no country wide population survey has been conducted. Some research has been done among special population groups for example truck drivers, transactional sex works and men who have sex with men. • A recently conducted research indicated that Intravenous drug use is not a significant problem in PNG from the HIV. • There is need to identify the specific needs for HIV prevention programmes to complement needs identified through small surveys, programme reports and field visit reports.

1.1 To what extent has HIV prevention been implemented?

The majority of people in need have access to...:

Blood safety: Strongly agree

Condom promotion: Agree

Harm reduction for people who inject drugs: N/A

HIV prevention for out-of-school young people: Disagree

HIV prevention in the workplace: Agree

HIV testing and counseling: Agree

IEC on risk reduction: Agree

IEC on stigma and discrimination reduction: Disagree

Prevention of mother-to-child transmission of HIV: Agree

Prevention for people living with HIV: Disagree

Reproductive health services including sexually transmitted infections prevention and treatment: Agree

Risk reduction for intimate partners of key populations: Disagree

Risk reduction for men who have sex with men: Agree

Risk reduction for sex workers: Agree

School-based HIV education for young people: 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 2013?: 3

Since 2011, what have been key achievements in this area: Respondent comments include: • Year of refocusing & re-strategizing on the prevention implementation was stronger towards the end of the year for MARPS. • Strategies and action plans are in place to guide implementation. • Option B+ introduced in 2012. • Development of the National HIV and AIDS Strategy 2011 - 2015 which prioritizes HIV prevention. Development of the Operational plan for Prevention of Mother to Child transmission of HIV and [paediatric HIV care 2011 - 2015 which is guiding scale up. HIV prevention services are scaling up especially the clinical interventions. • Scale up of HIV testing and counselling services and the two test algorithm introduced for HIV testing which facilitates clients to receive same day results, reduced loss to follow up of HIV positives and facilitates referral or initiation of HIV treatment. Recent improvement in coverage of PPTCT services. Services for early infant HIV diagnosis were initiated and are scaling up rapidly. Some research done among high risk groups. Increased funding to target MARPs. • Greater focus on key affected populations to meet response required of a concentrated epidemic. More services are available; however they require greater sensitization to needs of key affected populations as there is still a lot of stigma and discrimination reported. • Tingim Laip has developed training programs for members of key affected populations on range of topics relevant to HIV prevention: HIV, STIs, SRH, alcohol harm reduction, referrals. These can be delivered in flexible timeframes that meet schedules of these populations. Tingim Laip has conducted a series of micro-mappings in 11 locations (10 provinces) in mainland PNG to map sexual networks and develop informed intervention strategies reflecting each location and target population.

What challenges remain in this area: Respondent comments include: • PNG is still not using evidence to target prevention programs • PNG needs to move from a general population approach in its prevention programs to a targeted approach. • With the exception of the introduction of rapid testing PNG has not really considered the introduction of new technologies in HIV prevention (Microbicides, antiretroviral treatment as prevention (TasP), • Integration of family planning services into the HIV and PPTCT program in ANC clinics as an essential part of HIV prevention. • The National Strategy for

Comprehensive Condom Programming (CCP) is yet to be institutionalized and roll out. • The Mid-term review of the NHS in 2013 recommended that PNG should re-think 'prevention', and recognise that prevention and service delivery are part of a continuum that requires all parts to be closely coordinated, linked and reinforcing. Similarly condom promotion, distribution and use, particularly for MARPs, needs to be linked closely to other services – STI management, counselling and testing, treatment and care. • The Continuum of Prevention to Care model of service delivery is not yet a reality. • Research to identify specific needs to be addressed for HIV prevention programmes. Developed of targeted IEC materials for HIV prevention. • It is not clear what/ who is currently providing overall coordination of prevention efforts.

B.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:: Respondent comments include: • 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. • Number of ART sites has greatly increased as well as. • HIV testing is the entry point into treatment. • Provision of antiretroviral drugs for treatment and also dialogue is on-going on use of HIV treatment for prevention. Services target both adults and children and special groups like HIV infected pregnant women and TB patients are given high priority to be started on life-long antiretroviral treatment. • Treatment of opportunistic infections. • Counselling on positive living and adherence to medications. Nutrition education and family planning and other medical care. • Management of STI,TB/HIV collaborative activities. • Psychosocial support and where possible peers are used. Linkage with other organizations and CBOs to provide a holistic approach to HIV treatment care and support for example linking patients to organizations where they can be supported with IGA and orphans to OVC services. • Quality of HIV care implemented in major ART sites

Briefly identify how HIV treatment, care and support services are being scaled-up?: Respondent comments include: • Two test rapid testing algorithm is being introduced and rolled out • PICT is being scaled up • TB/HIV committees are being established at provincial level • Increase ART sites, use NGO clinics, use PLHIV expert clients, use PPTCT sites and ANC sites. • Testing and Treatment sites are maintained .Number of people tested have increased .Number of people on treatment have increased. • Treatment, care and support have been rolled out throughout the country. • Treatment has improved from one centre to many in a town making treatment accessibility easier & accessible. But in rural areas still a problem; • Has generally improved with support from partners but government itself has to come up with a care and support mechanism to continue after treatment. • Using public health approach; Trained nurses/HEOs are allowed to prescribe ARVs in non-complicated cases; Simplified training using IMAI approach; Regular clinical mentoring; The use of clinical criteria to initiate and monitor ART services in places where CD4 services are limited; Ensuring drugs are available and government is buying all ARVs timely; Establishment of vertical ARV drug distribution machinery • PICT in all facilities providing antenatal clinics; PICT for all people presenting with other STIs and TB; • Decentralisation of ART from provincial hospitals to district hospitals;

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

The majority of people in need have access to...:

Antiretroviral therapy: Strongly agree

ART for TB patients: Agree

Cotrimoxazole prophylaxis in people living with HIV: Agree

Early infant diagnosis: Strongly 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: Agree

Psychosocial support for people living with HIV and their families: Strongly disagree

Sexually transmitted infection management: Agree

TB infection control in HIV treatment and care facilities: Disagree

TB preventive therapy for people living with HIV: Disagree

TB screening for people living with HIV: Agree

Treatment of common HIV-related infections: Agree

Other [write in]:

:

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 2013?: 7

Since 2011, what have been key achievements in this area: 21 respondents answered to this questions and the majority rated 7. Respondents comments included: • Good scale up in some provinces, but not others. • Increase ART sites. Increase in No. of PLHIV on ART. Involvement of NGO & PLHIV (expert patients). • HIV treatment coverage has remained high, over 70%. • Improvement in procurement and supply chain management systems resulting in less stock outs. • Increased VCT Centers; Roll out of PPTCT Programs; Increased treatment centers, increased partnership in VCT, treatment, care & support. • More people needing ART have access to it. • The Treatment access has increased. The coverage increased to 74% 3rd highest in Asia Pacific. PPTCT services increased as well. Increased TB/HIV collaborative activities (Testing, 3Is, M&E and coordination); The new guidelines, CD4 350 was adopted are being implemented • All the Provinces have HIV treatment and support services. In major centers such as Port Moresby, Lae and Mt Hagen, several of these facilities are operating on a day to day basis.

What challenges remain in this area: Respondents comments include: • There are very few resources and services available to people living with HIV to help them understand the virus, importance of treatment adherence and how to prevent the onset of AIDS – the majority of services are focused on treatment provision only. • Existing home based care services are ad hoc in nature and reinforce ‘sick role’ behaviour, rather than promoting healthy and full life for those living with HIV. • Linkages to services still weak; High loss of patients from testing to ART sites; Loss to follow up and low retention rates. Limited diagnostic services (Viral Load) for monitoring patients not available. Program remains vertical and limited ownership; the new guidelines 2013 not yet adopted. • Many of the services provided are location specific. Quality of services is inconsistent and there is no monitoring of services to assess standards of delivery. • Many of the services reinforce ‘sick role’ behaviour rather than promote active and healthy lifestyle to prevent development of AIDS. • There is very little patient/ doctor interaction and most patients have very little understanding of what is being prescribed to them and for what reasons. There is little dialogue and discussion between patients and service providers and most patients are passive recipients of treatment, rather than empowered to take an active role in their own health and wellbeing. • Many services cannot manage case loads, having taken on too many patients without requisite additions to staff numbers (Hagen clinics in particular). Staffs are overworked. • Drug stock outs continue to be reported on a regular basis. • Clinical services including PPTCT, counselling and testing and care and treatment have expanded significantly, but linkage with prevention services provided in the community is weak and loss to follow up is a major issue

2. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?: No

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?: No

3. 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 2013?: 7

Since 2011, what have been key achievements in this area:: 16 respondents answered this questions and the majority of them rated it level 7. Respondents comments include: • Increase in No. Of PLHIV ART. Increase in ART sites. Increase in non-health sector involved in ART program. • Treatment for Antenatal and children are increasing in the area of rolling out of PPTCT Programme; Partnership has been essential in PPTCT Programme. Clinton etc. • No NGOs or organisations providing care for children (orphans). Families & relatives are providing care needed for children. • We don't really address that situation. Orphans are usually left to be taken care of by family members.

What challenges remain in this area:: Respondents comments include: • Sustained ART, condom, lubricants and OI treatment supplies. • Increased treatment centre for paediatric / children • Government need to accommodate for HIV related Orphans • Challenges remain that-families are inadequate to care for them and there are still many homeless children.