

# **Global AIDS Report 2012**

## **COUNTRY PROGRESS REPORT**

**Papua New Guinea**

**Reporting Period**

**January 2010 - December 2011**

---

**Submission date: 30 March 2012**

## Table of Contents

Acronyms	3
Acknowledgements	5
I. Status at a glance	6
a) Stakeholder involvement	
b) The status of the epidemic	
c) The policy and programmatic response	
d) Indicator data in an overview table	
II. Overview of the HIV epidemic in PNG	23
III. National response to the HIV epidemic in PNG	33
IV. Best practices	166
V. Major challenges and remedial actions	175
VI. Support from the country's development partners	190
VII. Monitoring and evaluation environment	192
Annexes	
Annex 1: Consultation and preparation process	199
Annex 2: National Commitments and Policy Instrument	204

## Acronyms

AAPs	Annual Activity Plans
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
AusAID	Australian aid/development agency
BAHA	Businesses Against HIV and AIDS, PNG
CBO	Community Based Organisation
CoPCT	Continuation of Prevention to Care and Treatment model
CSO	Civil Society Organisation
CSW	Commercial Sex Worker
FBO	Faith Based Organisations
FHI	Family Health International
FSW	Female sex worker
GAR	Global AIDS Report
GIPA	Greater Involvement of People with AIDS
HAMP Act	HIV and AIDS Management Prevention Act 2003
HIV	Human Immuno deficiency Virus
IHI	Igat Hope Incorporated
IMR	Institute of Medical Research
JUNTA	Joint UN Team on HIV and AIDS, PNG
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MSM	Men Who Have Sex with Men
MSW	Male sex workers
MTDP	Mid Term Development Plan 2011 -2015
NAC	National AIDS Council
NACS	National AIDS Council Secretariat
NAHTU	National AIDS and HIV Training Unit
NCD	National Capital District
NHS	National HIV and AIDS Strategy 2011-2015
NDoH	National Department of Health
NHSSC	NHS Steering Committee
NHSCG	NHS Core Group
NGO	Non-Government Organisation
NRI	National Research Institute
NSP	National Strategic Plan on HIV/AIDS 2006 - 2010
PACs	Provincial AIDS Councils
PACSO	PNG Alliance of Civil Society Organisations against HIV and AIDS
PLHIV	People Living with HIV
PNG	Papua New Guinea
PPTCT	Prevention of Parent to Child Transmission
S&D	Stigma and Discrimination
TG	Transgender
UNAIDS	Joint United Nations Program on HIV/AIDS

UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	UN Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
W.I.N	Women in NACS

## **Acknowledgement**

The successful completion of the Global AIDS Response (GAR) Progress Report was the result of efforts invested by many stakeholders and development partners, members of the GAR & UA Core Working Group and short term consultants during all stages of data collection, synthesis, writing and editing. The NACS is indebted to many, but would like to give special acknowledgements to the key members of the GAR & UA Core Working Group: Mr. Philip Tapo (NACS), Dr. S. Bieb – NDOH, Mrs. Agnes Gege (NACS), Mrs. Julie Airi (NACS), Dr. Wilfred Kaleva (NACS), Mr. Danny Beiyo (NACS), Ms. Leah Hoffman (PSI), Mr. Miles Kevin (Oil Search Health Foundation), Ms. Meagan Morrison (Anglicare PNG), Mr. William Yaka (FHI360), Dr. Ali Feizzadeh (UNAIDS), Mr. John Kelari (PACSO), Mrs Anne McPherson (Igat Hope Inc), Dr Holly Aruwafu (PNGNRI), Mrs. Geraldine Maibani (PNGIMR), Dr. Fabian Ndenzako (WHO), Dr. Nii-K Plange (AusAID), Dr. Nick Dala (NDoH), Dr. Peniel Boas (NDoH), Ms. Hannelly Kiromat (CHA), Dr Fumi Yokota (CHA), Mrs. Joan Robinson (PALJP), Ms Cristi Morf (UNICEF), Dr. Rachael Le Mesurier (GAR Consultant), Dr. Anastasiya Nitsoy (NASA Consultant), Mr. Nick Ganai (NACS), Mr. Jacob Kupe (DNPM) and Dr. John Millan (NDoH).

The National AIDS Council Secretariat (NACS) though played a major role in coordinating the process for the 2012 Global AIDS Progress Report production, depended heavily on the data generated by stakeholders both at national and subnational levels, therefore would like to take this opportunity to appreciate all HIV reporting facilities in the country (Public, Private, FBOs, NGOs), Research Institutions (PNG NRI, PNG IMR) and our international NGOs partners ( FHI and PSI) involved in research as well as other HIV implementing programs who provided data for this very important report.

For all stakeholders who participated in the Consensus Building workshop held in March 2012 to provide valuable input and reach consensus on the final report is highly commended.

Very special appreciations and acknowledgment also goes to the following 2012 Core working Group members who unselfishly committed themselves fully by way of providing technical and administrative support to the whole process until submission: Dr. Ali Feizzadeh (UNAIDS – Core Group member and M&E Adviser), Mrs. Agnes Gege (NACS – Core Group member & GAR Focal person), Dr John Millan (Short term UA Consultant – Core Group member), Dr. Rachael Le Mesurier (GAR Consultant), Dr. Anastasiya Nitsoy (NASA Consultant), Ms. Leah Hoffman (PSI, Core Group member), and Mrs. Joan Robinson (PALJP- Core Group member).

Lastly I would like to acknowledge the tireless job of data consolidation and verification by staff of NACS ICME Branch and NDoH Surveillance Unit, National Catholic AIDS, Oil Search Limited and Anglicare PNG be commended for a job well done in providing required data for the GAR and UA Report.

Finally, though NACS have been the major funder of the 2012 GAR we would like appreciate our key partners from UNAIDS and UNDP for the support in the hire of consultants and other shortfalls.

**Mr Wep Kanawi CSM, OBE**  
Director

**National AIDS Council Secretariat**  
Port Moresby  
Papua New Guinea

## I. Status at a glance

The following provides a brief summary of:

- (a) the inclusiveness of the stakeholders in the report writing process;
- (b) the status of the epidemic;
- (c) the policy and programmatic response; and
- (d) Indicator data in an overview table.

### A. Inclusiveness of the Stakeholders in the report writing process

Papua New Guinea, according to the GAR 2012's National Composite Policy Instrument (NCPI) respondents, has made a significant move forward in the consultation and meaningful involvement of civil society in the national response to HIV. The primary example provided by NCPI respondents from civil society of this transition to more equal engagement, is in the 2010 development of the National HIV and AIDS Strategy for PNG 2011-2015.

*"The Government recognised the process involved in developing and formulating strategy and with the lesson learnt from the previous NSP and its impact, the new NHS 2011 -2015 has undergone a tremendous consultation process". NCPI respondent 34. Part A.I.*

The process is described in the [IV Best Practice](#) section of this GAR 2012 report and the success of the process in expanding ownership of the NHS 2011-2015 can be seen throughout the National Composite Policy Instrument (NCPI) at [Annex 2](#). Respondents from Civil Society Organisations (CSOs), Faith Based Organisations (FBOs), the private sector and government departments all repeatedly acknowledged the marked improvement in the involvement of civil society in the national response, with a particular mention on the move forward in the commitment to Greater Involvement of People living with HIV and AIDS (GIPA).

As a result the NHS 2011-2015 is reported by many of the stakeholders in the NCPI 2012 as, not only one that better meets the particular needs and challenges of the HIV epidemic in PNG, but a strategy that they are all involved in progressing.

*"Civil Societies have contributed to the formulation of the NHS. ....  
(we helped) develop sections in the NHS on the most at risk populations  
(MARPS) in the current NHS, which were absent in the previous NSP". 2012*

The active involvement of the stakeholders in the development of the NHS 2011-2015 mirrored significant steps forward for civil society during this GAR period of 2010 to 2011.

- The first PLHIV organisation in PNG, Igat Hope, moved to a legally constituted national structure in November 2010. This new formal structure is composed of (10) new and (16) existing groups, bringing it to a total of 26 Province and District level PLHIV organisations/networks, such as Tru Warriors and Tru Friends (women with PLHIV) in the Western Highlands province.
- The first national organisation for men who have sex with men in the establishment of the Kapul Champions in 2010.
- In May 2010 Church leaders from 19 Christian denominations in PNG came together to launch the Christian Leaders Alliance, a network of Christian faith leaders committed to provide an effective response to HIV in the country.
- In March of 2011, the Business Coalition took on the condom distribution for the whole country as part of the national response. By December 2012 the set target of 25 million male and female condoms had been exceeded and 27million was recorded as distributed to the provincial aids committee storage areas. The distribution of this magnitude of condoms was possible due to the involvement and support of the Business Coalition network of private sector members.

*“It is a good plan, a better one that responds well with the stakeholders and people of PNG. It is relevant to our PNG settings”. 2012 NCPI respondent No.29. A.I. 2*

It is in this environment of increased stakeholder engagement in the implementation of the NHS 2011-2015 that the GAR 2012 Core working group formed in late 2011. The GAR Core Working Group has a wide membership from government departments, the private sector, research institutions, CSOs, FBOs, international NGOs, bilaterals and donor partners. This GAR CWG initiated a number of key improvements in stakeholder engagement compared with the UNGASS 2010 process. For example for GAR 2012 the NCPI includes, for the first time, both National and Provincial involvement. The three Provinces are Morobe, National Capital District and Western Highlands.

The GAR CWG also led the Consensus Workshop with the participants reporting greater engagement in the drafting of the NCPI report, the reporting of the GAR Indicators and in the key messages in the GAR report narrative.

## **B. The status of the epidemic**

**Increased MARPS Research:** A key recommendation from the UNGASS



2010 was to scale up the research and collection of evidence on the most at risk populations (MARPs) in PNG.

### **Challenges for indicator reporting improvement**

*There is special need for regular behavioural and bio-behavioural surveys among most-at-risk populations, and to include these surveys into the national surveillance plans. Indicator 8: HIV Testing in Most-at-risk Populations. Page 35.*

There has been a marked increase in reported behavioural studies on these most-at-risk/key affected populations (KAPs) in PNG in the last two years. The NACS Research Coordination Unit has approved over 20 research applications in the last two years, with a significant number focusing on at risk youth, mobile populations, MSM, young women who exchange sex, economic enclave workers, HIV stigma and rural populations. The results reported in 2011 have enhanced the quality of data for this GAR 2012.

Some of these reported results are both startling (59.72% of male sex worker respondents who reported having commercial sex in the last 12 months used a condom with their most recent opposite sex client for anal intercourse<sup>1</sup>) and very concerning (17.79% of sex workers in Port Moresby who were tested and tested positive for HIV<sup>2</sup>).

Whilst this increase in collecting and analysing data on the MARPs in PNG has been essential it is with some frustration that the quality and breadth of these surveys cannot be adequately reported in the GAR 2012 indicators. Particularly as some of these surveys were designed to inform the Indicators in the UNGASS 2012 that have now been removed in the GAR 2012 (i.e Indicator 14: Most-at-risk Populations: Knowledge about HIV Transmission Prevention).

**PLHIV partnership:** This period has also seen the PLHIV organisation Igat Hope become actively involved in partnering research in the People Living with HIV Stigma Index behavioural study.

**The Integrated Bio Behavioural Survey (IBBS): September 2011.** This will be the largest population-based bio-behavioural survey in PNG. It is important to note that whilst there has been an increase in the number of BSS surveys on MARPs from 2009 the absence of population based surveys in recent years has proved a challenge in reporting on the GAR 2012 Indicators.

## Summary of Overview

---

<sup>1</sup> Askim na Save (Ask and Understand): People who sell and exchange sex in Port Moresby 2011.

<sup>2</sup> Askim na Save (Ask and Understand): People who sell and exchange sex in Port Moresby 2011.

## C. The policy and programmatic response

The last two years of the national response to the HIV epidemic have been shaped by the development (2009 – completed in 2010) and then the implementation of the NHS 2011-2015. Included in the structure of the NHS 2011-2015 is the Implementing Framework and the Monitoring and Evaluation Framework. NCPI Respondents complimented the structure of the NHS 2011-2015 in providing much needed guidance and support for partners to be more effective partners in the national response.

*“More comprehensive and yet very simple to understand. Development of the user guides that goes with it makes a lot more easier to use. Most stakeholders finds easier to understand.” NCPI respondent 33. Part A.I*

At the same time as the development of the NHS 2011-2015 a number of significant national policies were also being developed. As evidenced by the high profile and integration of HIV issues in these plans, the government and stakeholders were able to ensure HIV was seen as a cross cutting issue for PNG. For example:

- The National Gender Equality Plan 2011-2015
- The Mid Term Development Goals 2011-2015
- The National Health Plan 2011-2020

Again the role and engagement of civil societies is reported to have been instrumental in the development of these national policies in respect to the national response to HIV.

*“Civil Societies have been instrumental in formulation and policies in child rights, women and girls most vulnerable population such as transgender, men who have sex with men and female sex workers” NCPI respondent 2. Part B.I.*

There a number of key events and activities that have influenced, and been integrated into, the national policy and programmatic response, as described by the NHS 2011-2015, throughout this period.

### 2010

- **Global Fund Round 10 Success:** In 2010 PNG was advised by the Global Fund that their Round 10 grant application focusing on Gender-based violence (GBV) and Prevention of Parent to Child Transmission (PPTCT) was successful. This was a significant success as the prior Round 9 grant application was declined and a great deal of work was needed to meet the concerns expressed by the Global Fund.
- **Decentralisation of the response to sub national levels:** In 2009 NACS developed the policy– ‘Strengthening PNG’s Decentralised Response to HIV and AIDS. This was integrated into the NHS 2011-2015 (PA.3 System Strengthening) and has resulted in increased

capacity and system development at the regional, provincial and district level. An example is the increased engagement of local MPs in the District AIDS Committees in the last two years.

- **NACS Restructuring 2010-2011:** Throughout this period the National AIDS Council Secretariat (NACS) was implementing a significant restructuring project. This period of change inevitably resulted in an impact on capacity for NACS in coordinating the response in 2010 that reportedly began to re-establish through 2011.
- **NACS annual activity planning workshops:** NCPI respondents noted that the planning workshops were an effective mechanism to support partners in aligning their programmes with the NHS 2011-2015.

*“The previous strategy is not clear in terms of developing plans and activity at community based level, however, the new NHS has clear priorities and can easily be aligned with community based organizations activities and programs”. NCPI Respondent 33. Part A.I*

- **Funding of ART drugs by the government. (2010).** The PNG government undertook the procurement of ART drugs from mid 2010 and has continued to do so.

## **2011**

- **Political Leadership and protecting Human Rights of Key Affected Populations: 2011.** In mid 2011 the then Minister for Community Development, Dame Carol Kidu and the Chair of NAC proposed a review of the laws with the thought to decriminalising sodomy and prostitution. This is currently pending the Attorney General’s attention.
- **Improved practice in Treatment: 2011:** PNG has also adopted several aspects of international best practice including rapid HIV testing algorithms, the initiation of ART at CD4 < 350 and has adopted WHO guidelines for PPTCT (but not yet begun implementation) that will provide HAART to all HIV positive mothers until at least the end of breast feeding<sup>3</sup>.
- **The sixth review by the Independent Review Group on HIV and AIDS: May 2011.** This report provided a detailed review of PNG’s national response within the Priority Areas of the NHS 2011-2015, with specific focus on: the current context, progress against the NHS 2011-2015 objectives, key issues requiring attention and a list of priority

---

<sup>3</sup>

Independent Review Group on HIV/AIDS: Report from an assessment visit 28 April – 13 May 2011. Prepared by Peter Aggleton, Shalini Bharat, Alex Coutinho, Felecia Dobunaba, Roger Drew and Tobi Saidel

actions for the following 12 months. This GAR Report draws extensively on the IRG's 2011 report.

- **National Dialogue on HIV, Human Rights and the Law: June 2011.** CSOs and NACS worked in partnership in hosting the first national dialogue on HIV human rights and the law. There was a particular focus on the lack of enforcement of the HAMP Act and on other laws that criminalize those most vulnerable to HIV that obstruct the national response to HIV.
- **HIV Leadership Framework Launch: August 2011.** The framework targets politicians, traditional leaders, religious leaders, youth, women, civil societies, government department heads, including para-statal, heads of provincial administration, heads of district, ward councillors, media personnel, business leaders and HIV-positive people.
- **Access to ARV Treatment: 2011.** In the UNGASS 2008 the percentage of those on ARVs at the end of 2007 was 23%. In the UNGASS 2010 report for the end of 2008 was 66% of adults and children. The Value reported for the end of 2009 was 74.5%. So it is heartening to note the increase for eligible children and adults who are currently receiving antiretroviral therapy has continued with the Value reported, as at 31 December 2011, being 83.74%

It is also of value for assessing the national response to consider the GAR Indicator reporting 78.42% of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy. This percentage was 82.19% for 2009.

- **PPTCT scale up:** The GAR 2012 Value of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother-to-child transmission has increased to 28.19%. This is a significant increase on the Value for 2009 (11.1%) and an extraordinary scale up from that reported in 2008 (3.5%). While this is a good indicator for PNG's progress in doubling access to PPTCT over the last two years, however it is interesting to note the additional study data from CHAI Port Moresby clinic which has an even higher Value at 97.38% in 2011.
- **Monitoring and Evaluation: 2010 & 2011:** In the period of this GAR further steps have been taken to improve the PROMEST system and reporting at the regional level. This included the completion of the M&E framework recruitment and induction of 20 provincial M&E officers and 5 National officers.

## D. Indicator data in an overview table

The NHS 2011-2015 was developed with a conscious decision to map, where feasible, the NHS 2011-2015 indicators against the UNGASS indicators, as at 2010. As the GAR 2012 has maintained the majority of the UNGASS core indicators a number of the NHS 2011-2015 indicators are able to be included in this GAR 2012 report.

Thus this GAR 2012 PNG Country Progress Report is also of value to inform the PNG national, regional and provincial response to the HIV with 2012. This has added value as it utilises UNGASS 2008 and UNGASS 2010 reports as points of comparison for measuring progress both against the NHS and the GAR indicators.

On this basis this 2012 GAR Report indicator data presented in the overview table below includes the mapping of the NHS indicators, where feasible. The NHS 2011-2015 indicator in italics denotes a close but not exact match.

## GAR Indicators Overview

*Italics for NHS 2011-2015 Indicator denotes close but not exact match.*

GAR Targets	GAR Indicators		Value	PA	NHS 2011-2015 PNG Indicators from the NHS Monitoring and Evaluation Plan	Method of Data Collection
1.	<b>Reduce Sexual Transmission of HIV by 50 % by 2015</b>			<b>Priority Area 1 (PA.1). Prevention</b>		
General population	1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	22.6%	PA.1	<i>37. Percentage of women and men 15 - 59 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission</i>	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
	1.2	Percentage of young women and men who have had sexual intercourse before the age of 15	13.93%	PA.1	39. Percentage of young women and men who have had sexual intercourse before the age of 15	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
	1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	16.6%	PA.1	<i>3. Percentage of women and men aged 15–59 who have had sexual intercourse with more than one partner in the last 12 months.</i>	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator

						Cluster Survey or other representative survey)
	1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	4.8%	PA.1	4. <i>Percentage of men and women aged 15 to 59 who had more than one sexual partner in the past 12 months and who report the use of a condom during last intercourse</i>	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	30.1%	PA.2	12. <i>Percentage of women and men aged 15 to 59 who received an HIV test in the last 12 months and who know the results</i>	Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)
	1.6	Percentage of young women aged 15–24 who are living with HIV*	No Value	PA.1	22. <i>Percentage of women and men who are HIV infected.</i>	UNAIDS/WHO guidelines for HIV sentinel surveillance
Sex workers	1.7	Percentage of sex-workers reached with HIV prevention programmes	36.42%	PA.1	30. <i>Percentage of more-at-risk populations reached with HIV prevention programs</i>	Behavioural surveillance or other special surveys
	1.8	Percentage of female and male sex workers reporting the use of a condom with their most recent client	79.67%	PA.1	5. <i>Percentage of female and male sex workers reporting the use of a condom with their most recent client</i>	Special surveys for the numerator and denominator, including the Family Health

						International Behaviour Surveillance Survey for sex workers
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	46.37%	PA. 2	<i>13. Percentage of more-at-risk populations that have received an HIV test in the last 12 months and know the results. (PA.2)</i>	Behavioural surveillance or other special surveys.
	1.10	Percentage of sex workers who are living with HIV	17.79%	PA.1	<i>23. Percentage of more-at-risk populations who are HIV infected.</i>	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV. (WHO/UNAIDS, 2011).
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	66.56%	PA.1	<i>30. Percentage of more-at-risk populations reached with HIV prevention programs</i>	Behavioural Surveillance or other special surveys
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	70.2%	PA.1	7. Percentage of men reporting condom use the last time they had anal sex with a male partner	Special surveys including the Family Health International Behavioural Surveillance Survey for men who have sex with men
	1.13	Percentage of men who have sex with men that have received	55.81%	PA.2	<i>13. Percentage of more-at-risk populations that have received an</i>	Behavioural Surveillance or other



		an HIV test in the past 12 months and know their results			<i>HIV test in the last 12 months and know the results. (PA.2)</i>	special surveys
	1.14	Percentage of men who have sex with men who are living with HIV	No Value	PA.1	<i>23. Percentage of more-at-risk populations who are HIV infected</i>	UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/UNAIDS, 2011).
<b>2.</b>	<b>Reduce transmission of HIV among people who inject drugs by 50 % by 2015</b>			<b>Priority Area 1. (PA1). Prevention</b>		
	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	No Value			Programme data used to count the number of syringes distributed (numerator)
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	No Value			Special surveys including the Family Health International Behavioural Surveillance Survey for people who inject drugs
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they	No Value			Special surveys including the Family Health International Behavioural

		injected				Surveillance Survey for people who inject drugs
	2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	No Value			Behavioural surveillance or other special surveys
	2.5	Percentage of people who inject drugs who are living with HIV	No Value			UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/UNAIDS, 2011)
<b>3.</b>	<b>Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths<sup>4</sup></b>		<b>Priority Area 1. (PA.1). Prevention Priority Area 2. (PA.2). Counselling, testing, treatment, care and support</b>			
	3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	12.3%	PA.1	9. Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission.	For the numerator: national programme records aggregated from programme monitoring tools, such as patient registers and

<sup>4</sup>The *Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping their Mothers Alive* defines this target as:

1. Reduce the number of new HIV infections among children by 90%

2. Reduce the number of AIDS-related maternal deaths by 50%

For further information see [http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609\\_JC2137\\_Global-Plan-Elimination-HIV-Children\\_en.pdf](http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf)

						summary reporting forms
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	22.06%	PA.2	33. Percentage of infants born to HIV infected women who are started on cotrimoxazole prophylaxis within two months of birth	Early Infant Diagnosis (EID) testing laboratories for the numerator, and Spectrum estimates, central statistical offices, and/or sentinel surveillance for the denominator
	3.3	Mother-to-child transmission of HIV (modelled)	35.4%			The mother-to-child transmission probability differs with the antiretroviral drug regimen received and infant-feeding practices. The transmission can be calculated by using the Spectrum model.
4.	<b>Have 15 million people living with HIV on antiretroviral treatment by 2015</b>			<b>Priority Area 2. (PA.2). Counselling, testing, treatment, care and support</b>		
	4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy*	61.2%	PA.2	16. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Programme monitoring and HIV surveillance For the numerator: facility-based antiretroviral therapy

						registers or drug supply management systems. For the denominator: HIV estimation models such as Spectrum
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	78.42%	PA.2	18. Percentage of adults and children with HIV known to be on treatment at 12/24/36/48 months after initiation of antiretroviral therapy	Programme monitoring tools; cohort/group analysis forms
<b>5.</b>	<b>Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015</b>			<b>Priority Area 2. (PA.2). Counselling, testing, treatment, care and support</b>		
	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	25.06%	PA.2	17. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Facility antiretroviral therapy registers and reports; programme monitoring tools
<b>6.</b>	<b>Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-income countries</b>			<b>Priority Area 3 (PA.3). System Strengthening</b>		
	6.1	Domestic and international AIDS spending by categories and financing sources	NASA	PA.3	24. Domestic and international AIDS spending by categories and financing sources	Primary tool/method: 1) National AIDS Spending Assessment (NASA)
<b>7.</b>	<b>Critical Enablers and Synergies with Development Sectors</b>			<b>Priority Area 3. (PA.3). System Strengthening</b>		
	7.1	National Commitments and	NCPI -	PA.3	25. National Composite Policy Index	See Annex 1.

		Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	See Annex 1.		(NCPI) (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and M&E)	
	7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	No Value			Population based surveys that are already being used within countries, such as WHO Multi-country surveys, DHS/AIS (domestic violence module), <sup>5</sup> , International Violence Against Women Surveys (IVAWS).
	7.3	Current school attendance among orphans and non-orphans aged 10–14*	No Value			Population-based survey (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative survey)

<sup>5</sup> The questions asked in the DHS module on domestic violence and the WHO multi-country study on domestic violence and women's health are slightly different. However, the estimates produced from either methodology are comparable.

		7.4	Proportion of the poorest households who received external economic support in the last 3 months	No Value		Population-based surveys such as Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other nationally representative survey
--	--	-----	--	----------	--	--

*\* Millennium Development Goals indicator*

*\*\* Individual indicators may be used to track more than one goal*

## Overview of the HIV Epidemic in Papua New Guinea

Many of the realities about the HIV epidemic in PNG we thought we knew have changed in the past three years. When PNG was declared as having a “generalised HIV epidemic” in 2004 based on trend data from Port Moresby General Hospital testing data coming from pregnant women, there was almost a consensus among stakeholders inside and outside the country that the epidemic would follow a similar pattern as had been earlier seen in many countries in East, Central, and South Africa. In 2006, an Australian Government-commissioned modelling exercise by the New South Global Pty Limited, known as the HIV Epidemiological Modelling and Impact (HEMI) Study, projected that by 2025 there would be a generalised epidemic with over 500,000 people living with HIV and a prevalence figure of over ten per cent among adults population in PNG<sup>6</sup>. Based on those projections, it had been estimated that in 2010 there would have been around 120,000 people living with HIV in PNG.

Other studies and projections also followed a similar path. The National AIDS Council and the National Department of Health estimated a prevalence figure of 1.28 per cent in the adult (15-49) population for 2006, and had projected an increase to 4.05% by 2011, with the number of people living HIV projected to increase from 46,275 in 2006 to 163,245 by 2011<sup>7</sup>.

In the past six years the number of sites providing prevention of parent to child transmission of HIV (PPTCT) services to pregnant women through provider-initiated testing and counselling has considerably increased from 17 sites in 2005 to 177 in 2009 and 203 sites in 2010<sup>8</sup>. Figure 1 illustrates this notable increase in the availability of data on HIV prevalence in pregnant women in both urban and rural areas over the past ten years.

---

<sup>6</sup> - HIV Epidemiological Modelling and Impact (HEMI) Study Team. Impacts of HIV/AIDS 2005–2025 in Papua New Guinea, Indonesia and East Timor. 2006, Australian Government, AusAID.

<sup>7</sup> - National AIDS Council and National Department of Health. The 2007 Estimation Report on the HIV Epidemic in Papua New Guinea. 2007. Papua New Guinea Government.

<sup>8</sup> - National Department of Health. The 2010 STI, HIV and AIDS Annual Surveillance Report. 2011. National Department of Health, PNG.

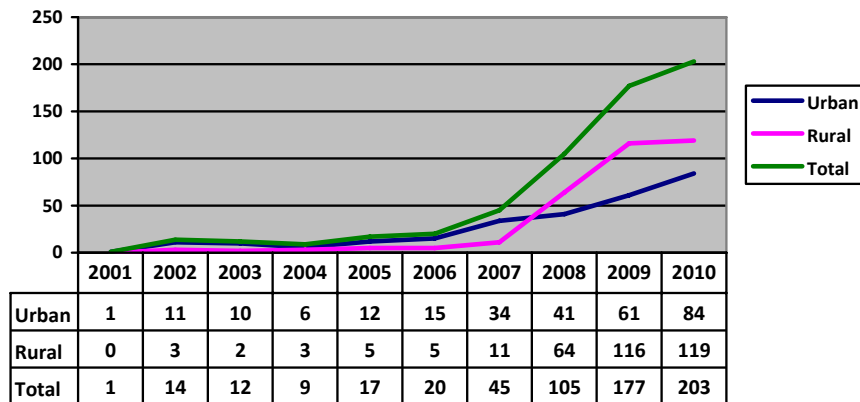


Figure 1 - Number of antenatal care sites providing HIV testing among pregnant women across PNG

Following these changes in data sources, our understanding of the HIV epidemic in PNG has changed as well. In the estimation and projection exercise conducted in 2010, data was used from 109 sites which had reported testing at least 50 pregnant women in one year. These sites were distributed across the four regions of PNG, with the Highlands region having the highest number with 46 sites, followed by the Southern region (24), the New Guinea Islands (24) region, and the MOMASE region (15 sites). In that estimation and projection exercise, the HIV prevalence among the adult population aged 15 to 49 years was estimated to be 0.9 per cent in 2009, with an estimated 34,100 people living with HIV in PNG (adult and children) by the end of 2009. For the first time, in the 2009 estimation exercise, four different HIV trend estimations were provided for each region, with the Southern and Highlands regions having the two highest prevalence figures, although these were levelling-off, and MOMASE and New Guinea Islands regions having lower prevalence, albeit these were increasing<sup>9-10</sup>.

In 2011, another round of HIV estimation and projection exercises was conducted using the UNAIDS Reference Group on Estimates, Modelling and Projection new integrated Spectrum and EPP software. The data that was used previously for the 2010 estimation exercise, covering surveillance data up to the end of 2009 and data from the 2010 annual surveillance report were the data sources of this exercise. These included: 1) HIV testing and prevalence figures from the ANC clinics or other facilities which were providing or had provided testing services to pregnant women as part of a PPTCT programme and tested at least 50 pregnant women in one single year; 2) population data for the four regions based on the PNG National Statistics Office (NSO) projections, and the original data go back to 2000 census; 3) anti-retroviral therapy (ART) figures, first and second line, as the number of adults and children receiving ART annually, from the start of ART

<sup>9</sup> - National AIDS Council and National Department of Health. Papua New Guinea HIV Prevalence: 2009 Estimates. 2010. Papua New Guinea Government.

<sup>10</sup> - National AIDS Council. Papua New Guinea National HIV and AIDS Strategy 2011-2015. 2010. Papua New Guinea National AIDS Council Secretariat.



programme up to 2010; and 4) figures on the number of pregnant women receiving anti-retroviral drugs (ARVs) either as part of a PPTCT programme or for their own health, disaggregated by drug regimen used. As there was no data available on breastfeeding practices, this section was left blank and other parameters were kept unchanged from the program defaults.

Based on the model from this exercise approved by the surveillance technical working group (STWG), the prevalence of HIV nation-wide among the adult population 15- to 49 years is estimated to be 0.8 per cent in 2010 and 2011. The national as well as regional prevalence projections are presented in figure 2.

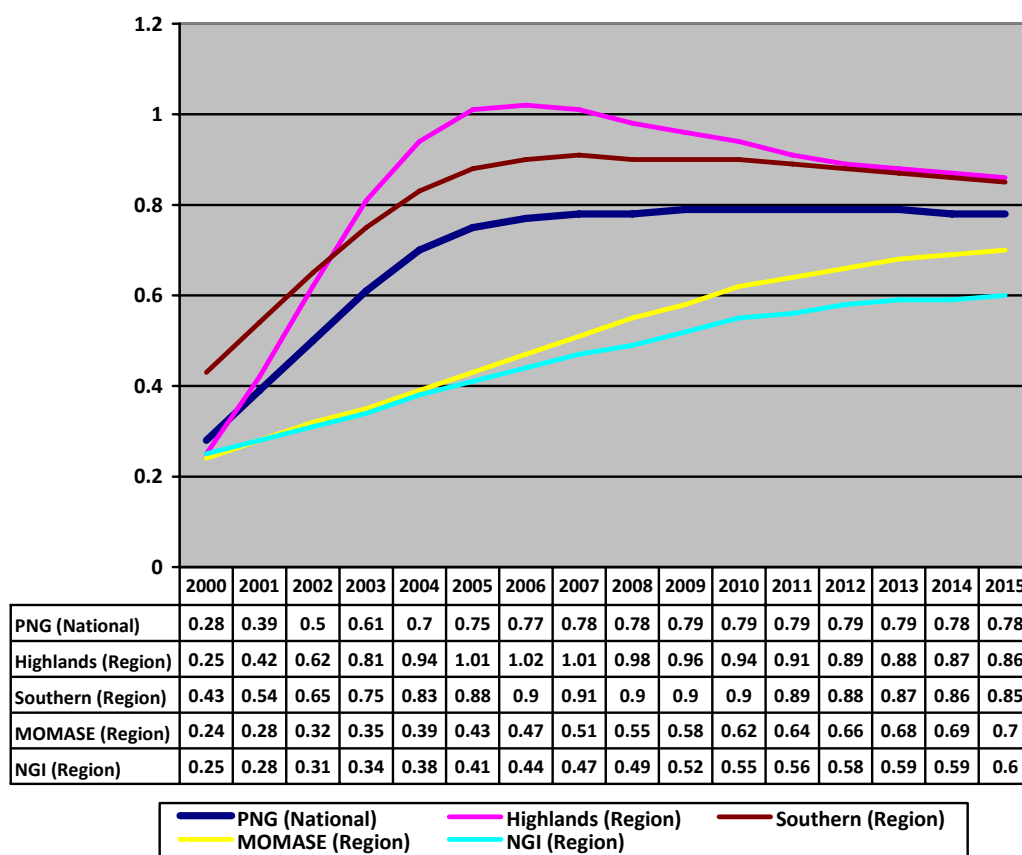


Figure 2 - Trends and projection of HIV prevalence (per cent) in 15 - 49 years old adults across PNG and the four regions from year 2000 to 2015

This national prevalence figure translates to an estimated median number of 31,421 (27,385 – 36,312) adults and children living with HIV in PNG in 2010. The median total number of adults aged 15 and more was estimated to be 27,430 (23,884 – 31,741) and children less than 15 years were estimated to be 3,991 (3,215 – 4,963). The range in parenthesis reflects the range between the lower and upper 2.5 per cent uncertainty interval. Figures 3 and 4 depict the projected number of adults and children living with HIV in PNG,

respectively.

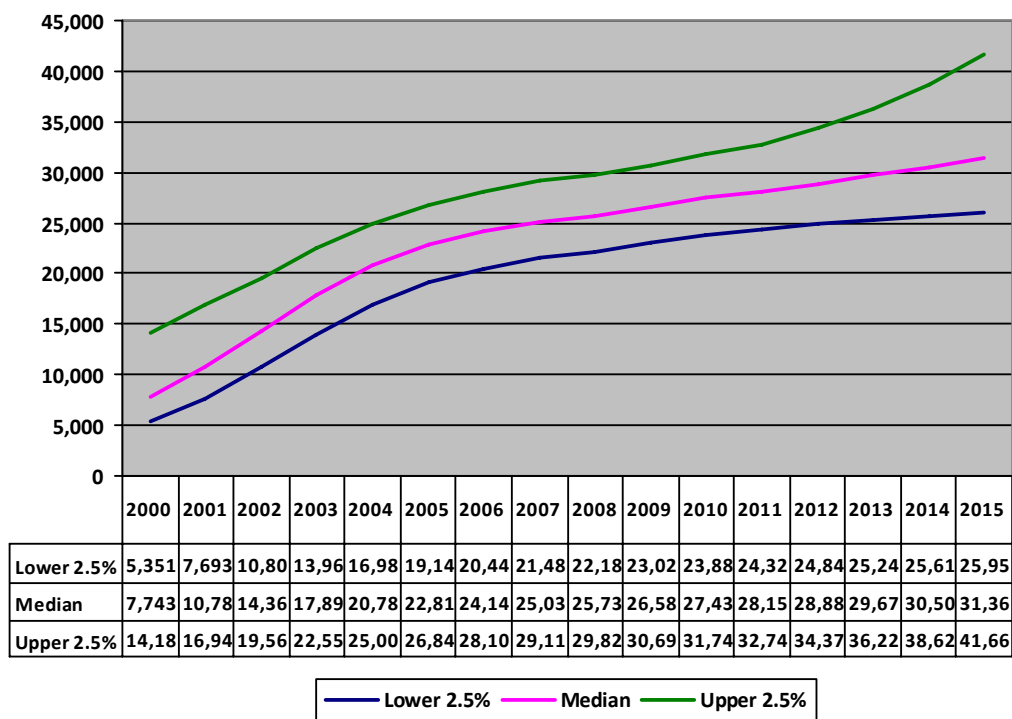


Figure 3 - Estimated number of adults (15 and more) living with HIV in PNG

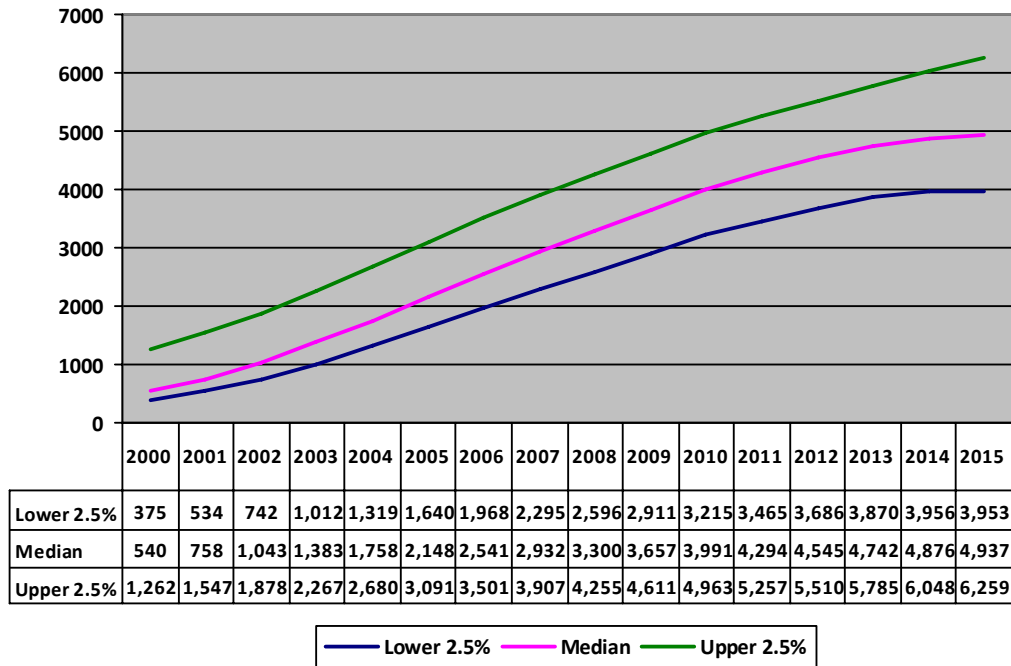


Figure 4 - Estimated number of children (less than 15) living with HIV in PNG

Other modelling techniques, using other models and assumptions and conducted by other stakeholders have also corroborated the significant downward adjustment in the initially over-estimated prevalence figures for PNG. The recently published model jointly developed by the PNG Institute of Medical Research (PNGIMR) and the Kirby Institute for Infection and Immunity in Society – University of New South Wales estimated an adult HIV prevalence of 0.85 per cent in 2010, slightly increasing to 1.0% by 2020, if all the model parameters stayed the same as they were in 2010<sup>11</sup>. This model basically incorporates parameters like the demographic characteristics of different population groups, their sexual behaviours, HIV diagnosis and treatment, and different prevention interventions. , details of the model can be read in the publications<sup>11</sup>.

The changes are not limited to the mere estimated prevalence figures, there are pieces of biological evidence available pointing toward a more “concentrated” type HIV epidemic, one which is linked to key populations at higher risks, like male and female sex workers, and their clients and potentially men who have sex with men. One bio-behavioural study among people who had sold or exchanged sex in Port Moresby with a sample size of 416 using a respondent driven sampling (RDS) method conducted in June

<sup>11</sup> - Gray, R.T., Murray, J.M., Wilson, D.P., Vallely, A., Kaldor, J. The PNG HIV Model - Summary and Results: Explaining the past, describing the present, and forecasting the future of the HIV epidemic in PNG. 2010. The Kirby Institute, The University of New South Wales, Sydney, Australia.

and July 2010 found an alarmingly high prevalence of 17.8 per cent<sup>12</sup>. The prevalence was 19 per cent among female sex workers, 15 times more than the prevalence among pregnant women tested through the PPTCT in the National Capital District. There are no biological data available from other parts of the country and there are also some limitations in the sampling and estimation of the HIV prevalence in this study; however there are clear behavioural indications about transactional and commercial sex outside the NCD and in many other cities and towns, as well as in and around economic enclaves.

Beside biological data, there is a relatively large amount of behavioural information related to risk and vulnerability across some populations, communities, and groups in PNG. In the study mentioned earlier conducted among sex workers in Port Moresby using RDS methods, it was found that vaginal sex with clients, i.e. paying sexual partners, is the most frequent type of sexual service provided by female sex workers; where 93% of female sex workers reported having vaginal intercourse and 46% reported having anal sex with a male client in the past six months. Interestingly, while 71% of male sex workers reported having anal sex with another male client in the last six months, 69% of male sex workers reported also having vaginal sex with a female client and 57% also had anal sex with a female client. Of transgender sex workers, 84% had anal sex with a male client, and 32% had vaginal sex and 30% had anal sex with their female clients. In another study among female sex workers in Port Moresby, conducted in November and December 2010 using an RDS methodology, 57% of female sex workers reported having anal sex with a male client in the previous month. Moreover, 18% of female sex workers reported paying men for sex in the same period, and 20% of them reported paying for anal sex with a male partner<sup>13</sup>. Among men who have sex with men, 79% had bought sex from men and 60% had sold sex to men in the previous month. In the same period, 71% of men who have sex with men had sex with a female partner, 59% of the total reported anal sex with a woman, 46% had sold sex to women and 37% had paid sex workers for sex<sup>13</sup>. Condom use in both studies were not high, with the Kelly et al reporting 27% to 44% consistent condom use in transactional vaginal sex, lowest among male and highest among transgender sex workers, and 38% among female sex workers. Consistent condom use was even lower in heterosexual transactional anal sex, from 20% among male sex workers to 24% among transgender and 34% among female sex workers. The highest proportion of consistent condom use was seen in male to male transactional anal sex, 42% in male and 51% in transgender sex workers<sup>12</sup>. In the FHI study, consistent condom use among men who have sex with men was in the range between 12% with female paying partners to 20% with male paying partners. In female

---

<sup>12</sup> - Kelly, A., Kupul, M., Man, W.Y.N., Nosi, S., Lote, N., Rawstorne, P., Halim, G., Ryan, C. & Worth, H. (2011) Askim na save (Ask and understand): People who sell and/or exchange sex in Port Moresby. Key Quantitative Findings. Papua New Guinea Institute of Medical Research and the University of New South Wales: Sydney, Australia.

<sup>13</sup> - United States Agency for International Development (USAID) and Family Health International (FHI). Behaviors, knowledge, and exposure to interventions. Report from a behavioral surveillance survey. Port Moresby, Papua New Guinea. USAID and FHI, May 2011, Port Moresby, Papua New Guinea.

sex workers, the figures range from seven per cent in sex with paid male partners to 30% with regular male clients<sup>13</sup>.

Other behavioural studies among other more at risk populations and communities have also reported transactional sex as a relatively common type of sexual practice. In one study among male and female workers at Oil Search Limited (OSL) conducted across seven sites in the Southern Highlands and Gulf provinces from October 2008 to January 2009, around 23.7% of male workers reported paying money or giving something to a woman to have sex with her in the previous year<sup>14</sup>. Around 10% of male workers had also received money or gifts for sex, although it was not clear if they had had exchanged sex with male or female partners.

In another study among male and female plantation workers in the WR Carpenters' Estates in the Western Highlands province conducted in 2008, around 24.2% of males have reported paying money or giving something for sex and six per cent of female workers reported receiving, money or gifts, for sex in the past year. Around 21% of men also reported ever receiving something in exchange of sex, and around seven per cent of female workers also reported being paid for having sex, although it is not clear if they had been paid by men or women<sup>15</sup>.

Data from routine HIV case reporting in 2009 and 2010 show an increase in the number of people diagnosed with HIV. In 2009, 3711 new HIV diagnoses were made, of which 2280 were female and 1383 were male. This figure increased to 4208 in 2010, with 2566 female and 1568 male<sup>16</sup>. Figure 5 shows the trend in the number of new HIV diagnoses disaggregated by sex. As can be seen, since 2002 the number of diagnoses among females has consistently surpassed males. However, it is not possible to conclude if it is a reflection of the actual epidemic or it is merely a reflection of more women being tested, mostly through PPTCT programme at ANC facilities. Even in voluntary counselling and testing centres, slightly more female clients (27,539) have been tested than male clients (26424) in 2010. It is worth noting that more female (3.8%) than male clients (2.9%) have been diagnosed with HIV in VCT sites. In STI clinics again more female clients were tested, 7,368 vs. 4,387 and more women were HIV positive compared to men, 3.5% vs. 2.5%. In TB clinics, however, a few more men had been tested (1744) than women (1606), but still more women (6.4%) had been found HIV positive than men (5.3%). Considering all sources of information, it sounds logical to conclude that prevalence is higher among women compared to men, but not

---

<sup>14</sup> - Buchanan H, Akunai F, Kupe F, Amos A, Sapak K, Be F, Kawage T, Frank R, Couch M. Behavioural surveillance research in rural development enclaves in Papua New Guinea: A study with the Oil Search Limited workforce. National Research Institute, 2011. Port Moresby, Papua New Guinea.

<sup>15</sup> - Buchanan H, Akuani F, Kupe F, Kawage T, Sapak K, Amos A, Naemon A, Couch M. Behavioural surveillance research in rural development enclaves in Papua New Guinea: A study with the WR Carpenters workforce. National Research Institute, 2010. Port Moresby, Papua New Guinea.

<sup>16</sup> - National Department of Health. The 2010 STI, HIV and AIDS Annual Surveillance Report. National Department of Health, STI, HIV and AIDS Surveillance Unit, January 2012, Port Moresby, Papua New Guinea.

as the level indicated by differences in the number of diagnoses.

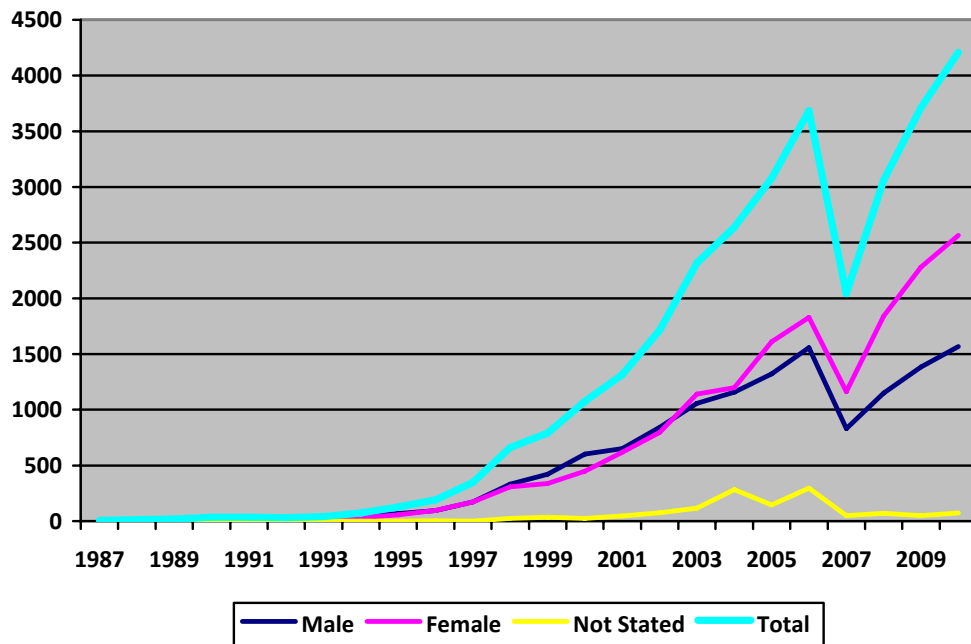


Figure 5 - Total number of new HIV cases diagnosed each year by sex

The age at the time of diagnosis has not been the same for female and male clients. While the majority of female clients were diagnosed between 15 and 34 years in 2010, for male clients the majority were between 25 and 44 years. Figures 6 and 7 show the trend in the age distribution in female and male clients diagnosed with HIV, respectively.

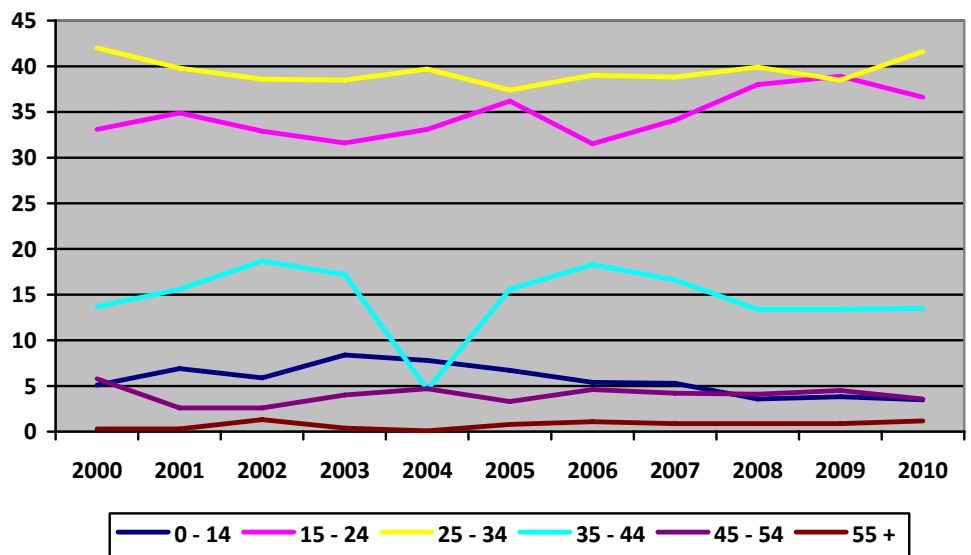


Figure 6 - Trend in relative distribution of age at the time of HIV diagnosis among females

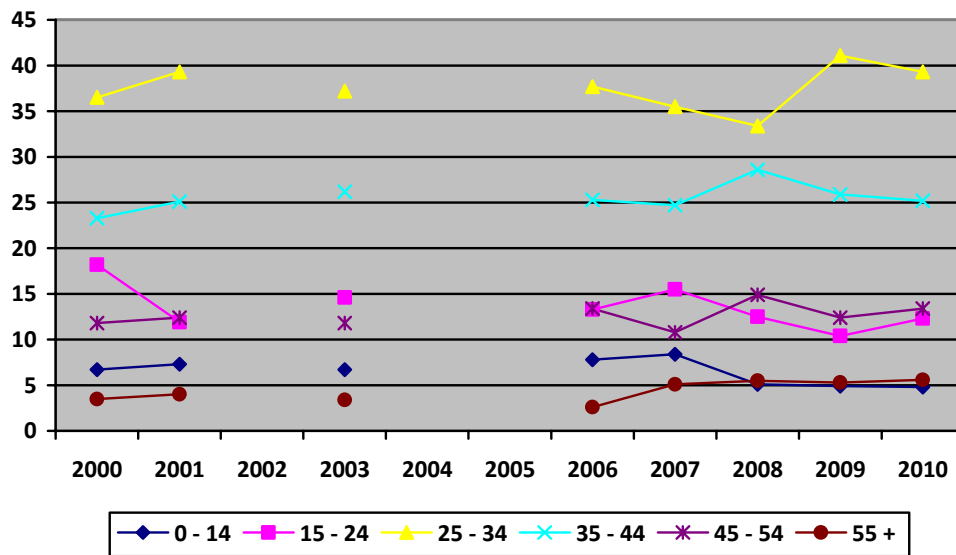


Figure 7 - Trend in relative distribution of age at the time of HIV diagnosis among males

The only meaningful trend one can see in the age groups might be a relative increase among 15 – 24 years old female youth; however, it still can be explained by expansion of testing into more ANC facilities, were more women at this age group tend to attend compare to other age groups.

As a conclusion, from available biological and behavioural data, we know that HIV is still a significant problem in PNG, even though HIV prevalence has not ever reached to the very high levels forecasted previously. It is not always easy to put an HIV epidemic into pre-defined boxes of either a “concentrated” or “generalised” epidemic. This statement stands clearly for PNG where the available evidence indicates that HIV prevalence might be several times higher among key populations at higher risk but it is also not very low among pregnant women.

Behavioural research also indicates that sexual practices across PNG vary a lot and it is not also feasible, or even desirable, to put people into small boxes like “sex workers” or “men who have sex with men”. Evidence indicates that men and women exchange sex with other men and women, and men have sex with men without identifying themselves as any specific population, while condom use during heterosexual anal sex which is commonly practiced and carries the same higher biological risk of HIV transmission as homosexual anal sex, is even less than condom use during homosexual anal sex.

One final consideration is that in almost all biological data available through the routine surveillance system, there is a high discrepancy between people testing “reactive” with the initial rapid test and those “confirmed positive” with the laboratory test. This discrepancy in some provinces has been as high as three times more “reactive” than “confirmed”, and these can not merely be

explained by the expected low positive predictive value of the screening test in relatively low prevalence settings. This area of test discrepancies certainly requires further assessment to understand the possible reasons for these differences.



### III.a. GAR Indicators 1 – 7

## *Target 1. Halve sexual transmission of HIV by 2015*

#### **General Population**

- 1.1 Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission\*
- 1.2 Percentage of young women and men who have had sexual intercourse before the age of 15
- 1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months
- 1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse\*
- 1.5 Percentage of women and men aged 15–49 who received an HIV test in the past 12 months and know their results
- 1.6 Percentage of women aged 15–24 who are living with HIV\*

#### **Sex Workers**

- 1.7 Percentage of sex-workers reached with HIV prevention programmes
- 1.8 Percentage of female and male sex workers reporting the use of a condom with their most recent client
- 1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results

1.10 Percentage of sex workers who are living with HIV

***Men who have Sex with Men***

1.11 Percentage of MSM reached with HIV prevention programmes

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

1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results

1.14 Percentage of men who have sex with men who are living with HIV

*\*Millennium Development Goals indicator*

## 1.1 Young People: Knowledge about HIV Prevention

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

### What it Measures

It measures progress towards universal knowledge of the essential facts about HIV transmission

### Rationale

HIV epidemics are perpetuated through primarily sexual transmission of infection to successive generations of young people. Sound knowledge about HIV and AIDS is an essential pre-requisite—albeit, often an insufficient condition—for adoption of behaviours that reduce the risk of HIV transmission.

**NHS 2011-2015. Priority Area 1: Prevention. Strategic Objective 1.1.1 & 2.2.1**

**Indicator No.37:** *Percentage of women and men 15 - 59 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*

**Purpose** To assess progress towards universal knowledge of the essential facts about HIV transmission.

### Method of Measurement:

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

**Denominator:** Number of "young people" respondents aged 15-24 years who have been asked the following three questions:

1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing food with someone who is infected?

**Numerator:** Number of respondents who have answered correctly to all five questions.

### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant but population-based survey and data is not available. Also submitting other data.

### Value of indicator:

In this study 22.6% of female and male youth aged from 15 to 24 years old-

correctly answered all 5 questions.

**Data Measurement Tool:**

Behavioural Surveillance Survey conducted by National Research Institute (NRI)

**From Date:** 29 June 2009

**To Date:** 29 July 2009

This Behavioural Surveillance Survey targeting higher risk young people in the Vanimo Green District of Sandaun Province (West Sepik) was the first round of BSS research collected by the National Research Institute with this more hidden population. These higher risk young people were recruited from the 29<sup>th</sup> of June to the 29<sup>th</sup> of July 2009 through the use of Respondent Driven Sampling (RDS) for a total sample size of 380 youth (237 male and 143 female youth). Young people were recruited with the criteria that they were between the ages of 15 and 29, who lived in Vanimo Green, were sexually active and who had had sex with more than one partner.

**Sample Size:** Number of survey respondents: 323

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

Male		
Age disaggregation		Total
15-19	20-24	
<b>Number of young men who gave the correct answer to all five questions</b>		
27	22	49
<b>Number of young men interviewed</b>		
118	88	206
<b>Percentage of young men having comprehensive knowledge about HIV prevention</b>		
22.9%	25.0%	23.8%

Female		
Age disaggregation		Total
15-19	20-24	
<b>Number of young women who gave the correct answer to all five questions</b>		
14	10	24
<b>Number of young women interviewed</b>		
79	38	117
<b>Percentage of young women having comprehensive knowledge on HIV prevention</b>		
17.7%	26.3%	20.5%

**Values from other Studies:**

1.  
In this additional study, 20% of young male truck drivers aged 15 to 24 correctly answered all 5 questions.

**Data Measurement Tool:**

Behavioural Surveillance Survey conducted by National Research Institute (NRI) PNG

**From Date:** 29 March 2010

**To Date:** 01 December 2010

This indicator when disaggregated 15-24 years, is less helpful to understand the comprehensive knowledge of truck drivers overall, as this was an older population group primarily with a mean age of 40.1 years old and over a third (35.0%) was over the age of 45. Also, of those interviewed 42 drivers (16.3%) did not know their age creating some limitation to age based indicators.

Of all drivers, of all ages and who knew their age or not, 36.6% had comprehensive knowledge about HIV and both correctly identified ways of preventing the sexual transmission of HIV and rejected misconceptions about HIV transmission through mosquito bites and sharing food.

This Behavioural Surveillance Survey among Highway Truck Drivers was the second round of BSS with this population. The first BSS survey with truck drivers was collected in 2006 by the National AIDS Council Secretariat and the second in 2010 by the National Research Institute. The catch all sampling was based on employee lists and daily rosters from eight trucking companies from across sixteen sites in the cities of Mt. Hagen and Lae, and the town of Goroka. All drivers available were targeted for interviewing and were recruited from trucking company sites during the time of collection, who had not been interviewed at another location. From 61.4% to 81.8% of drivers from each participating company were interviewed for a sample of 257 highway truck drivers. Data collection took 27 days and began in Mt Hagen from the 29<sup>th</sup> March to the 8<sup>th</sup> of April, 2010, continued in Lae from the 11<sup>th</sup> to the 20<sup>th</sup> of August and in Goroka from the 27<sup>th</sup> November to the 1<sup>st</sup> of December, 2010.

The Highlands Highway or the Lae–Okuk Highway is around 700 kilometres long, runs through 6 provinces connecting coastal areas and the Highlands, running from Lae in Morobe to Kopyago in the Southern Highlands Province. There were over 800 different routes and destinations identified for the truck drivers, but the most frequent routes travelled were between Lae and Mt. Hagen, between Goroka and Mt. Hagen and between Mt. Hagen and Porgera, and they travelled through areas of known higher prevalence of HIV.

The 2010 BSS data shows that the comprehensive knowledge of truck driver's increased by 21.5%, from 15.1% in 2006 to 36.6% in 2010; but there are still a very low proportion of truckers who had more comprehensive understanding of HIV transmission and prevention.

There was an increased belief by truck drivers that HIV could be transmitted by mosquito bites, with an increase of 17.4 percentage points from 2006 to 2010. There was a positive decrease of 36.9 percentage points in drivers that thought that HIV could be transmitted through sharing a meal. There was also a considerable decrease of 72.5 percentage points in drivers who believed that a healthy looking person could not have HIV between 2006 and 2010 and this is very positive and only 5.1% said that a healthy looking person could not have HIV in 2010.

Importantly, there were statistically significant relationships between the knowledge of HIV transmission from a mother to her unborn child, during pregnancy ( $p < 0.014$ ), during delivery ( $p < 0.000$ ) and breast feeding ( $p < 0.012$ ) for truck drivers, and their attitude that people living with HIV should have children. This indicates that knowledge of mother to child transmission was significantly related to more positive attitudes about the rights of HIV positive women to have children.

**Sample Size:** Number of survey respondents: 15

**The percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**

Age disaggregation		Total
15-19	20-24	
<b>Number of young Truck drivers who gave the correct answers to all five questions</b>		
1	2	3
<b>Number of young Truck drivers interviewed</b>		
2	13	15
<b>Percentage of young Truck drivers having comprehensive correct knowledge</b>		
50.0%	15.4%	20.0%

**2.**

In this additional study, 27.1% of younger Ramu Agri Industry plantation workers young aged between 15 to 24 correctly answered all 5 questions.

Fewer of the younger female workers (15.4%) than younger male workers (29.2%) young females aged 15-24 aged, correctly answered all 5 questions.

**Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 25 July 2010

**To Date:** 11 August 2010

It must be noted that 31.1% of male and female RAI plantation workforce did not know their age and this causes great limitations to age based indicators. Of 598 RAI plantation workers, whether they knew their age or not, 31.9% had comprehensive knowledge of HIV.

This Behavioural Surveillance Survey among the Ramu Agri Industry (RAI) workforce, was the second round of BSS with this population; however there have been major changes in the composition of the workforce between the first BSS data collection by the National AIDS Council Secretariat in 2006 with Ramu Sugar Factory workers and the 2<sup>nd</sup> BSS data collection with Ramu Agri Industries workers in 2010 by the National Research Institute. Ramu Sugar had expanded to Ramu Agri Industries by 2010 and the rapidly expanding oil palm and the beef plantations workers were also included for sampling with the sugar plantation workforce in 2010 because of the movement of people into the plantations and the changing nature of the workforce that was projected to continue to increase.

The random sampling with the workforce was based on employee lists and proportional and stratified to three types of work (sugar, beef and oil palm) across six sites. All workers selected were targeted for interviewing and were recruited from the sites during the day during the time of collection, for a sample of 602 RAI workers (494M and 108F). Data collection took eighteen days and began on the 25<sup>th</sup> of July and was completed on the 11<sup>th</sup> of August, 2010.

**Sample Size:** Number of survey respondents: 85

**The percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission**

Number of young RAI workers who gave the correct answers to all five questions								
Male			Female			Male &Female		
15-19	20-24	Total	15-19	20-24	Total	15-19	20-24	Total
3	18	21	0	2	2	3	20	23
Number of young RAI workers interviewed								
Male			Female			Male &Female		
15-19	20-24	Total	15-19	20-24	Total	15-19	20-24	Total
14	58	72	3	10	13	17	68	85
Percentage of young RAI workers who gave the correct answers to all five questions								
Male			Female			Male &Female		
15-19	20-24	Total	15-19	20-24	Total	15-19	20-24	Total
21.4%	31.0%	29.2%	0.0%	20.0%	15.4%	17.60%	29.4%	27.1%

### 3.

In this additional study, 23.7% of younger women who were exchanging sex in Mt Hagen, and who knew their age and were between 15 and 24 years, correctly answered all 5 questions.

#### **Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 29 March 2010

**To Date:** 08 April 2010

It must be noted that 42.6% of women exchanging sex in Mt. Hagen did not know their age and this causes great limitations to all age based indicators.

Of all 242 women interviewed, of all ages and whether they knew their age or not, 24.0% had comprehensive knowledge of HIV.

This Behavioural Surveillance Survey targeting women exchanging sex in Mt. Hagen was the first round of BSS research collected by the National Research Institute with this more hidden population. These women were recruited from the 29<sup>th</sup> of March to the 8<sup>th</sup> of April, 2010 through the use of Respondent Driven Sampling (RDS) for a total sample size of 242 women who exchanged sex and who lived in different parts of Mt. Hagen and the Western Highlands.

**Sample Size:** Number of survey respondents: 76

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

Number of young women exchanging sex who gave the correct answers to all five questions		
Female		
15-19	20-24	Total
5	13	18
Number of young women exchanging sex interviewed		
Female		
15-19	20-24	Total
32	44	76
Percentage of young women exchanging sex who gave the correct answers to all five questions		
Female		
15-19	20-24	Total
15.6%	29.5%	23.7%

**4.**

In the following four values the data was sourced from base line study for the Male Circumcision Acceptance Study undertaken by James Cook University (JCU) and the Pacific Adventist University between 10 June 2010 to 28 February 2011. Four of the five Indicator questions were asked and changes were made to the wording.

**Number of "young people" (aged 15 -24) who have been asked the following three questions:**  
 1: If condoms are used correctly during sex do they help protect people from getting HIV?  
 2: Can someone who looks healthy have HIV?  
 3: Can a person get HIV from mosquito bites?  
 4: Can a person get HIV by sharing food with someone who has HIV?

**4.a.**

In this additional study of Divine Word University students aged 15-24 in Madang where 4 of the 5 questions were asked 72.49% provided correct answers.

74.44% of females and 71.22% of males responded correctly to the 4 questions.

**Data Measurement Tool:**

Cross Sectional Survey by James Cook University (JCU) and Pacific Adventist University

**From Date:** 1 September 2010      **To Date:** 30 September 2010

**Sample Size:** Number of survey respondents: 229

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total



11	128	139	12	78	90	23	206	229
----	-----	-----	----	----	----	----	-----	-----

Number of people who have answered correctly all four questions

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
8	91	99	8	59	67	16	150	166

Indicator Value

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
72.73%	71.09%	71.22%	66.67%	75.64%	74.44%	69.57%	72.82%	72.49%

#### 4.b

In this additional study of University students aged 15-24 in at the Pacific Adventist University in Port Moresby where 4 of the 5 questions were asked, 53.31% provided correct answers.

60.55% of females and 47.37% of males responded correctly to the 4 questions.

#### Data Measurement Tool:

Cross Sectional Survey by James Cook University (JCU) and Pacific Adventist University

**From Date:** 1 September 2010      **To Date:** 30 September 2010

**Sample Size:** Number of survey respondents: 242

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
23	110	133	25	84	109	48	194	242

Number of people who have answered correctly to all four questions

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
13	49	63	17	49	66	30	98	129

Indicator Value

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
56.52%	44.55%	47.37%	68.00%	58.33%	60.55%	62.50%	50.52%	53.31%

#### 4.c

In this additional study of with Oil Palm workers aged 15-24 near Popondetta where 4 of the 5 questions were asked, 20.62% provided correct answers.

38.10% of females and 15.79% of males responded correctly to the 4 questions.

#### Data Measurement Tool:

Cross Sectional Survey by James Cook University (JCU) and Pacific Adventist University

**From Date:** 1 February 2011 **To Date:** 28 February 2011

**Sample Size:** Number of survey respondents: 97

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
31	45	76	4	17	21	35	62	97

Number of people who have answered "YES" to all five questions

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
4	8	12	1	7	8	5	15	20

Indicator Value

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
12.90%	17.78%	15.79%	25.00%	41.18%	38.10%	14.29%	24.19%	20.62%

#### 4.d

In this additional study of with mining workers aged 15-24 at Porgera where 4 of the 5 questions were asked, 36.36% provided correct answers.

50.00% of females and 27.27% of males responded correctly to the 4 questions.

#### Data Measurement Tool:

Cross Sectional Survey by James Cook University (JCU) and Pacific

Adventist University

**Date:** From: 1 November 2010 To: 30 November 2010

**Sample Size:** Number of survey respondents: 55

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
7	26	33	3	19	22	10	45	55

Number of people who have answered "YES" to all five questions

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
2	7	9	0	11	11	2	18	20

Indicator Value

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
28.57%	26.92%	27.27%	0.00%	57.89%	50.00%	20.00%	40.00%	36.36%

5.

In this study, 22.26% of female and male sex workers in Port Moresby, both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission.

19.50% female sex workers answered correctly and 30.26% of the male sex workers.

**Data Measurement Tool:**

Bio-Behavioural Surveillance Survey conducted by IMR

**From Date:** 10 June 2010

**To Date:** 17 July 2010

This is a comprehensive bio-behavioural study of sex work in Port Moresby in Papua New Guinea. The study was designed to fill gaps in knowledge about the sex industry in PNG and to map the sale and exchange of sex in Port Moresby to create a richer and more detailed understanding of sex workers and their vulnerability to HIV and was undertaken in between June and July 2010. This study provides the Government of Papua New Guinea and other interested stakeholders with the most comprehensive understanding of sex work in Port Moresby to date.

**Sample Size:** Number of survey respondents: 593

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
64	87	152	181	260	441	245	347	593

Number of people who have answered correctly to all five questions

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
21	25	46	32	54	86	53	79	132

Indicator Value

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
32.81%	28.74%	30.26%	17.68%	20.77%	19.50%	21.63%	22.77%	22.26%

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

The NHS 2011-2015 recognises the relevance of this particular Indicator for PNG and prioritises the particular vulnerability of young men and women in PNG. PA.1 Cluster 2.2: Vulnerability of young people states:

*Young women and men (aged 15 to 24 years) are particularly vulnerable to HIV, yet their voices have largely not been heard in the national response.*

*In order to reduce the vulnerability of young people, programs that provide income generation, life skills development and educational opportunities will be established. Young people are also vulnerable as a result of drug and alcohol use, sexual violence and abuse, gender inequalities, family breakdown and lack of access to youth-friendly sexual and reproductive health services and education. Young people who are particularly vulnerable include the unemployed, those exchanging sex, those who are illiterate, street youth, raskols and young men and women living with HIV.*

Interpretation of values reported for this Indicator

1: Behavioural Studies for both the general population and MARPs.

It is important to note that the Values reported from these additional studies are from sub populations, not the general population. The last general population based study was 2006. The need for a behavioural research on the general population, to complement the increased number of behavioural studies on sub-populations including MARPs, has been recognised with the launch of the IBBS in late 2011.

2: University and High School curriculum courses on HIV knowledge:

In respect to the two University student's samples, in the curriculum for Grade 12 at High school and in preparation courses for university, there is a basic STI/HIV knowledge component. So in the context of the this Indicator it is

interesting to note that that in these two samples for the sub population of university students the sharp contrast between the high percentage 72.49% of correct answers from Divine Word University (a Catholic University) compared with the 53.31% of correct answers by those at Pacific Adventist University (a Seventh Day Adventist University).

### 3. The vulnerability of young people at higher risk

The studies on younger people at higher risk (such as truck drivers, plantation workers and other mobile enclave workers, younger women exchanging sex, young male and female sex workers and higher risk youth) provide very important Values for those who are developing and delivering prevention programmes, in accordance with the NHS 2011-2015, for these vulnerable young people in PNG.

#### **Indicator changes compared with previous report**

UNGASS 2010 had one study that met the *Value of Indicator* (unchanged for GAR 2012) and one *Value from other studies*. Both studies reported that less than 25% of the respondents correctly answered both questions.

For Gar 2012 there are more additional studies that inform this Indicator which shows progress on the recommendation from the UNGASS 201 report, but still only one that is from a non high-risk population based survey - university students. The others are studies involve MARPs such as higher risk youth, mobile populations/enclave workers (mining workers, oil/beef/sugar plantation workers), truck drivers and younger women who exchanged sex.

Interestingly, while some studies reported that less than 25% of the respondents answered correctly, some of the studies on the MARPs sub populations reported a small increase in correctly identifying ways of preventing sexual transmission and who rejected the major misconceptions about HIV transmission.

However, overall the studies have not reported a significant change in this Indicator's Values amongst the MARPs, which is a particular concern, particularly when the low percentage of 22.6% comprehensive knowledge for the higher risk young people in the Vanimo Green District Study is considered.

#### **Challenges for indicator reporting improvement**

- a. The Mosquito question: This caused some debate at the Consensus workshop with varying views on the value of this question being included for the PNG context. The transmission of HIV by mosquito question comes up frequently and is the one that is most frequently answered incorrectly.

Some were of the view that it was of little relevance whilst others noted that it was the mosquito question that resulted in a high number of 'incorrect answers' as many could comfortably answer the first four correctly but did not answer the mosquito question correctly. In the Truck driver study it was noted that there was an increase in belief by truck drivers that HIV could be transmitted by mosquito bites, with an increase of 17.4 percentage points from 2006 to 2010.

The Consensus Workshop agreed that there is a need to test whether

people who think HIV can be transmitted by mosquitos are more or less likely to use condoms.

- b. Participants not knowing their age: A significant number of respondents in a number of studies did not know their age: for example in the Truck driver study (16.3%), the women exchanging sex in Mt. Hagen study (42.6%) and the RAI plantation workers (31.1%). Consequently their responses did not meet the criteria for their data to be considered in this Indicator and this creates a limitation to understanding the actual comprehensive knowledge of these samples of more at risk populations, whether they knew their age or not.

### **Recommendations for indicator reporting improvement**

- Need to investigate whether thinking HIV can be transmitted by mosquito bites is positively or negatively correlated with condom use

## **1.2 Sex Before the Age of 15**

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

#### **What it Measures**

It measures progress in increasing the age at which young women and men aged 15–24 first have sex.

#### **Rationale**

A major goal in many countries is to delay the age at which young people first have sex because it reduces their potential exposure to HIV and discourage premarital sexual activity because it reduces their potential exposure to HIV. There is also evidence to suggest that first having sex at a later age reduces susceptibility to HIV infection per act of sex, at least for women.

<b>NHS 2011-2015 Priority Area 1: Prevention. Strategic Objective 2.2.9</b>	
<b>Indicator No.39:</b>	Percentage of young women and men who have had sexual intercourse before the age of 15
<b>Purpose</b>	To assess progress in increasing the age at which young women and men aged 15-24 first have sex.

#### **Method of Measurement:**

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

#### **Indicator Relevance:**

Topic is relevant to PNG, the indicator is relevant and is available. Also submitting other data from more at risk populations.

#### **Value of Indicator:**

In this study **13.93%** of higher risk young people aged 15-24 had had sexual

intercourse before the age of 15.

Of female youth 9.4% had had sexual intercourse before the age of 15 and 16.5% of male youth also reported their first sexual debut before the age of 15.

**Data Measurement Tool:**

Behavioural Surveillance Surveys Plan conducted by NRI

**From Date:** 29 June 2009 **To Date:** 08 July 2009

This Behavioural Surveillance Survey targeting higher risk young people in the Vanimo Green District of Sandaun Province (West Sepik) was the first round of BSS research collected by the National Research Institute with this more hidden population. These higher risk young people were recruited from the 29<sup>th</sup> of June to the 29<sup>th</sup> of July 2009 through the use of Respondent Driven Sampling (RDS) for a total sample size of 380 youth (237 male and 143 female youth). Young people recruited were between the ages of 15 and 29, who lived in Vanimo Green, were sexually active and who had had sex with more than one partner.

If the other youth aged 25 to 29 are included, there would be four additional male youth and two more female youth who reported that they had had sex before the age of 15.

**Sample Size:** Number of survey respondents: 323

**The percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15**

Male		
Age disaggregation		Total
15-19	20-24	
<b>Number of young men who had sex before the age of 15</b>		
25	9	34
<b>Number of young men interviewed</b>		
118	88	206
<b>Percentage of young men who had sex before the age of 15</b>		
21.2%	10.2%	16.5%

Female		
Age disaggregation		Total
15-19	20-24	
<b>Number of young women who had sex before the age of 15</b>		
11	0	11
<b>Number of young women interviewed</b>		
79	38	117
<b>Percentage of young women who had sex before the age of 15</b>		
13.9%	0.0%	9.4%

**Values from other studies.**

1.  
In this additional study 0% of younger truck drivers aged 15-24 had had

sexual intercourse before the age of 15.

**Data Measurement Tool:**

Behavioural Surveillance Survey conducted by National Research Institute (NRI) PNG

**From Date:** 29 March 2010

**To Date:** 01 December 2010

This indicator when disaggregated 15-24 years, is less helpful to understand age at first sexual debut for all truck drivers, as numbers are very limited and most truck drivers sampled were older than 24 years. When looking at the overall sample, sexual debut was early for some truck drivers and quite late for others. Of the truck drivers that had had sex, 42.0% (105) did not know their age at first sex, creating a limitation to interpretation of this indicator. Of those (145) truck drivers who knew their age, five (3.4%) had had their first sex before they turned 15 years old. Most (60.0%) had their first sex between 15 and 19 years old or 20 to 24 years (29.7%). Fewer drivers (13.2%) had their first sex when they were over the age of twenty-five.

There was a slight decrease in percentage points (1.2%) for those who had ever had sex from the first BSS collected in 2006 and the 2010 collection with truck drivers. In 2006, all drivers reported that they had already had sex; while in 2010, three drivers reported that they had not yet had their first sexual experience. Those drivers who had ever had sex had decreased by 1.2 percentage points over the two collection periods.

**Sample Size:** Number of survey respondents: 15

Age disaggregation		Total
15-19	20-24	
<b>Number of younger Truck drivers who reported having their first sexual intercourse before the age of 15</b>		
0	0	0
<b>Number of young Truck drivers interviewed</b>		
2	13	15
<b>Percentage of younger Truck drivers having first sexual intercourse before the age of 15</b>		
0.0%	0.0%	0.0%

**2.**

In this study of young women who sell or exchange sex 22.92% have had sex before the age of 15. The operational definition of sex workers was having transactional sex with at least 2 people in the last 7 days.

14.86% of the young female sex workers and 30.72% of the young MSM have had sexual intercourse before the age of 15.

**Data Measurement Tool:**

Cross Sectional Survey conducted by FHI 360.

**From Date:** November 22 2010

**To Date:** December 18 2010



In late 2010, USAID funded FHI to conduct a Cross Sectional Survey among MSM and women in Port Moresby, Papua New Guinea. Respondent driven sampling (RDS) was used to survey 585 participants in November and December 2010. In total, 585 participants (302 MSM and 283 women) were surveyed during the USAID/FHI survey. Though the MSM and FSW study was conducted at the same time by the same investigators the two study populations were investigated separately. Only a portion of both study populations, i.e. FSW and MSM aged 15-24, contribute data for this indicator.

**Sample Size:** Number of survey respondents: 301

**Number of all respondents aged 15–24 years who have been asked the following two questions:**  
 1 - Have you ever had sexual intercourse?  
 2 - if yes, How old were you when you first had sexual intercourse for the first time?

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
42	111	153	49	99	148	91	210	301

**Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years**

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
17	30	47	8	14	22	25	44	69

**Indicator Value**

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
40.48%	27.03%	30.72%	16.33%	14.14%	14.86%	27.47%	20.95%	22.92%

**3.**  
 In this additional study, 10.6% of younger RAI plantation workers aged 15 to 24, had had sexual intercourse before the age of 15.

Of these, 7.7.7% of younger female workers and 11.1% of male workers aged between 15 and 24, had had sexual intercourse before the age of 15..

**Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 25 July 2010 **To Date:** 11 August 2010

It must be noted that 31.1% of male and female plantation workers did not

know their age and this causes limitations to age based indicators.

This Behavioural Surveillance Survey among the Ramu Agri Industry workforce was the second round of BSS with this population; however there have been major changes in the composition of the workforce between the first BSS data collection by the National AIDS Council Secretariat in 2006 with Ramu Sugar Factory workers and the 2<sup>nd</sup> BSS data collection with Ramu Agri Industries workers in 2010 by the National Research Institute. Ramu Sugar had expanded to Ramu Agri Industries by 2010 and the rapidly expanding oil palm and the beef plantations workers were also included for sampling with the sugar plantation workforce in 2010 because of the movement of people into the plantations and the changing nature of the workforce that was projected to continue to increase.

The random sampling with the workforce was based on employee lists and proportional and stratified to three types of work (sugar, beef and oil palm) across six sites. All workers selected were targeted for interviewing and were recruited from the sites during the day during the time of collection, for a sample of 602 RAI workers (494M and 108F). Data collection took eighteen days and began on the 25<sup>th</sup> of July and was completed on the 11<sup>th</sup> of August, 2010.

**Sample Size:** Number of survey respondents: 85

**The percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15**

Number of young RAI workers who had sex before the age of 15								
Male			Female			Male &Female		
15-19	20-24	Total	15-19	20-24	Total	15-19	20-24	Total
2	6	8	0	1	1	2	7	9
Number of young RAI workers interviewed								
Male			Female			Male &Female		
15-19	20-24	Total	15-19	20-24	Total	15-19	20-24	Total
14	58	72	3	10	13	17	68	85
Percentage of young RAI workers having first sexual intercourse before the age of 15								
Male			Female			Male &Female		
15-19	20-24	Total	15-19	20-24	Total	15-19	20-24	Total
14.3%	10.3%	11.1%	0.0%	10.0%	7.7%	11.8%	10.3%	10.6%

#### 4.

In this additional study, 19.7% of younger women exchanging sex in Mt Hagen aged between 15 and 24, had had sexual intercourse before the age of 15.

#### **Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 29 March 2010 **To Date:** 08 April 2010

It must be noted that 42.6% of women exchanging sex in Mt. Hagen did not

know their age and this causes great limitations to all age based indicators.

This Behavioural Surveillance Survey targeting women exchanging sex in Mt. Hagen was the first round of BSS research collected by the National Research Institute with this more hidden population. These women were recruited from the 29<sup>th</sup> of March to the 8<sup>th</sup> of April, 2010 through the use of Respondent Driven Sampling (RDS) for a total sample size of 242 women who exchanged sex and who lived in different parts of Mt. Hagen and the Western Highlands.

**Sample Size:** Number of survey respondents: 76

The percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15

Number of young women exchanging sex who had sex before the age of 15		
Female		
15-19	20-24	Total
10	5	15
Number of young women exchanging sex interviewed		
Female		
15-19	20-24	Total
32	44	76
Percentage of young women exchanging sex having first sexual intercourse before the age of 15		
Female		
15-19	20-24	Total
31.3%	11.4%	19.7%

## 5.

In the following four values the data was sourced from the base line study for the Male Circumcision Acceptance Study undertaken by Pacific Adventist University.

### 5.a

In this additional study of 4.26% of students at Madang University aged 15-24 have had sex for the first time before the age of 15.

### Data Measurement Tool:

Behavioural Survey by James Cook University (JCU) and Pacific Adventist University

**From Date:** 1 September 2010      **To Date:** 30 September 2010

**Sample Size:** Number of survey respondents: 235

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
11	131	142	13	80	93	24	211	235

Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years
--

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
0	8	8	1	1	2	1	9	10

Indicator Value

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
0.00%	6.11%	5.63%	7.69%	1.25%	2.15%	4.17%	4.27%	4.26%

### 5.b

In this additional study 5.16% University students aged 15-24 in Port Moresby have had sex for the first time before the age of 15.

#### Data Measurement Tool:

Behavioural Survey by James Cook University (JCU) and Pacific Adventist University

**From Date:** 1 September 2010      **To Date:** 30 September 2010

**Sample Size:** Number of survey respondents: 252

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
23	112	135	25	92	117	48	204	252

Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
1	10	11	0	2	2	1	12	13

Indicator Value

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
4.35%	8.93%	8.15%	0.00%	2.17%	1.71%	2.08%	5.88%	5.16%

### 5.c

In this additional study 17.17% of the Oil Palm workers aged 15-24 (near Popondetta) have had sex for the first time before the age of 15.

0% of females and 21.79% of males have had sex for the first time before the

age of 15

**Data Measurement Tool:**

Behavioural Survey by James Cook University (JCU) and Pacific Adventist University

**From Date:** 1 February 2011

**To Date:** 28 February 2011

**Sample Size:** Number of survey respondents: 99

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
32	46	78	3	18	21	35	64	99

Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
10	7	17	0	0	0	10	7	17

Indicator Value

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
31.25%	15.22%	21.79%	0.00%	0.00%	0.00%	28.57%	10.94%	17.17%

**5.d.**

In this additional study 11.48% mining workers aged 15-24 at Porgera have had sex for the first time before the age of 15.

0% of females and 18.42% of males have had sex for the first time before the age of 15.

**Data Measurement Tool:**

Behavioural Survey by James Cook University (JCU) and Pacific Adventist University

**From Date:** 1 November 2010

**To Date:** 30 November 2010

**Sample Size:** Number of survey respondents: 61

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
10	28	38	4	19	23	14	47	61

Number of respondents (aged 15–24 years) who report

the age at which they first had sexual intercourse as under 15 years

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
4	3	7	0	0	0	4	3	7

Indicator Value

MALE			FEMALE			MALE & FEMALE		
15 -19	20 - 24	Total	15 -19	20 - 24	Total	15 -19	20 - 24	Total
40.00%	10.71%	18.42%	0.00%	0.00%	0.00%	28.57%	6.38%	11.48%

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

The NHS 2011-2015 recognises the relevance of this particular Indicator for PNG and prioritises the particular vulnerability of young men and women in PNG. PA.1 Cluster 2.2. Vulnerability of young people states.

*Young women and men (aged 15 to 24 years) are particularly vulnerable to HIV, yet their voices have largely not been heard in the national response.*

*Interventions that promote delay of sexual debut will be established and expanded. In order to reduce the vulnerability of young people, programs that provide income generation, life skills development and educational opportunities will be established. Young people are also vulnerable as a result of drug and alcohol use, sexual violence and abuse, gender inequalities, family breakdown and lack of access to youth-friendly sexual and reproductive health services and education. Young people who are particularly vulnerable include the unemployed, those exchanging sex, those who are illiterate, street youth, raskols and young men and women living with HIV.*

The NHS 2011-2015 emphasis on the importance of the age of sexual debut is affirmed by the study on young people who had sex with more than one partner in the last 12 months, with the Value double that of UNGASS 2010, of 13.93%.

However highly concerning is the percentages for young women exchanging sex in Mt Hagen 19.7% and in Port Moresby 14.86%. Lastly and most importantly the population that had the highest percentage of sexual intercourse before the age of 15 is male sex workers (30.72%) in Port Moresby.

### Indicator changes compared with previous report

The UNGASS 2010 reported on one study that gave a *Value for the Indicator* and six *Values from other studies*. The UNGASS 2008 reported on data from a large population based survey (Demography and Health Survey).

For GAR 2012 there has not been a population based survey of young people

on age of first sexual intercourse for this time period. However there are 8 studies that are reported under the Value and *Values from other studies*. They all involve MARPs such as higher risk youth, mobile populations and enclave workers (mining workers, palm oil/beef/sugar plantation workers), truck drivers, university students, and younger people who sold or exchanged sex.

### **Challenges for indicator reporting improvement**

- Participants not knowing their age: A significant number of those interviewed did not know their age: Truck drivers (16.3%), women exchanging sex in Mt. Hagen (42.6%) and RAI plantation workers (31.1%). Consequently their not knowing their age did not meet the criteria for their data to be considered in this Indicator.
- Changes in age range: It is important to note that the NHS 2011-2015 Indicators were designed to follow the UNGASS indicators. The changes in age range for the GAR Indicators has resulted in studies developed on the UNGASS and NHS 2011-2015 are collecting data outside the GAR 2012 Indicator age range.

### **Recommendations for indicator reporting improvement**

### 1.3 Multiple sexual partnerships

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

##### **What it Measures**

It measures progress in reducing the percentage of people who have multiple sexual partnerships

##### **Rationale**

The spread of HIV largely depends upon unprotected sex among people with a high number of partnerships. Individuals who have multiple partners have a higher risk of HIV transmission than individuals that do not link into a wider sexual network.

#### **NHS 2011-2015 Priority Area 1: Prevention. Strategic Objective 1.1.4 Top 10 Interventions**

**Indicator No.3:** *Percentage of women and men aged 15–59 who have had sexual intercourse with more than one partner in the last 12 months.*

**Purpose** To assess progress in reducing the percentage of people who have multiple sexual partners.

##### **Method of Measurement:**

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

##### **Indicator Relevance:**

Topic is relevant to PNG, the indicator is relevant and data is available. Also submitting other data.

##### **Value of Indicator:**

In this additional study, 16.6% of the Ramu Agri-Industry workforce aged 15-49, had had sexual intercourse with more than one partner in the last 12 months.

Of the Ramu plantation workers, 8.3% of female workers and 17.9% of the male workers aged 15-49, had had sexual intercourse with more than one sex partner in the last 12 months.

##### **Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 25 July 2010

**To Date:** 11 August 2010



This Behavioural Surveillance Survey among the Ramu workforce was the second round of BSS with this population; however there have been major changes in the composition of the workforce between the first BSS data collection by the National AIDS Council Secretariat in 2006 with Ramu Sugar Factory workers and the 2<sup>nd</sup> BSS data collection with Ramu Agri Industries workers in 2010 by the National Research Institute. Ramu Sugar had expanded to Ramu Agri Industries by 2010 and the rapidly expanding oil palm and the beef plantations workers were also included for sampling with the sugar plantation workforce in 2010 because of the movement of people into the plantations and the changing nature of the workforce that was projected to continue to increase.

The random sampling with the workforce was based on employee lists and proportional and stratified to three types of work (sugar, beef and oil palm) across six sites. All workers selected were targeted for interviewing and were recruited from the sites during the day during the time of collection, for a sample of 602 RAI workers (494M and 108F). Data collection took eighteen days and began on the 25<sup>th</sup> of July and was completed on the 11<sup>th</sup> of August, 2010.

**Sample Size:** Number of survey respondents: 356

Number of RAI workers age 15-49 who have had sexual intercourse with more than one partner in the last 12 months											
Male				Female				Male &Female			
15-19	20-24	25-49	Total	15-19	20-24	25-49	Total	15-19	20-24	25-49	Total
0	13	42	55	1	1	2	4	1	14	44	59
Number of RAI workers aged 15-49 interviewed											
Male				Female				Male &Female			
15-19	20-24	25-49	Total	15-19	20-24	25-49	Total	15-19	20-24	25-49	Total
14	58	236	308	3	10	35	48	17	68	271	356
Percentage of RAI workers age 15-49 who have had sexual intercourse with more than one partner in the last 12 months											
Male				Female				Male &Female			
15-19	20-24	25-49	Total	15-19	20-24	25-49	Total	15-19	20-24	25-49	Total
0.0%	22.4%	17.8%	17.9%	33.3%	10.0%	5.7%	8.3%	5.9%	20.6%	16.2%	16.6%

### Values from other studies.

1.

In this additional study, 47.2% of male truck drivers aged 15 to 49 years old, had had sexual intercourse with more than one partner in the last 12 months.

### Data Measurement Tool:

Behavioural Surveillance Survey conducted by National Research Institute (NRI) PNG

**From Date:** 29 March 2010

**To Date:** 01 December 2010

Drivers could be away for a week or for months – but it was found that having concurrent partners was less to do with duration of time away, but more about mobility and just being away.

Overall sample, just under half (48.2%; 122) of truck drivers had more than one sex partner last year. Over half (54.0%) of drivers who had sex last year had more than one sexual partner. Of those 122 drivers who had more than sex one partner in the past year, 46.7% had 2 or 3 female sex partners in the past year; while more (53.3%) had between four and nine female partners they had sex with in the last 12 months. Truck drivers had a concurrency of regular sexual partners, and of the 225 drivers reporting that had regular partners in the past year, a third (36.9%; 83) reported having more than one regular sex partner last year. Of those who had regular partners, 45.3% (102) also had had non-regular partners, 40.9% (92) had transactional partners and one driver (0.4%) had a same sex partner.

**Sample Size:** Number of survey respondents: 161

Age disaggregation Male			Total
15-19	20-24	25-49	
<b>Number of Truck drivers who have had sexual intercourse with more than one partner in the last 12months</b>			
2	5	69	76
<b>Number of Male Truck drivers interviewed</b>			
2	13	146	161
<b>Percentage of Truck drivers who have had sexual intercourse with more than one partner in the last 12months</b>			
100.0%	38.5%	47.3%	47.2%

## 2.

In this additional study, 66.9% of Vanimo young people aged between 15 and 49 (15-29) had sexual intercourse with more than one partner in the last 12 months.

Of the higher risk young people, 71.8% of female youth and 64.0% of male youth had had sexual intercourse with more than one partner in the last 12 months. .

### **Data Measurement Tool:**

Behavioural Surveillance Surveys Plan conducted by NRI

**From Date:** 29 June 2009 **To Date:** 08 July 2009

This Behavioural Surveillance Survey targeting higher risk young people in the Vanimo Green District of Sandaun Province (West Sepik) was the first round of BSS research collected by the National Research Institute with this more hidden population. These higher risk young people were recruited from the 29<sup>th</sup> of June to the 29<sup>th</sup> of July 2009 through the use of Respondent Driven Sampling (RDS) for a total sample size of 380 youth (237 male and 143 female youth). Young people recruited were between the ages of 15 and 29, who lived in Vanimo Green, were sexually active and who had had sex with more than one partner.

**Sample Size:** Number of survey respondents: 378

The percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months

Male			
Age disaggregation			Total
15-19	20-24	25-49	
<b>Number of young men who have had sexual intercourse with more than one partner in the last 12 months</b>			
78	57	16	151
<b>Number of young men interviewed</b>			
118	88	30	236
<b>Percentage of young men having multiple sexual partners in the last 12 months</b>			
66.1%	64.8%	53.3%	64.0%

Female			
Age disaggregation			Total
15-19	20-24	25-49	
<b>Number of young women who have had sexual intercourse with more than one partner in the last 12 months</b>			
57	25	20	102
<b>Number of young women interviewed</b>			
79	38	25	142
<b>Percentage of young women having multiple sexual partners in the last 12 months</b>			
72.2%	65.8%	80.0%	71.8%

#### 4.

In this additional study, 56.89% of sexually active men aged 18-49, from an economic enclave and the neighbourhood had had sexual intercourse with more than one partner in the last 12 months.

#### Data Measurement Tool:

Cross sectional Study undertaken by Population Services International (PSI)

**From Date:** 01 August 2011

**To Date:** 01 October 2011

The study population was sexually active men from economic enclaves aged 18-49 who spoke Tok Pisin and either worked for one of the five partner enclave companies (Higaturu Oil Palm, Oil Search Limited, WR Carpenters, Porgera Joint Venture, or Ramu Agri-Industries) and who were there at the time of interview or sexually active men aged 18-49 who lived in villages that neighbour company worksites. \*Please note that no participants were under the age of 18 in this study. This sample is not nationally representative.

**Sample Size:** Number of survey respondents 1,320

MALE				FEMALE				MALE & FEMALE			
15-19*	20-24	25-49	All Ages	15-19	20-24	25-49	All Ages	15-19	20-24	25-49	All Ages
138	275	907	1,320								

Number of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months
---

MALE				FEMALE				MALE & FEMALE			
15-19*	20-24	25-49	All Ages	15-19	20-24	25-49	All Ages	15-19	20-24	25-49	All Ages
105	189	457	751								

Indicator Value
-----------------

MALE				FEMALE				MALE & FEMALE			
15-19	20-24	25-49	All Ages	15-19	20-24	25-49	All Ages	15-19	20-24	25-49	All Ages
76.09%	68.73%	50.39%	56.89%								

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

The NHS 2011-2015 PA.1 Cluster 1.1 Sexual Transmission of HIV and other STIs. Describes the relevance of high numbers of sexual partnering in the PNG context.

*Reducing sexual transmission of HIV and other STIs is a core priority. Addressing risks associated with sexual transmission means increasing access to programs, services and resources which help people understand HIV risk in relation to their own behaviour and life circumstances. Risk reduction interventions that address sexual transmission will need to motivate, support, educate and give people the skills to make the changes needed to protect themselves and others.*

*Reducing the number of concurrent sexual partners, increasing correct and consistent condom use, and increasing the availability of gender and age-sensitive post-exposure prophylaxis (PEP) for HIV and STIs are just some of the critical interventions that will be implemented.*

*In recognition that not everyone has the same level of risk, more-at-risk populations will be identified and targeted with combination prevention interventions. Interventions that help protect people engaged in sex work or who exchange sex for cash, goods and services will be rapidly scaled-up.*

Of particular interest for HIV prevention programmes are the high percentage Values for mobile populations (47.20% truck drivers), enclave worker (56.89% PSI study) and higher risk youth (66.93%). Population based studies are necessary to see whether lower Values would be found in the general population, but this data supports the NHS 2011-2015 focus on most at risk populations.

### Indicator changes compared with previous report

The UNGASS 2008 Value for this Indicator was 7.50% and was from a large demographic population based health survey. The UNGASS 2010 Value for the Indicator is 22.4% and is from a smaller survey conducted in one urban/peri urban location with four Values from other studies reported.

For GAR 2012 there has not been a population based survey however one study provides the Value and there have been four studies that provide *Values from other Studies* that provide interesting evidence about the risk factors for more at risk populations in PNG.

While Ramu Agri Industries workers (16.6%) reported percentages lower than the UNGASS 2010 reporting on this indicator, all other 2012 studies reported far higher percentages. The percentage of Truck drivers (47.20)% and sexually active male enclave workers (56.89%) for having more than one sex partner in the last year were high. Of most concern was the highest percentage of 66.93% of higher risk young people in the Vanimo District who had had sexual intercourse with more than one partner in the last 12 months.

### **Challenges for indicator reporting improvement**

- It is important to note that the NHS 2011-2015 Indicators were designed to follow the UNGASS 2010 indicators. The changes in age ranges for the GAR Indicators has resulted in studies developed on the UNGASS and NHS 2011-2015 to be now collecting data outside the changed age ranges for GAR indicators.
- Participants not knowing their age: A significant number of people interviewed in a number of studies did not know their age: Truck drivers (16.3%), RAI workers (31.1%) and women exchanging sex in Mt. Hagen (42.6%). Consequently their responses did not meet the criteria for their data to be considered in this Indicator

### **Recommendations for indicator reporting improvement**

None

## 1.4 Condom Use at last sex among people with multiple sexual partnerships

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

### What it Measures

It measures progress towards preventing exposure to HIV through unprotected among people with multiple sexual partners

### Rationale

Condom use is an important measure of protection against HIV, especially among people with multiple sexual partners.

### NHS 2011-2015 Priority Area 1: Prevention. Strategic Objective 1.1.2

#### Top 10 Interventions

**Indicator No.4:** *Percentage of women and men aged 15–59 who had more than one sexual partner in the last 12 months and who report the use of a condom during last intercourse.*

**Purpose** To assess progress towards increasing the percentage of people with multiple sexual partners who used a condom during last intercourse

### Method of Measurement:

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

### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available. Also submitting other data.

### Value of Indicator:

In this additional study, **4.8%** of the Ramu workforce aged 15-49, had had more than one sexual partner in the last 12 months and reported using a condom during their last sexual intercourse.

Of Ramu plantation workers, 2.1% of female workers and 5.2% of the male workers aged 15-49, had had more than one sexual partner in the last 12 months and reported using a condom during their last sexual intercourse..

### Data Measurement Tool:

Behavioural Surveillance Survey conducted by NRI

**From Date:** 25 July 2010

**To Date:** 11 August 2010

This Behavioural Surveillance Survey among the Ramu workforce was the second round of BSS with this population; however there have been major changes in the composition of the workforce between the first BSS data collection by the National AIDS Council Secretariat in 2006 with Ramu Sugar Factory workers and the 2<sup>nd</sup> BSS data collection with Ramu Agri Industries workers in 2010 by the National Research Institute. Ramu Sugar had expanded to Ramu Agri Industries by 2010 and the rapidly expanding oil palm and the beef plantations workers were also included for sampling with the sugar plantation workforce in 2010 because of the movement of people into the plantations and the changing nature of the workforce that was projected to continue to increase.

The random sampling with the workforce was based on employee lists and proportional and stratified to three types of work (sugar, beef and oil palm) across six sites. All workers selected were targeted for interviewing and were recruited from the sites during the day during the time of collection, for a sample of 602 RAI workers (494M and 108F). Data collection took eighteen days and began on the 25<sup>th</sup> of July and was completed on the 11<sup>th</sup> of August, 2010.

For the previous indicator, 59 (16.6%) of RAI workers had had more than one sex partner in the past 12 months ; however of these less than half (27) had used a condom at last sex.

**Sample Size:** Number of survey respondents: 356

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

Number of RAI workers who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex											
Male				Female				Male &Female			
15-19	20-24	25-49	Total	15-19	20-24	25-49	Total	15-19	20-24	25-49	Total
0	2	14	16	0	0	1	1	0	2	15	17
Number of RAI workers aged 15-49 interviewed											
Male				Female				Male &Female			
15-19	20-24	25-49	Total	15-19	20-24	25-49	Total	15-19	20-24	25-49	Total
14	58	236	308	3	10	35	48	17	68	271	356
Percentage of RAI workers who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex											
Male				Female				Male &Female			
15-19	20-24	25-49	Total	15-19	20-24	25-49	Total	15-19	20-24	25-49	Total
0.0%	3.4%	5.9%	5.2%	0.0%	0.0%	2.9%	2.1%	0.0%	2.9%	5.5%	4.8%

---

### Values from other studies.

1.

In this additional study, 63.7% of female youth aged 15 to 29, and 58.9% of male youth aged 15 to 29, had had sex with more than one sexual partner in the last 12 months and reported using a condom during their last sexual intercourse.

**Data Measurement Tool:**

Behavioural Surveillance Surveys Plan conducted by NRI

**From Date:** 29 June 2009 **To Date:** 08 July 2009

This Behavioural Surveillance Survey targeting higher risk young people in the Vanimo Green District of Sandaun Province (West Sepik) was the first round of BSS research collected by the National Research Institute with this more hidden population. These higher risk young people were recruited from the 29<sup>th</sup> of June to the 29<sup>th</sup> of July 2009 through the use of Respondent Driven Sampling (RDS) for a total sample size of 380 youth (237 male and 143 female youth). Young people recruited were between the ages of 15 and 29, who lived in Vanimo Green, were sexually active and who had had sex with more than one partner.

**Sample Size:** Number of survey respondents: 253

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

Male			
Age disaggregation			Total
15-19	20-24	25-49	
<b>Number of young men who reported having multiple sexual partners in the last 12 months and used a condom at last sexual intercourse</b>			
45	36	8	89
<b>Number of young men who reported having multiple sexual partners in the last 12 months</b>			
78	57	16	151
<b>Percentage of young men having multiple sexual partners in the last 12 months</b>			
57.7%	63.2%	50.0%	58.9%

Female			
Age disaggregation			Total
15-19	20-24	25-49	
<b>Number of young women who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex</b>			
38	15	12	65
<b>Number of young women who reported having had more than one sexual partner in the last 12 months</b>			
57	25	20	102
<b>Percentage of young women having had more than one sexual partner in the last 12 months and who used a condom the last time had sex</b>			
66.7%	60.0%	60.0%	63.7%

**2.**

In this additional study, 33.5 % of male truck drivers aged 15 – 49, had had sexual intercourse with more than one partner in the last 12 months, and reported using a condom during their last sexual intercourse

**Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 29 March 2010 **To Date:** 01 December 2010



Of the 122 truck drivers (of all ages) who reported having more than one sex partner in the last year, 35.5% (48) of drivers had used a condom at their last sex.

There were significant statistical associations in the 2010 data, between having a transactional or a non-regular partner and using a condom at last sex. There were also significant statistical associations between numbers of regular partners and condom use. Drivers, who had more than one regular partner, used a condom more often at last sex than those who had only one regular partner.

When comparing the data first collected with truck drivers in 2006 and 2010, there were decreases in the frequency that truck drivers had non-regular sex partners and increases in their condom use, with a decrease of 28.0 percentage points in 2010 in the number of truck drivers who had non-regular partners in the last year. There was an increase of 49.8 percentage points in those who used a condom with their non-regular partner at last sex, and a great improvement in consistent condom use by truck drivers with their non-regular partners across different time frames seen in 2010.

Between 2006 and 2010, there were also positive trends in truck drivers reducing their paid or transactional sex, as well as decreasing their numbers of transactional partners, and increasing numbers of drivers who didn't have any transactional or paid sex in the previous year. There was also improvement in condom use at last paid sex by a 9.2 percentage point increase by truck drivers with their transactional partners and a notable improvement in consistent condom use, with an increase of 25.7 percentage points between 2006 and 2010 of truck drivers using condoms more consistently with their transactional partners in the past year.

Indications of behavioural change are positive when looking at the trends in truck drivers reducing their numbers of concurrent non-regular and transactional partners and greater condom use and consistent condom use being reported in these sexual relationships. It was clear in the 2010 data that more drivers used condoms to a greater degree with their concurrent non-regular and transactional sex partners, indicating they are assessing that this sex may be higher risk for them.

Despite driver's having high condom use and higher consistency of condom use within networks of non-regular and transactional sex partners; the inconsistency of condom use by around a quarter to a third of truck drivers in these more casual higher risk sexual relationships, create risk of HIV and STI transmission for truck drivers, their monogamous and polygamous marriage partners and their other concurrent sex partners.

There are unmet prevention needs for harm reduction for truck drivers to increase their condom use when they have concurrent sex partners. There is a need to increase more tailored HIV prevention for drivers, and to nurture that truck drivers appear to be weighing their risks of HIV infection within more

casual 'higher risk' relationships, but there is a need to also nurture perceptions of risk of HIV transmission within their marriages and with other steady regular sex partners.

**Sample Size:** Number of survey respondents: 76

The percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months who reported the use of a condom during their last sexual intercourse

Age disaggregation			Total
15-19	20-24	25-49	
<b>Number of Truck drivers who have had sexual intercourse with more than one partner in the last 12 months and used a condom at last sex</b>			
0	5	22	27
<b>Number of Truck drivers who have had sexual intercourse with more than one partner in the last 12 months</b>			
2	5	69	76
<b>Percentage of Truck drivers who have had sexual intercourse with more than one partner in the last 12 months</b>			
0.0%	100.0%	31.9%	35.5%

### 3.

In this additional study 68.58% of sexually active men, aged 18-49, who speak Tok Pisin and either work for one of the five partner enclave companies (Higaturu Oil Palm, Oil Search Limited, WR Carpenters, Pogera Joint Venture, or Ramu Agri-Industries) and are there at the time of interview or sexually active men aged 18-49 who live in villages that neighbour company worksites, who have had more than one sexual partner in the last 12 months report using a condom during their last sexual intercourse

#### Data Measurement Tool:

Cross Sectional Study undertaken by Population Services International (PSI)

**From Date:** 01 August 2011

**To Date:** 01 October 2011

The study population was sexually active men aged 18-49 who speak Tok Pisin and either work for one of the five partner enclave companies (Higaturu Oil Palm, Oil Search Limited, WR Carpenters, Pogera Joint Venture, or Ramu Agri-Industries) and are there at the time of interview or sexually active men aged 18-49 who live in villages that neighbour company worksites. \*Please note that no participants were under age 18 in this study.

**Sample Size:** Number of survey respondents 751

MALE				FEMALE				MALE & FEMALE			
15-19*	20-24	25-49	All Ages	15-19	20-24	25-49	All Ages	15-19	20-24	25-49	All Ages
105	189	457	751								

**Number of respondents (15-49) who have answered more than one to the previous question**

and have answered "YES" to the following question:  
Did you or your partner use a condom the last time you had sexual intercourse?

MALE				FEMALE				MALE & FEMALE			
15-19*	20-24	25-49	All Ages	15-19	20-24	25-49	All Ages	15-19	20-24	25-49	All Ages
67	129	319	515								

Indicator Value

MALE				FEMALE				MALE & FEMALE			
15-19	20-24	25-49	All Ages	15-19	20-24	25-49	All Ages	15-19	20-24	25-49	All Ages
63.81 %	68.25 %	69.80 %	68.58 %								

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

The NHS 2011-2015 PA.1 Cluster 1.1 Sexual Transmission of HIV and other STIs. Describes the relevance of high numbers of sexual partnering, and increasing the correct and consistent condom use, in the PNG context.

*Reducing sexual transmission of HIV and other STIs is a core priority. Addressing risks associated with sexual transmission means increasing access to programs, services and resources which help people understand HIV risk in relation to their own behaviour and life circumstances. Risk reduction interventions that address sexual transmission will need to motivate, support, educate and give people the skills to make the changes needed to protect themselves and others.*

*Reducing the number of concurrent sexual partners, increasing correct and consistent condom use, and increasing the availability of gender and age-sensitive post-exposure prophylaxis (PEP) for HIV and STIs are just some of the critical interventions that will be implemented.*

*In recognition that not everyone has the same level of risk, more-at-risk populations will be identified and targeted with combination prevention interventions. Interventions that help protect people engaged in sex work or who exchange sex for cash, goods and services will be rapidly scaled-up.*

This study data is important for the national response to HIV in PNG, as it provides evidence of the particular vulnerability of higher risk young people and economic enclave workers in the context of PNG.

### **Indicator changes compared with previous report**

The UNGASS 2008 *Value for this Indicator* was 42.50% which was drawn from the large Demographic Health Survey (2006-2007). The *Value* for UNGASS 2010 of 38.9% was drawn from a far smaller sample size.

GAR 2012 does not have a population-based survey to report on the *Value for this Indicator*. There is one *Value* for a sub population and four special surveys drawn from more at risk populations.

Ramu Agri Industries workers with multiple partners reported the lowest level of condom use (5.96%) in comparison to the UNGASS 2010 and 2008 similar indicators. The male truck drivers who had more than one partner last year had higher condom use (33.5%).

The remaining two studies reported far higher percentages of condom use than the UNGASS 2008 or 2010 reporting. Considerable (63.7%) female youth and male youth (58.9%) from the higher risk youth survey, and more and the highest percentage at 68.58% of sexually active male enclave workers had had more than one sex partner in the last 12 months and used a condom during their last sexual intercourse.

### **Challenges for indicator reporting improvement**

- Participants not knowing their age: A significant number of people interviewed in the a number of studies did not know their age: - Truck drivers(16.3%) and the women exchanging sex in Mt. Hagen (42.6%). Consequently their responses did not meet the criteria for their data to be considered in this Indicator

### **Recommendations for indicator reporting improvement**

- There is value in respect to relative risk of sexual transmission through GAR Studies to report on condom use for both vaginal and anal intercourse.

## 1.5 HIV Testing in the General Population

### Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results

#### What it Measures

It measures progress in implementing HIV testing and counselling.

#### Rationale

In order to protect themselves and to prevent infecting others, it is important for individuals to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment.

#### NHS 2011-2015 Priority Area 2: Counselling, Testing, Treatment, Care and Support. Strategic Objective 1.1.1 & 1.1.2

##### Top 10 Interventions

**Indicator No.12:** *Percentage of women and men aged 15 to 59 who received an HIV test in the last 12 months and who know the results*

##### Purpose

This indicator measures the percentage of people who had an HIV test in the previous 12 months and received their result.

#### Method of Measurement:

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

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available. Also submitting other data.

#### Value of Indicator:

In this study **27.9%** of Ramu Agri Industry workers aged 15 to 49, had an HIV test in the last 12 months and received their results.

Of these, 18.8% of female Ramu plantation workers and 29.3% of male workers aged 15-49, had been tested for HIV test in the last 12 months and knew their results.

#### Data Measurement Tool:

Behavioural Surveillance Survey conducted by NRI

**From Date:** 25 July 2010

**To Date:** 11 August 2010

This Behavioural Surveillance Survey among the Ramu workforce was the second round of BSS with this population; however there have been major changes in the composition of the workforce between the first BSS data

collection by the National AIDS Council Secretariat in 2006 with Ramu Sugar Factory workers and the 2<sup>nd</sup> BSS data collection with Ramu Agri Industries workers in 2010 by the National Research Institute. Ramu Sugar had expanded to Ramu Agri Industries by 2010 and the rapidly expanding oil palm and the beef plantations workers were also included for sampling with the sugar plantation workforce in 2010 because of the movement of people into the plantations and the changing nature of the workforce that was projected to continue to increase.

The random sampling with the workforce was based on employee lists and proportional and stratified to three types of work (sugar, beef and oil palm) across six sites. All workers selected were targeted for interviewing and were recruited from the sites during the day during the time of collection, for a sample of 602 RAI workers (494M and 108F). Data collection took eighteen days and began on the 25<sup>th</sup> of July and was completed on the 11<sup>th</sup> of August, 2010.

**Sample Size:** Number of survey respondents: 356

**The percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results**

Number of RAI workers aged 15-49 who have been tested for HIV during the last 12 months and who know their results											
Male				Female				Male & Female			
15-19	20-24	25-49	Total	15-19	20-24	25-49	Total	15-19	20-24	25-49	Total
4	14	80	98	0	1	8	9	4	15	88	107
Number of RAI workers aged 15-49 interviewed											
Male				Female				Male & Female			
15-19	20-24	25-49	Total	15-19	20-24	25-49	Total	15-19	20-24	25-49	Total
14	58	263	335	3	10	35	48	17	68	298	383
Percentage of RAI workers who reported having had an HIV test in the last 12 months and who had received their results											
Male				Female				Male & Female			
15-19	20-24	25-49	Total	15-19	20-24	25-49	Total	15-19	20-24	25-49	Total
28.6%	24.1%	30.4%	29.3%	0.0%	10.0%	22.9%	18.8%	23.5%	22.1%	29.5%	27.9%

### Values from other studies.

1.

In this additional study, 10.9% of youth aged 15 to 29 had been tested for HIV in the last 12 months and knew their results.

Of these higher risk youth, 15.5% of female youth aged 15 to 29, and 8.1% of male youth aged 15-29 had been tested for HIV in the last 12 months and knew their results.

### Data Measurement Tool:

Behavioural Surveillance Surveys Plan conducted by NRI

**From Date:** 29 June 2009 **To Date:** 08 July 2009

This Behavioural Surveillance Survey targeting higher risk young people in the Vanimo Green District of Sandaun Province (West Sepik) was the first round of BSS research collected by the National Research Institute with this more hidden population. These higher risk young people were recruited from

the 29<sup>th</sup> of June to the 29<sup>th</sup> of July 2009 through the use of Respondent Driven Sampling (RDS) for a total sample size of 380 youth (237 male and 143 female youth). Young people recruited were between the ages of 15 and 29, who lived in Vanimo Green, were sexually active and who had had sex with more than one partner.

**Sample Size:** Number of survey respondents: 378

**The percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results**

<b>Male</b>			
<b>Age disaggregation</b>			<b>Total</b>
<b>15-19</b>	<b>20-24</b>	<b>25-49</b>	
<b>Number of young men who have been tested for HIV during the last 12 months and who know their results</b>			
9	8	2	19
<b>Number of young men interviewed</b>			
118	88	30	236
<b>Percentage of young men who have been tested in the last 12 months and knew their results</b>			
7.6%	9.1%	6.7%	8.1%

<b>Female</b>			
<b>Age disaggregation</b>			<b>Total</b>
<b>15-19</b>	<b>20-24</b>	<b>25-49</b>	
<b>Number of young women who have been tested for HIV during the last 12 months and who know their results</b>			
13	4	5	22
<b>Number of young women interviewed</b>			
79	38	25	142
<b>Percentage of young women who have been tested in the last 12 months and knew their results</b>			
16.5%	10.5%	20.0%	15.5%

**2.**

In this additional study, 29.8% of male truck drivers aged 15 to 49, had been tested for HIV test in the last 12 months and knew their results.

**Data Measurement Tool:**

Behavioural Surveillance Survey conducted by National Research Institute (NRI) PNG

**From Date:** 29 March 2010

**To Date:** 01 December 2010

**Sample Size:** Number of survey respondents: 161

Overall ages of truck drivers, 28.5% of truck drivers had been tested for HIV in the last year and knew their results. All except for four (5.2%) of those seventy-seven drivers who had tested in the past year had received their test results.

**The percentage of men aged 15-49 who received an HIV test in the past 12 months and know their results**

<b>Age disaggregation</b>	<b>Total</b>
---------------------------	--------------

15-19	20-24	25-49	
<b>Number of Truck drivers who have been tested in the last 12 months and who received their results</b>			
0	3	45	48
<b>Number of Truck drivers interviewed</b>			
2	13	146	161
<b>Percentage of Truck drivers who have been tested and received their results</b>			
0.0%	23.1%	30.8%	29.8%

### **Interpretation of value in the context of the epidemic in PNG**

The NHS 2011-2015 has a specific focus and a high priority given to increasing access to VCT - PA.2 Strategic Priority 2. Cluster 1.1 Scale up HIV Counselling and Testing

*Expanding access to and increasing uptake of HCT is fundamental to the achievement of the NHS goals. Equitable access to these services, regardless of gender, age, geographic location or sexual practice is both a moral and public health obligation. HCT is an important entry point to prevention and care, treatment and support services. The availability of HCT will be extended to all parts of the country. The priority is to make these services available at the local level in provinces and districts with the highest HIV prevalence.*

*HCT will move beyond the traditional models of VCT and make PICT and outreach testing more widely available, while respecting individual informed consent.*

It is important that there is an understanding on why the Ramu workforce (27.9%), and Truck drivers (29.8%) have higher *Values for this Indicator* and whether there is something specific in the VCT strategies at this economic enclave or in the transport companies of the Highway truck drivers that has focused on increasing HIV counselling and testing prior to the 2010 study dates.

### **Indicator changes compared with previous report**

This Indicator was not reported on in 2008 UNGASS. In UNGASS 2010 the Value of the Indicator was 5%.

There has not been a population-based survey for this GAR Indicator however there are four *Values of other studies*. In all of these studies the Value is higher than that reported in 2010.

The higher risk youth of Vanimo Green had the lowest percentages of HIV testing in the past year and knowing their results (10.9%) Male truck drivers (29.8%) and Ramu workers (27.9%) had higher percentages of HIV testing and knowing their results.

### **Challenges for indicator reporting improvement**

The IBBS will provide data for the GAR 2014 report, as it is currently a challenge not having research data for this indicator on the general



population. However the Consultation Workshop noted the need to have both more at risk sub population and general population studies to best inform the national response to HIV in PNG.

**Recommendations for indicator reporting improvement**

None

## 1.6 HIV Prevalence in Young People

### Percentage of women aged 15–24 who are living with HIV

#### What it Measures

It measures progress towards reducing HIV infection.

#### Rationale

The goal in the response to HIV is to reduce HIV infection.

HIV prevalence at any given age is the difference between the cumulative numbers of people that have become infected with HIV up to this age minus the number who have died, expressed as a percentage of the total number alive at this age. At older ages, changes in HIV prevalence are slow to reflect changes in the rate of new infections (HIV incidence,) because the average duration of infection is long. Furthermore, declines in HIV prevalence can reflect saturation of infection among those individuals who are most vulnerable and rising mortality, rather than behaviour change. At young ages, trends in HIV prevalence are a better indication of recent trends in HIV incidence and risk behaviour. Thus, reductions in HIV incidence associated with genuine behaviour change should first become detectable in trends in HIV prevalence figures for 15–24 years old (or even earlier in those 15 to 19 years if this age breakdown is available). Where available, parallel behavioural surveillance survey data should be used to aid interpretation of trends in HIV prevalence.

#### NHS 2011-2015 Priority Area 1: Prevention.

**Indicator No.22:** Percentage of women and men who are HIV infected

**Purpose** To assess progress in reducing HIV infection.

#### Method of Measurement:

UNAIDS/WHO guidelines for HIV sentinel surveillance

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

HIV prevalence among pregnant women attending ANC clinics was 0.6% in 2011.

#### Data Measurement Tool:

HIV testing among clients of antenatal care (ANC) services offered HIV testing and accepted to do so as part of the prevention of parent to child transmission of HIV (PPTCT) programme.

**From Date:** 1 January 2011

**To Date:** 31 December 2011

Provider initiated testing and counselling (PITC) is an integral part of the PPTCT programme in PNG. In 2011 from a total estimated number of 210,000 pregnant women, a sum of 49,280 (23%) were tested for HIV as part of their antenatal care. Among them, 21,480 were 15 – 24 years old and 121 of them were tested positive.

Age disaggregation		Total
15-19	20-24	
<b>Number of pregnant women 15 - 24 tested positive for HIV</b>		
30	91	121
<b>Number of pregnant women 15 - 24 tested for HIV</b>		
5986	15494	21480
<b>Percentage of women 15 – 24 living with HIV</b>		
0.5%	0.6%	0.6%

---

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

Heterosexual transmission of HIV is believed to be the most important route of transmission in PNG, and HIV prevalence among younger women is generally accepted as a proxy for HIV incidence in general population. Having a prevalence figure of 0.6% among pregnant women 15 – 24 indicates that there is a considerable HIV transmission happening among sexually active women in this age group and their heterosexual partners. From a prevention point of view, it means that access to preventive measures still is much less than needed considering the behavioural context. From a care and treatment view, this figure predicts the future added need for ART and other care needs.

### Indicator changes compared with previous report

In UNGASS 2010 this Indicator reported on *Young people aged 15-24 who are HIV infected*. PNG in it's report in UNGASS 2010 only gave a Value for this Indicator for Young Women aged 15-24 who are HIV infected 0.74%. In UNGASS 2008 the Indicator differed again but PNG did not have data available. While comparing the current figure with the 2010 report indicates a considerable decrease in prevalence in this age group, we have to also take into account a difference in data source between the two reports. In the 2010 UNGASS progress report, data from sentinel site in ANC clinics have been used, where most if not all the sites by that year were based in urban areas. The decrease in the prevalence can be a result of covering more rural/lower prevalence areas or a genuine decrease in HIV incidence or a combination of both.

### Challenges for indicator reporting improvement

Not all pregnant women in PNG have access to ANC services; in 2011 only 125,892 pregnant women from the estimated 210,000 pregnancies have had at least one ANC visit (~60%). Moreover, HIV testing has only been offered to less than 50,000 of them, which means that HIV testing as part of the PPTCT programme has only covered less than 40% of ANC clients and less than a quarter of all pregnant women. Many of the pregnant women without access to ANC and PPTCT services live in the most remote and less accessible

areas in PNG. Therefore, one of the main challenges that has to be overcome is the representativeness of population tested. Another major challenge is the interruptions in the availability of testing materials; the chain from supply of the test kits at the national level to distribution in provinces and availability of them at facility levels has been seriously stressed in the past months which can hamper the quality and coverage of reporting against this indicator.

### **Recommendations for indicator reporting improvement**

Increasing access of pregnant women to ANC services and HIV testing as part of these services is a must for improving the quality and representativeness of reporting on this indicator. At the same time, all those ANC facilities have to have an uninterrupted access to testing and other related commodities as well as providing either anti-retroviral medicines at their sites or a clear and easy to follow referral mechanism.

## 1.7 Sex Workers: Prevention Programmes

### Percentage of sex workers reached with HIV prevention programmes

#### What it Measures

It measures progress in implementing basic elements of HIV prevention programmes for sex workers<sup>17</sup>.

#### Rationale

Sex workers are often difficult to reach with HIV prevention programmes. However, in order to prevent the spread of HIV and AIDS among sex workers, as well as into the general population, it is important that they access these services.

<b>NHS 2011-2015 Priority Area 1: Prevention. Strategic Objectives 1.1.9, 2.4.1, 2.4.4, 2.4.5.</b>	
<b>Indicator No.30:</b>	<i>Percentage of more-at-risk populations reached with HIV prevention programs</i>
<b>Purpose</b>	To measure the coverage for HIV prevention programmes for MARPS.

#### Method of Measurement:

Behavioural surveillance or other special surveys

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

1.

In this study **36.42%** of female and male sex workers in Port Moresby reported having been reached with HIV Prevention programmes.

#### Data Measurement Tool:

Bio-Behavioural Surveillance Survey conducted by IMR

**From Date:** 10 June 2010

**To Date:** 17 July 2010

This is a comprehensive bio-behavioural study of sex work in Port Moresby in Papua New Guinea. The study was designed to fill gaps in knowledge about

<sup>17</sup> This indicator only covers two basic elements of prevention programmes for sex workers. It is recognised that the indicator does not measure the frequency with which members of these populations access services, nor the quality of these services. These limitations suggest that the indicator may overestimate the coverage of HIV prevention services or sex workers. While continued monitoring of this indicator is recommended in order to determine trends in coverage of minimum services, additional measures are required in order to accurately determine whether adequate HIV prevention services are being provided for these populations.

the sex industry in PNG and to map the sale and exchange of sex in Port Moresby to create a richer and more detailed understanding of sex workers and their vulnerability to HIV and was undertaken in between June and July 2010. This study provides the Government of Papua New Guinea and other interested stakeholders with the most comprehensive understanding of sex work in Port Moresby to date.

We asked whether they received free condoms in the last 12 months from any source (including clients, manager of guesthouse, shop/market and others not stated). The answer for question 2 is derived from subsequent question about source of free condoms and it is "yes" for those who received free condoms in the last 12 months from Poro Sapot, drop-in centre, sexual health clinic and/or outreach service. (Total include 1 male with missing age.)

July 2010 in which survey data were collected through a structured questionnaire administered through PDAs, while qualitative data were collected through in depth interviews amongst a smaller sub-set of the total sample. A biological component was included and this consisted of HIV and syphilis testing and HIV molecular epidemiology.

The study site was chosen in consultation with members of the stakeholder group who identified a guest house in Boroko as the study site that was central for the majority of the population who sell or exchange sex in Port Moresby while at the same time being a place where members of this population, in particular transgender, were safe and welcomed.

Criteria for participating in the survey were:

- \* Had either sold or exchanged sex in the last six months in Port Moresby
- \* Had seen at least one other sex worker whom they knew by name in the last two months
- \* 9 years or older

Rather than using traditional paper surveys, we used mini handheld computers known as personal digital assistants (PDAs). All that was required of participants to use the PDA was familiarity with a mobile phone. For illiterate participants, participants can listen to the pre-recorded questions which guide them through the questionnaire. A qualified researcher was readily available to assist participants.

A participant was deemed to have successfully completed the survey if they had answered to the end of the section on sex work. The questionnaire was available on the PDA in both English and Tok Pisin. For practical reasons, some sections of the questionnaire were different across the gender groups (e.g. questions on anal intercourse position, sexual identity, circumcision).

**Sample Size:** Number of survey respondents: 593

**Number of "Sex Workers" who have been asked the following two**

questions:  
 1 - Do you know where you can go if you wish to receive an HIV test?  
 2 - In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in center or sexual health clinic)?

MALE			FEMALE			MALE & FEMALE		
< 25	>+25	Total	< 25	>+25	Total	< 25	>+25	Total
64	87	152	181	260	441	245	347	593

Number of people who have answered "YES" to both questions

MALE			FEMALE			MALE & FEMALE		
< 25	>+25	Total	< 25	>+25	Total	< 25	>+25	Total
21	31	52	74	90	164	95	121	216

Indicator Value

MALE			FEMALE			MALE & FEMALE		
< 25	>+25	Total	< 25	>+25	Total	< 25	>+25	Total
32.81%	35.63%	34.21%	40.88%	34.62%	37.19%	38.78%	34.87%	36.42%

### Value of additional studies

1.

In this study 90.34% of female sex workers and MSM who have indicated that they sold anal sex in exchange for money or other favours, knew where to go if they wished to receive an HIV test and had been given condoms (through an outreach service, drop in centre or sexual health clinic).

Scores for each indicator were not available. The composite score for both indicators in this study by sex showed 87.71% male sex workers and 98.21% FSW knew where to go if they wished to receive an HIV test and had been given condoms (through an outreach service, drop in centre or sexual health clinic). The time period differed for FSW and for MSM who were sex workers.

98.21% female sex workers over the age of 25 knew where to go if they wished to receive an HIV test and had been given condoms in the last 12 months (through an outreach service, drop in centre or sexual health clinic) compared with 86.99% under the age of 25. For MSM who have indicated that they sold anal sex in exchange for money or other favours, 88.89% over the age of 25 knew where to go if they wished to receive an HIV test and had been given condoms in the last 12 months (through an outreach service, drop in centre or sexual health clinic) compared with 86.52% under the age of 25.

### Data Measurement Tool:

Cross Sectional Survey conducted by FHI 360.

**From Date:** November 22 2010 **To Date:** December 18 2010

In late 2010, USAID funded FHI, an international non-government organisation, to conduct a Cross Sectional Survey conducted by FHI 360. Survey among MSM and women in Port Moresby, Papua New Guinea. Respondent driven sampling (RDS) was used to survey 585 participants in November and December 2010. In total, 585 participants (302 MSM and 283 women) were surveyed during the USAID/FHI survey. Though the MSM and FSW study was conducted at the same time by the same investigators the two study populations were investigated separately. Only a portion of the MSM population, i.e., MSM who have indicated that they sold anal sex in exchange for money or other favours in the last four weeks plus all FSW in the specified age categories are reported here.

**Sample Size:** Number of survey respondents: 414

Number of "Sex Workers" who have been asked the following two questions:  
 1 - Do you know where you can go if you wish to receive an HIV test?  
 2 - In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in centre or sexual health clinic)?

MALE			FEMALE			MALE & FEMALE		
< 25	>+25	Total	< 25	>+25	Total	< 25	>+25	Total
89	90	179	123	112	235	212	202	414

Number of people who have answered "YES" to both questions

MALE			FEMALE			MALE & FEMALE		
< 25	>+25	Total	< 25	>+25	Total	< 25	>+25	Total
77	80	157	107	110	217	184	190	374

Indicator Value

MALE			FEMALE			MALE & FEMALE		
< 25	>+25	Total	< 25	>+25	Total	< 25	>+25	Total
86.52%	88.89%	87.71%	86.99%	98.21%	92.34%	86.79%	94.06%	90.34%

2.  
 In this additional study, 31.9% of female higher risk youth had exchanged sex for cash, goods, or services and reported having been reached with HIV prevention programmes.

**Data Measurement Tool:**  
 Behavioural Surveillance Surveys Plan conducted by NRI

**From Date:** 29 June 2009 **To Date:** 8 July 2009



This Behavioural Surveillance Survey targeting higher risk young people in the Vanimo Green District of Sandaun Province (West Sepik) was the first round of BSS research collected by the National Research Institute with this more hidden population. These higher risk young people were recruited from the 29<sup>th</sup> of June to the 29<sup>th</sup> of July 2009 through the use of Respondent Driven Sampling (RDS) for a total sample size of 380 youth (237 male and 143 female youth). Young people recruited were between the ages of 15 and 29, who lived in Vanimo Green, were sexually active and who had had sex with more than one partner.

**Sample Size:** Number of survey respondents: 94

**The percentage of female higher risk youth who exchanged sex and who were reached with HIV prevention programmes**

Female		
Age disaggregation		Total
< 25	25+	
<b>Number of young women who exchanged sex for goods, services or money replied "yes" to both questions</b>		
25	5	30
<b>Total number of young women who exchanged sex for goods, services or money</b>		
78	16	94
<b>Percentage of young women who exchanged sex for goods, services or money replied "yes" to both questions</b>		
32.1%	31.3%	31.9%

Ninety-five female youth reported ever having transactional partners and seventy-one female youth had transactional sex in the last year. Sixty-two young women used a condom the last time they had sex with a man who gave money or gifts for sex. Seventy three young men reported paying for sex, and of these, 64 were below the age of 25 and 9 were over the age of 25. Fifty-three young men reported ever giving money or gifts to a woman to have sex over the past year, while forty-seven male youth had used a condom the last time they had sex with a woman who gave money or gifts for sex

### 3.

In this additional study, 56.8% of women exchanging sex for cash, goods, or services in Mt Hagen, reported having been reached with HIV Prevention programmes.

#### **Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 29 March 2010

**To Date:** 08 April 2010

This Behavioural Surveillance Survey targeting women exchanging sex in Mt. Hagen was the first round of BSS research collected by the National Research Institute with this more hidden population. These women were recruited from the 29<sup>th</sup> of March to the 8<sup>th</sup> of April, 2010 through the use of

Respondent Driven Sampling (RDS) for a total sample size of 242 women who exchanged sex and who lived in different parts of Mt. Hagen and the Western Highlands. It must be noted that 42.6% of women did not know their age and this causes great limitations to age based indicators.

**Sample Size:** Number of survey respondents: 139

**The percentage of sex workers reached with HIV prevention programmes**

Number of women exchanging sex aged who said 'yes' to both questions		
Female		
<25	>+25	Total
43	36	79
Number of women exchanging sex aged interviewed		
Female		
<25	>+25	Total
76	63	139
Percentage of women exchanging sex who said 'yes' to both questions		
Female		
<25	>+25	Total
56.6%	57.1%	56.8%

#### **Interpretation of value in the context of the epidemic in PNG**

The NHS 2011-2015. Highlighted the need to focus HIV prevention programmes on the MARPs as seen in PA.1. Cluster 2.4 Vulnerability of more-at-risk populations.

*An effective combination of HIV prevention approaches includes strategies for working directly with people who are more-at-risk of HIV infection due to sexual practices, life circumstances, and social, cultural and legal structural factors that create risk and vulnerability. In PNG, more-at-risk populations include women and men involved in sex work, men who have sex with men, migrant workers, enclave workers, prisoners and mobile men with money (such as public servants, police, politicians, landowners, cash crop buyers and sellers, transport sector workers, and business men). The sexual partners of these more-at-risk populations are also vulnerable to HIV and will be included in prevention interventions.*

*.....Vulnerability can change and it is important that research and surveillance be continuously used to inform interventions. It is possible that different groups could be considered vulnerable in time as trends and patterns in the HIV epidemic change and evolve.*

The NRI's study with women exchanging sex in Mt Hagen gave a Value of 56.8% as having been reached by HIV prevention programmes. This was far higher than the other Values reported and whilst it did not quite fit the criteria for reporting, it is of significant importance for the national response to understand what programmes are being used in Mt Hagen to reach this most at risk population.

#### **Indicator changes compared with previous report**

The PNG report for the UNGASS 2010 did not have a value to report in 2010 and so repeating the Value from UNGASS 2008 with 31.5% of sex workers being reached with HIV prevention programmes.

GAR 2012 has four studies that report on the *Value of this Indicator* which is a remarkable improvement on the prior two UNGASS reports. Three of the studies report *Values* just above that provided from 2008 data, whilst the higher risk youth who exchanged sex for goods, services or money was just point four percentage points higher at 31.9%.

The Port Moresby IMR study on FSW and MSW was 36.42%, whilst the *Value* in the FHI 360 study value was 90.34% for FSW and MSW in Port Moresby however it is important to note the definitions of 'sex workers' and the period of time of having been reached by HIV prevention programmes differed.

### **Challenges for indicator reporting improvement**

- Three studies (FHI-2010 90.34%, NRI-Mt Hagen 56.8%, IMR 36.42%) all focused on people who either are commercially involved in selling sex or are involved in transactional or the exchange of sex. All three studies have used different criteria for 'sex worker'. The GAR guideline defines as "reported having commercial sex in the last 12 month".
- The GAR 2012 definition for this Indicator also required the period of HIV services to be 12 months period (whilst not detailed as such in the title of the Indicator). The FHI 360 study did not match this criteria. Consequently, as can be seen in the different Values, the studies reached a different band of people when tracked over a week or a longer period i.e. several months

### **Recommendations for indicator reporting improvement**

Consider expanding the definition of sex worker to include those who exchange sex or have transactional sex as this 'type' of transactional sex is not included in the GAR definition of 'commercial sex work'.

## 1.8 Sex Workers: Condom Use

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

#### What it Measures

It measures progress in preventing exposure to HIV among sex workers through unprotected sex with clients.

#### Rationale

Various factors increase the risk of exposure to HIV among sex workers, including multiple, non-regular partners and more frequent sexual intercourse. However, sex workers can substantially reduce the risk of HIV transmission, both from clients and to clients, through consistent and correct condom use.

#### NHS 2011-2015 Priority Area 1: Prevention. Strategic Objectives 1.1.6.

##### Top 10 Intervention

**Indicator No.5:** Percentage of female and male sex workers reporting the use of a condom with their most recent client

**Purpose** To assess progress in increasing the percentage of sex workers who used a condom with their most recent client.

#### Method of Measurement:

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

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

1.

In this study 79.67% of female and male sex workers in Port Moresby who reported having commercial sex in the last 12 months used a condom with their most recent client for vaginal intercourse.

80.39% female respondents who reported having commercial sex in the last 12 months used a condom with their most recent their most recent client for vaginal intercourse and 76.19% male respondents.

#### Data Measurement Tool:

Bio-Behavioural Surveillance Survey conducted by IMR

**From Date:** 10 June 2010

**To Date:** 17 July 2010

This is a comprehensive bio-behavioural study of sex work in Port Moresby in Papua New Guinea. The study was designed to fill gaps in knowledge about

the sex industry in PNG and to map the sale and exchange of sex in Port Moresby to create a richer and more detailed understanding of sex workers and their vulnerability to HIV and was undertaken in between June and July 2010. This study provides the Government of Papua New Guinea and other interested stakeholders with the most comprehensive understanding of sex work in Port Moresby to date.

We asked very detailed questions on sex with clients. This is for vaginal intercourse with clients.

July 2010 in which survey data were collected through a structured questionnaire administered through PDAs, while qualitative data were collected through in depth interviews amongst a smaller sub-set of the total sample. A biological component was included and this consisted of HIV and syphilis testing and HIV molecular epidemiology.

The study site was chosen in consultation with members of the stakeholder group who identified a guest house in Boroko as the study site that was central for the majority of the population who sell or exchange sex in Port Moresby while at the same time being a place where members of this population, in particular transgender, were safe and welcomed.

Criteria for participating in the survey were:

- \* Had either sold or exchanged sex in the last six months in Port Moresby
- \* Had seen at least one other sex worker whom they knew by name in the last two months
- \* 9 years or older

Rather than using traditional paper surveys, we used mini handheld computers known as personal digital assistants (PDAs). All that was required of participants to use the PDA was familiarity with a mobile phone. For illiterate participants, participants can listen to the pre-recorded questions which guide them through the questionnaire. A qualified researcher was readily available to assist participants.

A participant was deemed to have successfully completed the survey if they had answered to the end of the section on sex work. The questionnaire was available on the PDA in both English and Tok Pisin. For practical reasons, some sections of the questionnaire were different across the gender groups (e.g. questions on anal intercourse position, sexual identity, circumcision).

**Sample Size:** Number of survey respondents: 492

<b>Number of respondents who reported having commercial sex in the last 12 months</b>
---

<b>MALE</b>	<b>FEMALE</b>	<b>MALE &amp; FEMALE</b>
-------------	---------------	--------------------------

<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
32	51	84	167	241	408	199	292	492

**Number of respondents who reported that a condom was used with their last client**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
27	36	64	123	205	328	150	241	392

**Indicator Value**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
84.38%	70.59%	76.19%	73.65%	85.06%	80.39%	75.38%	82.53%	79.67%

---

**Values from additional studies:**

1.

In this study of female sex workers and men who have sex with men in Port Moresby, 71.62% who reported having commercial sex in the last 12 months reported using a condom with their most recent client.

71.32% of female sex workers and 72.07% MSM who indicated they sold anal sex in exchange for money, who reported having commercial sex in the last 12 months (for female sex workers) and 1 month (for MSM) and using a condom with their client.

**Data Measurement Tool:**

Cross Sectional Survey conducted by FHI 360.

**From Date:**

November 22 2010

**To Date:** December 18 2010

In late 2010, USAID funded FHI to conduct a Cross Sectional Survey among MSM and women in Port Moresby, Papua New Guinea. Respondent driven sampling (RDS) was used to survey 585 participants in November and December 2010. In total, 585 participants (302 MSM and 283 women) were surveyed during the USAID/FHI survey. Though the MSM and FSW study was conducted at the same time by the same investigators the two study populations were investigated separately. Only a portion of the MSM population, i.e., MSM who have indicated that they sold anal sex in exchange for money or other favours in the last four weeks plus all FSW in the specified age categories are reported here.

**Sample Size:**

Number of survey respondents: 451

**Number of respondents who reported having commercial sex in the last 12 months**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
89	90	179	140	132	272	229	222	451

**Number of respondents who reported that a condom was used with their last client**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
62	67	129	97	97	194	159	164	323

**Indicator Value**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
<b>69.66%</b>	<b>74.44%</b>	<b>72.07%</b>	<b>69.29%</b>	<b>73.48%</b>	<b>71.32%</b>	<b>69.43%</b>	<b>73.87%</b>	<b>71.62%</b>

**2.**

In this additional study, 71.2% of women exchanging sex in Mt Hagen who reported having exchanged sex in the last 12 months and had used a condom with their most recent client.

**Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 29 March 2010

**To Date:** 08 April 2010

This Behavioural Surveillance Survey targeting women exchanging sex in Mt. Hagen was the first round of BSS research collected by the National Research Institute with this more hidden population. These women were recruited from the 29<sup>th</sup> of March to the 8<sup>th</sup> of April, 2010 through the use of Respondent Driven Sampling (RDS) for a total sample size of 242 women who exchanged sex and who lived in different parts of Mt. Hagen and the Western Highlands. It must be noted that 42.6% of women did not know their age and this causes great limitations to age based indicators.

**Sample Size:** Number of survey respondents: 139

The percentage of sex workers reporting the use of condom with their most recent client

**Number of women exchanging sex who said that condom was used with their last**

client		
Female		
<25	>+25	Total
55	44	99
Number of women exchanging sex aged interviewed		
Female		
<25	>+25	Total
76	63	139
Percentage of women exchanging sex who said that condom was used with their last client		
Female		
<25	>+25	Total
72.4%	69.8%	71.2%

### 3.

In this additional study 77.66% of female and male sex workers in Port Moresby who reported having commercial sex in the last 12 months used a condom with their most recent opposite sex client for anal intercourse.

84.08% female respondents who reported having commercial sex in the last 12 months used a condom with their most recent opposite sex client for anal intercourse and 59.72% male respondents.

#### Data Measurement Tool:

Bio-Behavioural Surveillance Survey conducted by IMR

**From Date:** 10 June 2010

**To Date:** 17 July 2010

This is a comprehensive bio-behavioural study of sex work in Port Moresby in Papua New Guinea. The study was designed to fill gaps in knowledge about the sex industry in PNG and to map the sale and exchange of sex in Port Moresby to create a richer and more detailed understanding of sex workers and their vulnerability to HIV and was undertaken in between June and July 2010. This study provides the Government of Papua New Guinea and other interested stakeholders with the most comprehensive understanding of sex work in Port Moresby to date.

July 2010 in which survey data were collected through a structured questionnaire administered through PDAs, while qualitative data were collected through in depth interviews amongst a smaller sub-set of the total sample. A biological component was included and this consisted of HIV and syphilis testing and HIV molecular epidemiology.

The study site was chosen in consultation with members of the stakeholder group who identified a guest house in Boroko as the study site that was central for the majority of the population who sell or exchange sex in Port Moresby while at the same time being a place where members of this population, in particular transgender, were safe and welcomed.

Criteria for participating in the survey were:

\* Had either sold or exchanged sex in the last six months in Port Moresby



\* Had seen at least one other sex worker whom they knew by name in the last two months

\* 9 years or older

Rather than using traditional paper surveys, we used mini handheld computers known as personal digital assistants (PDAs). All that was required of participants to use the PDA was familiarity with a mobile phone. For illiterate participants, participants can listen to the pre-recorded questions which guide them through the questionnaire. A qualified researcher was readily available to assist participants.

A participant was deemed to have successfully completed the survey if they had answered to the end of the section on sex work. The questionnaire was available on the PDA in both English and Tok Pisin. For practical reasons, some sections of the questionnaire were different across the gender groups (e.g. questions on anal intercourse position, sexual identity, circumcision).

We asked very detailed questions on sex with clients. This is for anal intercourse with opposite-sex clients.

**Sample Size:** Number of survey respondents: 273

**Number of respondents who reported having commercial sex in the last 12 months**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
32	40	72	88	113	201	120	153	273

**Number of respondents who reported that a condom was used with their last client**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
22	21	43	67	102	169	89	123	212

**Indicator Value**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
68.75%	52.50%	59.72%	76.14%	90.27%	84.08%	74.17%	80.39%	77.66%

4.

In this additional study 76.99% male sex workers in Port Moresby who reported having commercial sex in the last 12 months used a condom for anal sex with their most recent male client.

**Data Measurement Tool:**

Bio-Behavioural Surveillance Survey conducted by IMR

**From Date:** 10 June 2010

**To Date:** 17 July 2010

This is a comprehensive bio-behavioural study of sex work in Port Moresby in Papua New Guinea. The study was designed to fill gaps in knowledge about the sex industry in PNG and to map the sale and exchange of sex in Port Moresby to create a richer and more detailed understanding of sex workers and their vulnerability to HIV and was undertaken in between June and July 2010. This study provides the Government of Papua New Guinea and other interested stakeholders with the most comprehensive understanding of sex work in Port Moresby to date.

July 2010 in which survey data were collected through a structured questionnaire administered through PDAs, while qualitative data were collected through in depth interviews amongst a smaller sub-set of the total sample. A biological component was included and this consisted of HIV and syphilis testing and HIV molecular epidemiology.

The study site was chosen in consultation with members of the stakeholder group who identified a guest house in Boroko as the study site that was central for the majority of the population who sell or exchange sex in Port Moresby while at the same time being a place where members of this population, in particular transgender, were safe and welcomed.

Criteria for participating in the survey were:

- \* Had either sold or exchanged sex in the last six months in Port Moresby
- \* Had seen at least one other sex worker whom they knew by name in the last two months
- \* 9 years or older

Rather than using traditional paper surveys, we used mini handheld computers known as personal digital assistants (PDAs). All that was required of participants to use the PDA was familiarity with a mobile phone. For illiterate participants, participants can listen to the pre-recorded questions which guide them through the questionnaire. A qualified researcher was readily available to assist participants.

A participant was deemed to have successfully completed the survey if they had answered to the end of the section on sex work. The questionnaire was available on the PDA in both English and Tok Pisin. For practical reasons, some sections of the questionnaire were different across the gender groups (e.g. questions on anal intercourse position, sexual identity, circumcision).

We asked very detailed questions on sex with clients. This is for anal intercourse with same-sex clients (which is only applicable for males). (Total

includes 1 male with missing age.)

**Sample Size:** Number of survey respondents: 113

**Number of respondents who reported having commercial sex in the last 12 months**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
48	64	113						

**Number of respondents who reported that a condom was used with their last client**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
37	49	87						

**Indicator Value**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
<b>77.08%</b>	<b>76.56%</b>	<b>76.99%</b>						

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

The NHS 2011-2015. PA.1. at Cluster 1.1: Sexual transmission of HIV and other STIs makes express reference to the interventions for sex workers.

*Reducing sexual transmission of HIV and other STIs is a core priority. Addressing risks associated with sexual transmission means increasing access to programs, services and resources which help people understand HIV risk in relation to their own behaviour and life circumstances. Risk reduction interventions that address sexual transmission will need to motivate, support, educate and give people the skills to make the changes needed to protect themselves and others.*

*Reducing the number of concurrent sexual partners, increasing correct and consistent condom use, and increasing the availability of gender and age-sensitive post-exposure prophylaxis (PEP) for HIV and STIs are just some of the critical interventions that will be implemented.*

*In recognition that not everyone has the same level of risk, more-at-risk populations will be identified and targeted with combination prevention interventions. Interventions that help protect people engaged in sex work or who exchange sex for cash, goods and services will be rapidly scaled-up.*

These studies reported for the GAR 2012 have significant relevance for the

context of PNG. Whilst it must be noted the variation across all four studies it is fascinating to note how statistically similar the Values are. The key messages is that prevention interventions are reaching these vulnerable populations and they need to be sustained and supported.

The other key information in these studies is the evidence merging of the relevance of anal intercourse as a sexual behaviour in PNG. This is very important in PNG where there is a belief that HIV is not transmitted by anal sex.

The most interesting data reported in this Indicator is the evidence of anal sex between male sex workers and their female clients. The commonly held view (globally) is that in general women do not purchase sex and secondly, that if they do, it would be vaginal sex as a matter of personal preference for women. More research in this area is essential in view of the far higher risk of HIV transmission for women through receptive anal sex than vaginal sex. Particular focus needs to be on the role of contraception and avoidance of conception as well as personal pleasure for women.

The following information was provided by Friends Frangipani and provides background information that will be of value in future GAR reports.

Friends Frangipani is a sex workers umbrella organisation looking after sex workers operating in 7 respective provinces. The organisations key role is to advocate for their human rights and sexual health issues. So far the organisation has got eight (8) sex workers groups operating in 7 provinces.

Sex works operations are not fully functioning as most sex workers are still feeling insecure due to legal implications. According to the Friends Frangipani records:

Port Moresby in the National Capital District has 90 SW, EHP province with 63 i.e.: (Goroka 20 and Kainantu 43), Simbu 60, Madang 27, Lae 45, Wewak 17, Mt Hagen 31.

### **Indicator changes compared with previous report**

The UNGASS 2008 data was collected through Round One of the BSS, the value was 93.7% for condom use with the most recent client. The UNGASS 2010 reported the Value 50% from the Poro Sapot project program monitoring report.

For the *Values* reported in GAR 2012 for this Indicator the studies are remarkably consistent and they are higher than the Value reported in 2010 UNGASS.

For MSM and FSW in the POM FHI 360 study the *Value* is 71.62% and for the NRI Mt Hagen women exchanging sex the *Value* is 71.22%. For the IMR POM study for FSW and MSW using a condom for vaginal sex the *Value* is 79.67%, for those using a condom for anal sex with an opposite sex partner 77.66% and MSW using a condom for anal sex with their most recent same sex partner 76.99%.

### **Challenges for indicator reporting improvement**

- It was thought that it is very difficult for people to report for over a 12 month period as they cannot remember and that 1 month is much easier for them to remember their partners and condom use.

**Recommendations for indicator reporting improvement**

- Indicators should ask for separate values for males and females.
- Indicators should differentiate between condom use for vaginal sex and those used for anal sex
- There is a need to increase research in PNG and globally on anal sex between male sex workers and their female clients.

## 1.9 HIV Testing in Sex Workers

### Percentage of sex workers who received an HIV test in the past 12 months and know their results

#### What it Measures

It measures progress in implementing HIV testing and counselling among sex workers

#### Rationale

In order to protect themselves and to prevent infecting others, it is important for sex workers to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment. Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more most-at-risk populations. If so, they should calculate and report this indicator for those populations.

#### NHS 2011-2015 Priority Area 2: Counselling, testing, Treatment, Care and Support. Strategic Objectives. 1.1.3

##### Top 10 Intervention

##### Indicator No.13:

*Percentage of most at risk populations that have received an HIV test in the last 12 months and know the results.*

##### Purpose

This indicator measures the percentage of MARPs who had an HIV test in the previous 12 months and received their result.

#### Data Measurement Tool:

Behavioural surveillance or other special surveys.

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

1.

In this study 46.37% sex workers in Port Moresby who received an HIV test in the last 12 months report they know their results.

47.17% female sex workers who received an HIV test in the last 12 months report they know their results and 44.08% male sex workers.

#### Data Measurement Tool:

Bio-Behavioural Surveillance Survey conducted by IMR

**From Date:**

10 June 2010

**To Date:**

17 July 2010

This is a comprehensive bio-behavioural study of sex work in Port Moresby in

Papua New Guinea. The study was designed to fill gaps in knowledge about the sex industry in PNG and to map the sale and exchange of sex in Port Moresby to create a richer and more detailed understanding of sex workers and their vulnerability to HIV and was undertaken in between June and July 2010. This study provides the Government of Papua New Guinea and other interested stakeholders with the most comprehensive understanding of sex work in Port Moresby to date.

July 2010 in which survey data were collected through a structured questionnaire administered through PDAs, while qualitative data were collected through in depth interviews amongst a smaller sub-set of the total sample. A biological component was included and this consisted of HIV and syphilis testing and HIV molecular epidemiology.

The study site was chosen in consultation with members of the stakeholder group who identified a guest house in Boroko as the study site that was central for the majority of the population who sell or exchange sex in Port Moresby while at the same time being a place where members of this population, in particular transgender, were safe and welcomed.

Criteria for participating in the survey were:

- \* Had either sold or exchanged sex in the last six months in Port Moresby
- \* Had seen at least one other sex worker whom they knew by name in the last two months
- \* 9 years or older

Rather than using traditional paper surveys, we used mini handheld computers known as personal digital assistants (PDAs). All that was required of participants to use the PDA was familiarity with a mobile phone. For illiterate participants, participants can listen to the pre-recorded questions which guide them through the questionnaire. A qualified researcher was readily available to assist participants.

A participant was deemed to have successfully completed the survey if they had answered to the end of the section on sex work. The questionnaire was available on the PDA in both English and Tok Pisin. For practical reasons, some sections of the questionnaire were different across the gender groups (e.g. questions on anal intercourse position, sexual identity, circumcision).

We did ask for self-reported results in this study. (Total include 1 male with missing age.) NB:  $\geq 25$ , not  $>+25$

**Sample Size:** Number of survey respondents: 593

<p>Number of "Sex Workers" who have been asked the following two questions:</p> <p>1 - I don't want to know the results, but have you been tested for HIV in the last 12 months?</p> <p>2 - If yes: I don't want to know the results, but did you get the results of that</p>
---

test?

MALE			FEMALE			MALE & FEMALE		
< 25	>+25	Total	< 25	>+25	Total	< 25	>+25	Total
64	87	152	181	260	441	245	347	593

Number of people who have answered correctly to both questions

MALE			FEMALE			MALE & FEMALE		
< 25	>+25	Total	< 25	>+25	Total	< 25	>+25	Total
26	40	67	80	128	208	106	168	275

Indicator Value

MALE			FEMALE			MALE & FEMALE		
< 25	>+25	Total	< 25	>+25	Total	< 25	>+25	Total
40.63%	45.98%	44.08%	44.20%	49.23%	47.17%	43.27%	48.41%	46.37%

**Values for additional studies:**

1.

In this additional study of female sex workers and MSM who have indicated that they sold anal sex in exchange for money or other favours in Port Moresby, 46.94% reported having been tested for HIV in the last 12 months and receiving their results.

49.11% of female sex workers and 43.50% MSM who have indicated that they sold anal sex in exchange for money or other favours reported having been tested for HIV in the last 12 months and receiving their results.

**Data Measurement Tool:**

Cross Sectional Survey conducted by FHI 360.

**From Date:** November 22 2010 **To Date:** December 18 2010

In late 2010, USAID funded FHI to conduct a Cross Sectional Survey among MSM and women in Port Moresby, Papua New Guinea. Respondent driven sampling (RDS) was used to survey 585 participants in November and December 2010. In total, 585 participants (302 MSM and 283 women) were surveyed during the USAID/FHI survey. Though the MSM and FSW study was conducted at the same time by the same investigators the two study populations were investigated separately. Only a portion of the MSM population, i.e., MSM who have indicated that they sold anal sex in exchange for money or other favours in the last four weeks plus all FSW in the specified age categories are reported here.



**Sample Size:** Number of survey respondents: 458

Number of "Sex Workers" who have been asked the following two questions:  
 1 - I don't want to know the results, but have you been tested for HIV in the last 12 months?  
 2 - If yes: I don't want to know the results, but did you get the results of that test?

MALE			FEMALE			MALE & FEMALE		
< 25	>+25	Total	< 25	>+25	Total	< 25	>+25	Total
89	88	177	148	133	281	237	221	458

Number of people who have answered "YES" to both questions

MALE			FEMALE			MALE & FEMALE		
< 25	>+25	Total	< 25	>+25	Total	< 25	>+25	Total
33	44	77	64	74	138	97	118	215

**Indicator Value**

MALE			FEMALE			MALE & FEMALE		
< 25	>+25	Total	< 25	>+25	Total	< 25	>+25	Total
37.08%	50.00%	43.50%	43.24%	55.64%	49.11%	40.93%	53.39%	46.94%

**2.**

In this additional study, 19.1% of female youth who exchanged sex for goods, services or money, had been tested for HIV during the last 12 months and k their results. .

**Data Measurement Tool:**

Behavioural Surveillance Surveys Plan conducted by NRI

**From Date:** 29 June 2009

**To Date:** 08 July 2009

This Behavioural Surveillance Survey targeting higher risk young people in the Vanimo Green District of Sandaun Province (West Sepik) was the first round of BSS research collected by the National Research Institute with this more hidden population. These higher risk young people were recruited from the 29<sup>th</sup> of June to the 29<sup>th</sup> of July 2009 through the use of Respondent Driven Sampling (RDS) for a total sample size of 380 youth (237 male and 143 female youth). Young people recruited were between the ages of 15 and 29, who lived in Vanimo Green, were sexually active and who had had sex with more than one partner.

**Sample Size:** Number of survey respondents: 94

The percentage of sex workers who received an HIV test in the past 12 months and know their results

Female		
Age disaggregation		Total
< 25	25+	
<b>Number of young women who exchange sex for goods, services or money who have been tested for HIV during the last 12 months and who know their results</b>		
14	4	18
<b>Total number of young women who exchange sex for goods, services or money for sex</b>		
78	16	94
<b>Percentage of young women who exchange sex for goods, services or money who have been tested for HIV during the last 12 months and who know their results</b>		
17.9%	25.0%	19.1 %

### 3.

In this study, 46.0% of women exchanging sex in Mt Hagen had been tested for HIV in the last 12 months and knew their results.

#### Data Measurement Tool:

Behavioural Surveillance Survey conducted by NRI

**From Date:** 29 March 2010

**To Date:** 08 April 2010

This Behavioural Surveillance Survey targeting women exchanging sex in Mt. Hagen was the first round of BSS research collected by the National Research Institute with this more hidden population. These women were recruited from the 29<sup>th</sup> of March to the 8<sup>th</sup> of April, 2010 through the use of Respondent Driven Sampling (RDS) for a total sample size of 242 women who exchanged sex and who lived in different parts of Mt. Hagen and the Western Highlands. It must be noted that 42.6% of women did not know their age and this causes great limitations to age based indicators.

**Sample Size:** Number of survey respondents: 139

The percentage of sex workers who received an HIV test in the past 12 months and know their results

<b>Number of women exchanging sex who received a HIV test in the last 12 months and know their result</b>		
Female		
<25	>+25	Total
41	23	64
<b>Number of women exchanging sex aged interviewed</b>		
Female		
<25	>+25	Total
76	63	139
<b>Percentage of women exchanging sex who received a HIV test in the last 12 months and know their result</b>		
Female		
<25	>+25	Total
53.9%	36.5%	46.0%

---

### **Interpretation of value in the context of the epidemic in PNG**

The NHS 2011-2015 has a specific focus and a high priority given to increasing access to VCT - PA.2 Strategic Priority 2. Cluster 1.1 Scale up HIV Counselling and Testing

*Expanding access to and increasing uptake of HCT is fundamental to the achievement of the NHS goals. Equitable access to these services, regardless of gender, age, geographic location or sexual practice is both a moral and public health obligation. HCT is an important entry point to prevention and care, treatment and support services. The availability of HCT will be extended to all parts of the country. The priority is to make these services available at the local level in provinces and districts with the highest HIV prevalence.*

*HCT will move beyond the traditional models of VCT and make PICT and outreach testing more widely available, while respecting individual informed consent.*

**Strategic Objective:** 1.1.3 *Priority target populations have access to quality HCT services that are sensitive to their specific needs, concerns and situation*

It is of interest for the national response to note how the results in three of these four studies are remarkably consistent. Whilst this gives an indication of some consistency in the response to the interventions that have been made with these populations it also strongly suggests further focus needs to be on understanding the significant difference seen in the Vanimo youth study.

#### **Indicator changes compared with previous report**

The UNGASS 2008 did not include male sex workers and the Value was drawn from Round One BSS. UNGASS 2010 Value of 55.8% was drawn from programme data from Poro Sapot.

There are four behavioural surveillance studies that inform this Value for PNG for selling sex and testing for HIV in the last year and knew their results. Three of the four studies are close. The lowest Value is from the NRI study with higher risk youth in the Vanimo District where 19.1% of female youth exchanged and had been tested for HIV during the last 12 months and knew their results. For male and female sex workers in the FHI 360 study, the Value is 46.94%, and for the Mt Hagen young women exchanging sex 46.4% and for the IMR study 46.7%.

#### **Challenges for indicator reporting improvement**

As detailed previously

#### **Recommendations for indicator reporting improvement**

As detailed previously

## 1.10 HIV Prevalence in Sex Workers:

### Percentage of sex workers risk who are living with HIV

#### What it Measures

It measures progress on reducing HIV prevalence among sex workers.

#### Rationale

Sex workers typically have higher HIV prevalence than the general population in both concentrated and generalized epidemics. In many cases, prevalence among these populations can be more than double the prevalence among the general population. Reducing prevalence among sex workers is a critical measure of a national-level response to HIV.

#### NHS 2011-2015 Priority Area 1: Impact of the NHS

##### Top 10 Intervention

**Indicator No.23:** *Percentage of more-at-risk populations who are HIV infected.*

**Purpose** To assess progress on reducing HIV prevalence among MARPS.

#### Data Measurement Tool:

UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV. (WHO/UNAIDS, 2011).

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

1.

In this study **17.79%** sex workers in Port Moresby who were tested and tested positive for HIV.

19.03% female sex workers who were tested for HIV and tested positive for HIV and 14.06% male sex workers.

#### Data Measurement Tool:

Bio-Behavioural Surveillance Survey conducted by IMR

**From Date:** 10 June 2010

**To Date:** 17 July 2010

This is a comprehensive bio-behavioural study of sex work in Port Moresby in Papua New Guinea. The study was designed to fill gaps in knowledge about the sex industry in PNG and to map the sale and exchange of sex in Port Moresby to create a richer and more detailed understanding of sex workers and their vulnerability to HIV and was undertaken in between June and July 2010. This study provides the Government of Papua New Guinea and other interested stakeholders with the most comprehensive understanding of sex

work in Port Moresby to date.

July 2010 in which survey data were collected through a structured questionnaire administered through PDAs, while qualitative data were collected through in depth interviews amongst a smaller sub-set of the total sample. A biological component was included and this consisted of HIV and syphilis testing and HIV molecular epidemiology.

The study site was chosen in consultation with members of the stakeholder group who identified a guest house in Boroko as the study site that was central for the majority of the population who sell or exchange sex in Port Moresby while at the same time being a place where members of this population, in particular transgender, were safe and welcomed.

Criteria for participating in the survey were:

- \* Had either sold or exchanged sex in the last six months in Port Moresby
- \* Had seen at least one other sex worker whom they knew by name in the last two months
- \* 9 years or older

Rather than using traditional paper surveys, we used mini handheld computers known as personal digital assistants (PDAs). All that was required of participants to use the PDA was familiarity with a mobile phone. For illiterate participants, participants can listen to the pre-recorded questions which guide them through the questionnaire. A qualified researcher was readily available to assist participants.

A participant was deemed to have successfully completed the survey if they had answered to the end of the section on sex work. The questionnaire was available on the PDA in both English and Tok Pisin. For practical reasons, some sections of the questionnaire were different across the gender groups (e.g. questions on anal intercourse position, sexual identity, circumcision).

**Sample Size:** Number of survey respondents: 416

**Number of sex workers tested for HIV**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
41	64	106	116	194	310	157	258	416

**Number of sex workers who test positive for HIV**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total

6	9	15	14	45	59	20	54	74
---	---	----	----	----	----	----	----	----

**Indicator Value**

MALE			FEMALE			MALE & FEMALE		
<25	>=25	Total	<25	>=25	Total	<25	>=25	Total
14.63%	14.06%	14.15%	12.07%	23.20%	19.03%	12.74%	20.93%	17.79%

---

### **Interpretation of value in the context of the epidemic in PNG**

This indicator for the NHS 2011-2015 measures the Impact of the NHS 2011-2015, most crucially the reduction of HIV infections.

Most significantly for the PNG context is the very high percentage of HIV infection amongst sex workers in this study. 17.79% is one of the highest reported for sex workers in PNG.

### **Indicator changes compared with previous report**

Not reported in UNGASS 2008 and the *Value* in UNGASS 2010 was 5.86% drawn from programme data with Poro Sapot.

The IMR study in Port Moresby provided a Value of 17.79%, with 19.0% of female SW and 14.06% of male SW. This is a significant increase on the Value provided in the UNGASS 2010 report.

### **Challenges for indicator reporting improvement**

Note prior comments

### **Recommendations for indicator reporting improvement**

## 1.11 Men who have sex with men: Prevention Programmes

### Percentage of men who have sex with men reached with HIV prevention programmes

#### What it Measures

It measures progress in implementing basic elements of HIV prevention programmes for MSM<sup>18</sup>.

#### Rationale

Men who have sex with men (MSM) are often difficult to reach with HIV prevention programmes. However, in order to prevent the spread of HIV and AIDS among MSM as well as into the general population, it is important that they access these services.

**NHS 2011-2015 Priority Area 1: Prevention. Strategic Objectives 1.1.9, 2.4.1, 2.4.4, 2.4.5.**

**Indicator No.30:** *Percentage of more-at-risk populations reached with HIV prevention programs*

**Purpose** To measure the coverage for HIV prevention programmes for MARPS.

**Number of "Men who have Sex with Men" who have been asked the following two questions:**

- 1 - Do you know where you can go if you wish to receive an HIV test?
- 2 - In the last twelve months, have you been given condoms (e.g. through an outreach service, drop-in center or sexual health clinic)?

#### Data Measurement Tool:

Behavioural Surveillance or other special surveys

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

1.

In this study **66.56%** MSM in Port Moresby reported having been reached with HIV prevention programmes

#### Data Measurement Tool:

Cross Sectional Survey conducted by FHI 360.

**From Date:** November 22 2010      **To Date:** December 18

<sup>18</sup> This indicator only covers two basic elements of prevention programmes for MSM. It is recognised that the indicator does not measure the frequency with which members of these populations access services, nor the quality of these services. These limitations suggest that the indicator may overestimate the coverage of HIV prevention services for MSM. While continued monitoring of this indicator is recommended in order to determine trends in coverage of minimum services, additional measures are required in order to accurately determine whether adequate HIV prevention services are being provided for these populations.

2010

In late 2010, USAID funded FHI to conduct a Cross Sectional Survey among MSM and women in Port Moresby, Papua New Guinea. Respondent driven sampling (RDS) was used to survey 585 participants in November and December 2010. In total, 585 participants (302 MSM and 283 women) were surveyed during the USAID/FHI survey. Though the MSM and FSW study was conducted at the same time by the same investigators the two study populations were investigated separately.

The operational definition of MSM for this study were biological males aged between 15 and 49 years old who had anal sex with at least one man in the past 3 months and who had been living in Port Moresby for at least 12 months. Only a portion of this MSM population, i.e., MSM who have indicated that they sold anal sex in exchange for money or other favours in the last four weeks were included in this study question.

**Sample Size:** Number of survey respondents: 299

ALL		
< 25	>+25	Total
152	147	299

**Number of people who have answered "YES" to both questions**

ALL		
< 25	>+25	Total
122	117	199

**Indicator Value**

ALL		
< 25	>+25	Total
80.26%	79.59%	66.56%

---

**Values of additional studies:**

1.

In this additional study, forty-one male youth reported having male to male sex and of these, 34.1% of these male youth reported having been reached with HIV prevention programmes.

**Data Measurement Tool:**

Behavioural Surveillance Surveys Plan conducted by NRI

**From Date:** 29 June 2009

**To Date:** 8 July 2009

This study was done within higher risk young people and was not a sample of



MSM but data considers those male youth reporting male to male sex within the sample. This Behavioural Surveillance Survey targeting higher risk young people in the Vanimo Green District of Sandaun Province (West Sepik) was the first round of BSS research collected by the National Research Institute with this more hidden population. These higher risk young people were recruited from the 29<sup>th</sup> of June to the 29<sup>th</sup> of July 2009 through the use of Respondent Driven Sampling (RDS) for a total sample size of 380 youth (237 male and 143 female youth). Young people recruited were between the ages of 15 and 29, who lived in Vanimo Green, were sexually active and who had had sex with more than one partner.

**Sample Size:** Number of survey respondents: 41

**The percentage of men who have sex with men reached with HIV prevention programs**

Male		
Age disaggregation		Total
< 25	25+	
<b>Number of young men who have sex with men who replied "yes" to both questions</b>		
12	2	14
<b>Total number of young men who have sex men interviewed</b>		
35	6	41
<b>Percentage of young men who have sex with men who replied "yes" to both questions</b>		
34.3%	33.3%	34.1%

Note that thirty-three young men reported having had same sex partners in the last 12 months. Of these, 17 youths reported using a condom while 16 youths reported not using a condom the last time they had anal sex with a male partner, and they were between the ages of 15-29.

## 2.

In this study, only eight male workers who knew their ages reported having male to male sex and of these eight, and 12.5% (1) of these male workers reported In this study 16.7% MSM report having been reached with HIV prevention programmes.

### **Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 25 July 2010      **To Date:** 11 August 2010

This study was done within a workforce and was not a sample of MSM but data considers those men reporting male to male sex within the sample. This Behavioural Surveillance Survey among the Ramu Agri Industry workforce was the second round of BSS with this population; however there have been major changes in the composition of the workforce between the first BSS data collection by the National AIDS Council Secretariat in 2006 with Ramu Sugar Factory workers and the 2<sup>nd</sup> BSS data collection with Ramu Agri Industries workers in 2010 by the National Research Institute. Ramu Sugar had expanded to Ramu Agri Industries by 2010 and the rapidly expanding oil palm and the beef plantations workers were also included for sampling with the sugar plantation workforce in 2010 because of the movement of people into

the plantations and the changing nature of the workforce that was projected to continue to increase.

The random sampling with the workforce was based on employee lists and proportional and stratified to three types of work (sugar, beef and oil palm) across six sites. All workers selected were targeted for interviewing and were recruited from the sites during the day during the time of collection, for a sample of 602 RAI workers (494M and 108F). Data collection took eighteen days and began on the 25<sup>th</sup> of July and was completed on the 11<sup>th</sup> of August, 2010.

**Sample Size:** Number of survey respondents: 8

**The percentage of men who have sex with men reached with HIV prevention programs**

Number of RAI men who have sex with men who were reached with HIV programs		
Male		
<25	>+25	Total
0	1	1
Number RAI men who have sex with men interviewed		
Male		
<25	>+25	Total
2	6	8
Percentage of RAI men who have sex with men who were reached with HIV prevention programmes		
Male		
<25	>+25	Total
0.0%	16.7%	12.5%

---

### **Interpretation of value in the context of the epidemic in PNG**

The NHS 2011-2015 provides an express focus on the risk of transmission for MSM in PA.1.Cluster 1.1. and in the Strategic Priority 1. SO 1.1.8.

*Reducing sexual transmission of HIV and other STIs is a core priority. Addressing risks associated with sexual transmission means increasing access to programs, services and resources which help people understand HIV risk in relation to their own behaviour and life circumstances. Risk reduction interventions that address sexual transmission will need to motivate, support, educate and give people the skills to make the changes needed to protect themselves and others.*

*Reducing the number of concurrent sexual partners, increasing correct and consistent condom use, and increasing the availability of gender and age-sensitive post-exposure prophylaxis (PEP) for HIV and STIs are just some of the critical interventions that will be implemented.*

*In recognition that not everyone has the same level of risk, more-at-risk populations will be identified and targeted with combination prevention interventions. Interventions that help protect people engaged in sex work or who exchange sex for cash, goods and services will be rapidly scaled-up. And S.O. 1.1.8 Men who have sex with men adopt and sustain behaviours that reduce the risk of HIV transmission*

Overall the Values reported all show a significant improvement in the percentage of MSM reached by HIV prevention programmes in the period of this GAR report. However, numbers in some of these studies were limited. This informs the national response to ensure the programmes that have achieved this improvement are understood and sustained.

### **Indicator changes compared with previous report**

The UNGASS 2008 report provided two separate *Values* drawn from a 2006 study on FSW that also collected data on MSW. 11.67% of MSW answered yes to having been given condoms and 78% answered yes to the question on where to access an HIV test. (Questions were the same as the GAR 2012 Indicator).

The UNGASS 2010 gave a Value of 10.3% for those who answered yes to both questions. For the GAR 2012 three Values are reported. The lowest Values are amongst the populations of Ramu workers at 12.5% and amongst 7%, the higher risk male youth from Vanimo District the Value at 34.1%. The FHI 360 study with MSM has a Value that is the highest at 66.56%.

### **Challenges for indicator reporting improvement**

It is noted that differing operational definitions of MSM and varying timeframes made the interpretation of these different studies a challenge. The Consensus Workshop recommended that PNG revitalise the 2009 workshops previously ran by NRI about standardising behavioural survey indicators for future GAR reports and for reporting on NHS 2011-2015 Indicators.

### **Recommendations for indicator reporting improvement**

The GAR 2012 does not provide any definition for MSM for this Indicator just a description about how they got the condoms. A more detailed description of MSM would be beneficial for greater accuracy in study design and in indicator reporting.

## 1.12 Men Who Have Sex with Men: Condom Use

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

#### What it Measures

It measures progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner.

#### Rationale

Condoms can substantially reduce the risk of the sexual transmission of HIV. Consequently, consistent and correct condom use is important for men who have sex with men because of the high risk of HIV transmission during unprotected anal sex. In addition, men who have anal sex with other men may also have female partners, who could become infected as well. Condom use with their most recent male partner is considered a reliable indicator of longer-term behaviour.

#### NHS 2011-2015 Priority Area 1: Prevention. Strategic Objectives 1.1.8.

##### Top 10 Interventions

**Indicator No.7:** Percentage of men reporting condom use the last time they had anal sex with a male partner

**Purpose** To assess the progress in increasing the percentage of men reporting condoms used the last time they had anal sex with a male partner.

#### Data Measurement Tool:

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

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

1.

In this study **70.2%** men reported condom use for anal sex with the last casual partner. The denominator was the number of MSM who reported having had anal sex with a male partner in the last three months, not six as stipulated in the GAR guidelines.

#### Data Measurement Tool:

Cross Sectional Survey conducted by FHI 360.

**From Date:** November 22 2010 **To Date:** December 18 2010

In late 2010, USAID funded FHI to conduct a Cross Sectional Survey among MSM and women in Port Moresby, Papua New Guinea. Respondent driven sampling (RDS) was used to survey 585 participants in November and December 2010. In total, 585 participants (302 MSM and 283 women) were surveyed during the USAID/FHI survey. Though the MSM and FSW study was conducted at the same time by the same investigators the two study populations were investigated separately. Only a portion of the MSM population, i.e., MSM who have indicated that they sold anal sex in exchange for money or other favours in the last four weeks.

Eligibility criteria MSM in this BSS in Port Moresby was "men who had anal sex with other men in the past three months. The question about condom use at last sex was not straight forward. There were four questions relating to condom use at last time they had anal sex: 1) with regular partner 2) with casual partner and 3) with one-time commercial sex partner, and 4) regular commercial partner making it difficult to get a numerator for this indicator as we are not sure if last time sex was with which partner. The results are therefore as follows: 1) 49.0%, 2) 63.09%, 3) 71.7% and 4) 70.2%. The reported result here is only for a "condom use with last casual partner".

**Sample Size:** Number of survey respondents: 298

**Number of respondents who reported having had anal sex with a male partner in the last six months**

Total		
<25	>=25	Total
152	146	298

**Number of respondents who reported that a condom was used the last time they had anal sex**

Total		
<25	>=25	Total
91	97	188

**Indicator Value**

Total		
<25	>=25	Total
<b>59.87%</b>	<b>66.44%</b>	<b>63.09%</b>

---

**Values of additional Studies**

1.

In this study, eight male workers reported having male to male sex and only one worker (12.5%) reported the use of a condom the last time they had anal sex with a male partner

**Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 25 July 2010      **To Date:** 11 August 2010

This study was done within a workforce and was not a sample of MSM but data considers those men reporting male to male sex within the sample. This Behavioural Surveillance Survey among the Ramu Agri Industry workforce was the second round of BSS with this population; however there have been major changes in the composition of the workforce between the first BSS data collection by the National AIDS Council Secretariat in 2006 with Ramu Sugar Factory workers and the 2<sup>nd</sup> BSS data collection with Ramu Agri Industries workers in 2010 by the National Research Institute. Ramu Sugar had expanded to Ramu Agri Industries by 2010 and the rapidly expanding oil palm and the beef plantations workers were also included for sampling with the sugar plantation workforce in 2010 because of the movement of people into the plantations and the changing nature of the workforce that was projected to continue to increase.

The random sampling with the workforce was based on employee lists and proportional and stratified to three types of work (sugar, beef and oil palm) across six sites. All workers selected were targeted for interviewing and were recruited from the sites during the day during the time of collection, for a sample of 602 RAI workers (494M and 108F). Data collection took eighteen days and began on the 25<sup>th</sup> of July and was completed on the 11<sup>th</sup> of August, 2010.

Eight men reported ever having same sex partners. Of these 5 did not have same sex partners in the last 12 months while 2 men reported having one partner and 1 RAI male worker did not know how many men he had sex with in the last 12 months. Of these 3 men who had male sexual partners in the last year, 1 man who was between 20-24 years old used a condom at last sex while 2 men (who were between the ages of 30-39) did not use a condom.

**Sample Size:**                      Number of survey respondents: 8**The percentage of men reporting the use of a condom the last time they had anal sex with a male partner**

Number of RAI men who have sex with men who used a condom at last anal sex		
Male		
<25	>+25	Total
1	0	1
Number RAI men who have sex with men interviewed		
Male		

<25	>+25	Total
2	6	8
<b>Percentage of RAI men who have sex with men who used a condom at last anal sex</b>		
<b>Male</b>		
<25	>+25	Total
50.0%	0.0%	12.5%

---

### **Interpretation of value in the context of the epidemic in PNG**

The NHS 2011-2015 has recognised the importance of correct and consistent condom use for MSM as seen in PA .1. SO 1.1.3 - *Increased correct and consistent use of condoms and lubricant for heterosexual and homosexual anal sex*

The need to increase the investment in condom behaviour change programmes for MSM is highlighted by the varying Values in these studies.

### **Indicator changes compared with previous report**

The UNGASS 2008 Value in the study did not match the Indicator as it did not ask the exact question however the Value reported was 88.49% MSM sex workers who used a condom in the last sexual intercourse with a one time client. The UNGASS 2010 reported the Value as 51.4% for MSM drawn from the Poro Sapot programme data.

GAR 2012 Values vary from the Ramu enclave population survey 12.57% (8 in the survey sample) and the FHI 360 MSM in Port Moresby Value 70.2%. The contrast may be explained by the difference in setting (urban versus economic enclave) but more so in target of population, as the sample for Ramu were not a sample of MSM but were male workers who had male to male sex and the FHI study focused on all MSM sample; however this highlights the need for targeted HIV prevention services to MSM or men who have male to male sex in non-urban settings.

### **Challenges for indicator reporting improvement**

PNG needs to harmonise the definitions and study designs for the NHS 2011-2015 national indicators but also a challenge with UNAIDS changing the indicators between UNGASS 2010 and GAR 2012.

### **Recommendations for indicator reporting improvement**

As noted in the previous Indicator report more specific guidance is needed for the definitions for MSM.

## 1.13 HIV Testing in men who have sex with men

### Percentage of men who have sex with men who received an HIV test in the past 12 months and know their results

#### What it Measures

It measures progress in implementing HIV testing and counselling among men who have sex with men

#### Rationale

In order to protect themselves and to prevent infecting others, it is important for men who have sex with men to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment.

#### NHS 2011-2015

Priority Area 2: Counselling, testing, Treatment, Care and Support.

Strategic Objectives. 1.1.3

#### Top 10 Intervention

#### Indicator No.13:

*Percentage of most at risk populations that have received an HIV test in the last 12 months and know the results.*

#### Purpose

**This indicator measures the percentage of MARPs who had an HIV test in the previous 12 months and received their result.**

#### Data Measurement Tool:

Behavioural Surveillance or other special surveys

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is not available. Submitting additional studies.

#### Value of Indicator:

1.

In this study **55.81%** MSM reported an HIV test in the last 12 months and knowing their results.

#### Data Measurement Tool:

Cross Sectional Survey conducted by FHI 360.

#### From Date:

November 22 2010

**To Date:** December 18 2010

In late 2010, USAID funded FHI to conduct a Cross Sectional Survey among MSM and women in Port Moresby, Papua New Guinea. Respondent driven sampling (RDS) was used to survey 585 participants in November and December 2010. In total, 585 participants (302 MSM and 283 women) were surveyed during the USAID/FHI survey. Though the MSM and FSW study was conducted at the same time by the same investigators the two study



populations were investigated separately. Only a portion of the MSM population, i.e., MSM who have indicated that they sold anal sex in exchange for money or other favours in the last four weeks.

Eligibility criteria MSM in this BSS in Port Moresby was "men who had anal sex with other men in the past three months".

**Sample Size:** Number of survey respondents: 301

**Number of ""Men who have Sex with Men" who have been asked the following two questions:**  
**1 - I don't want to know the results, but have you been tested for HIV in the last 12 months?**  
**2 - If yes: I don't want to know the results, but did you get the results of that test?**

ALL		
< 25	>+25	Total
124	177	301

**Number of people who have answered "YES" to both questions**

ALL		
< 25	>+25	Total
78	90	168

**Indicator Value**

ALL		
< 25	>+25	Total
<b>62.90%</b>	<b>50.85%</b>	<b>55.81%</b>

---

### Value of additional studies

1.

In this study 25% of eight male workers who had male to male sex reported an HIV test in the last 12 months and knew their results.

### Data Measurement Tool:

Behavioural Surveillance Survey conducted by NRI

**From Date:** 25 July 2010      **To Date:** 11 August 2010

This study was done within a workforce and was not a sample of MSM but data considers those men reporting male to male sex within the sample. This Behavioural Surveillance Survey among the Ramu Agri Industry workforce was the second round of BSS with this population; however there have been major changes in the composition of the workforce between the first BSS data

collection by the National AIDS Council Secretariat in 2006 with Ramu Sugar Factory workers and the 2<sup>nd</sup> BSS data collection with Ramu Agri Industries workers in 2010 by the National Research Institute. Ramu Sugar had expanded to Ramu Agri Industries by 2010 and the rapidly expanding oil palm and the beef plantations workers were also included for sampling with the sugar plantation workforce in 2010 because of the movement of people into the plantations and the changing nature of the workforce that was projected to continue to increase.

The random sampling with the workforce was based on employee lists and proportional and stratified to three types of work (sugar, beef and oil palm) across six sites. All workers selected were targeted for interviewing and were recruited from the sites during the day during the time of collection, for a sample of 602 RAI workers (494M and 108F). Data collection took eighteen days and began on the 25<sup>th</sup> of July and was completed on the 11<sup>th</sup> of August, 2010.

**Sample Size:** Number of survey respondents: 8

**The percentage of men who have sex with men who received an HIV test in the past 12 months and know their results**

Number of RAI male workers who have sex with men who have received HIV test during the last 12 months and know their result		
Male		
<25	>+25	Total
1	1	2
Number RAI men who have sex with men interviewed		
Male		
<25	>+25	Total
2	6	8
Percentage of RAI men who have sex with men who received an HIV test during the last 12 months and know their result		
Male		
<25	>+25	Total
50.0%	16.7%	25.0%

---

### Value of additional studies

2.

In this study 26.8% of forty-one male youth who had male to male sex reported an HIV test in the last 12 months and knew their results.

### Data Measurement Tool:

Behavioural Surveillance Survey conducted by NRI

**From Date:** 29 June 2009

**To Date:** 8 July 2009

This study was done within higher risk young people and was not a sample of MSM but data considers those male youth reporting male to male sex within the sample. This Behavioural Surveillance Survey targeting higher risk young people in the Vanimo Green District of Sandaun Province (West Sepik) was the first round of BSS research collected by the National Research Institute

with this more hidden population. These higher risk young people were recruited from the 29<sup>th</sup> of June to the 29<sup>th</sup> of July 2009 through the use of Respondent Driven Sampling (RDS) for a total sample size of 380 youth (237 male and 143 female youth). Young people recruited were between the ages of 15 and 29, who lived in Vanimo Green, were sexually active and who had had sex with more than one partner.

**Sample Size:** Number of survey respondents: 41

**The percentage of men who have sex with men who received an HIV test in the past 12 months and know their results**

**Number of RAI male workers who have sex with men who have received HIV test during the last 12 months and know their result**

Male		
Age disaggregation		Total
< 25	25+	
<b>Number of young men who have sex with men who have been tested during the last 12 months and who know their results</b>		
10	1	11
<b>Total number of young men who have sex men interviewed</b>		
35	6	41
<b>Percentage of young men who have sex with men who have been tested during the last 12 months and who know their results</b>		
28.6%	16.7%	26.8%

### **Interpretation of value in the context of the epidemic in PNG**

The NHS 2011-2015. Is clear that access and use of HIV testing services by MARPs is essential in the national response as seen in PA.2 - *Expanding access to and increasing uptake of HCT is fundamental to the achievement of the NHS goals. Equitable access to these services, regardless of gender, age, geographic location or sexual practice is both a moral and public health obligation. HCT is an important entry point to prevention and care, treatment and support services* And SO 1.1.3. *Priority target populations have access to quality HCT services that are sensitive to their specific needs, concerns and situation*

All studies report an increase on the Value reported in 2008 (the last behavioural surveillance study undertaken in 2006) however the increase is marginal and that is a concern for ensuring progress on the PA.2. and SO above.

### **Indicator changes compared with previous report**

UNGASS 2008 used a behavioural surveillance study with a Value of 41.67%. The UNGASS 2010 used programme data so was not comparable at a Value of 67%.

GAR 2012 data both came from behavioural surveillance surveys with the FHI 360 Value 55.8%, which is an increase on the 2008 Value but as that was drawn from a 2006 study the small increase over four years is concerning. The Values for the samples of male workers and male youth who had male to male sex were less but not from a targeted population of MSM; with the Ramu

male workers who had male to male sex with a Value of 25.0% and male youth with a Value of 26.8%.

**Challenges for indicator reporting improvement**

None other than resourcing the research studies

**Recommendations for indicator reporting improvement**

None

## 1.14 HIV Prevalence in Men who have sex with Men

### Percentage of men who have sex with men risk who are living with HIV

#### What it Measures

It measures progress on reducing HIV prevalence among men who have sex with men.

#### Rationale

Men who have sex with men typically have the highest HIV prevalence in countries with either concentrated or generalized epidemics. In many cases, prevalence among these populations can be more than double the prevalence among the general population. Reducing prevalence among men who have sex with men is a critical measure of a national-level response to HIV.

<b>NHS 2011-2015 Priority Area 1: Impact of the NHS</b>	
<b>Top 10 Intervention</b>	
<b>Indicator No.23:</b>	<i>Percentage of more-at-risk populations who are HIV infected.</i>
<b>Purpose</b>	To assess progress on reducing HIV prevalence among MARPS.

#### Method of Measurement:

UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/UNAIDS, 2011).

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is not available.

#### Value of Indicator:

No Value

---

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

The NHS 2011-2015 – notes that this Indicator is essential to measure the overall progress of the impact of the NHS 2011-2015 on HIV in PNG.

It is of significant concern for PNG that the on-going absence of surveillance data for this indicator will reduce the impact of the NHS 2011-2015 over the next four years.

#### Indicator changes compared with previous report

No data was available for UNGASS 2008 and the UNGASS 2010 Value was 4.35% drawn from programme data not surveillance reports.

#### Challenges for indicator reporting improvement

All available resources for research in PNG that would normally be directed

towards behavioural surveillance is going to IBBS during 2012 and 2013, which means behavioural surveillance with sub populations will be limited during that time.

**Recommendations for indicator reporting improvement**

None

*Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015*

- 2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes
- 2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse
- 2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected
- 2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results
- 2.5 Percentage of people who inject drugs who are living with HIV

## 2.1 People who inject drugs: Prevention Programmes

### Number of Syringes distributed per person who injects drugs per year by Needle and Syringe Programmes

#### What it Measures

It measures progress in improving coverage of an essential HIV prevention service for people who inject drugs.

#### Rationale

Injecting drug use is the main route of transmission for approximately 10% of HIV infections globally and 30% of infections outside of sub Saharan Africa. Preventing HIV transmission through injecting drug use is one of the key challenges to reducing the burden of HIV.

Needle and syringe programmes (NSPs) are one of nine interventions in the WHO UNODC and UNAIDS comprehensive package for the prevention, treatment and care of HIV among IDUs.

Needle and syringe programmes have the greatest impact on HIV prevention for people who inject drugs

#### NHS 2011-2015 Priority Area 1: Impact of the NHS

##### Priority Area. 1. Prevention

##### Strategic Objectives. 1.4.3

Interventions are prepared to reduce the risk of HIV transmission from injecting drug use.

No Indicator:

#### Indicator Relevance:

Topic is of emerging relevance to PNG, the indicator is not relevant.

#### Value of Indicator:

No Value



## 2.2 People who inject drugs: Condom Use

### Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse

#### What it Measures

It measures progress in preventing sexual transmission of HIV among people who inject drugs.

#### Rationale

Safer injecting and sexual practices among people who inject drugs are essential, even in countries where other modes of HIV transmission predominate, because: (i) the risk of HIV transmission from contaminated injecting equipment is extremely high; and (ii) people who inject drugs can spread HIV (e.g. through sexual transmission) to the wider population.

#### NHS 2011-2015 Priority Area 1: Impact of the NHS

##### Priority Area. 1. Prevention

##### Strategic Objectives. 1.4.3

Interventions are prepared to reduce the risk of HIV transmission from injecting drug use.

No Indicator:

#### Method of Measurement:

Special surveys including the Family Health International Behavioural Surveillance Survey for people who inject drugs.

#### Indicator Relevance:

Topic is of emerging relevance to PNG, the indicator is relevant and but data is not available.

#### Value of Indicator:

No Value

---

#### Value of additional studies:

1.

In this additional study 75.0% of women exchanging sex, had injected in the last month and had had sex in the last month and used a condom at last sex.

#### Data Measurement Tool:

Behavioural Surveillance Survey conducted by NRI

**From Date:** 29 March 2010

**To Date:** 08 April 2010

Overall, fifteen women exchanging sex in Mt. Hagen reported that they had ever injected drugs and the numbers for this Value are extremely limited (4).

This Behavioural Surveillance Survey targeting women exchanging sex in Mt. Hagen was the first round of BSS research collected by the National Research Institute with this more hidden population. These women were recruited from the 29<sup>th</sup> of March to the 8<sup>th</sup> of April, 2010 through the use of Respondent Driven Sampling (RDS) for a total sample size of 242 women who exchanged sex and who lived in different parts of Mt. Hagen and the Western Highlands. It must be noted that 42.6% of women did not know their age and this causes great limitations to age based indicators.

**Sample Size:** Number of survey respondents: 4

**The percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse**

Number of women exchanging sex who have injected in the last month and have had sex in the last month and used a condom at last sex		
Female		
<25	>+25	Total
3	0	3
Number women exchanging sex who have injected in the last month and have had sex in the last month		
Female		
<25	>+25	Total
4	0	4
Percentage of women exchanging sex who have injected in the last month and have had sex in the last month and used a condom at last sex		
Female		
<25	>+25	Total
75.0%	0.0%	75.0%

## 2.

In this additional study of Vanimo higher risk youth, sixty young people reported injecting drugs. Twenty-five male youth reported injecting drugs not prescribed by a doctor in the last 12 months. Of these, 17 reported using condom while 7 reported not using condom the last time they had sexual intercourse. Of those 17 who used a condom, 16 were below 25 and of those who did not use a condom 4 were below the age of 25.

Thirty five female youth reported injecting drugs not prescribed by a doctor in the last 12 months. Of these, 30 reported using a condom and 26 were below the age of 25 and 4 women were over the age of 25 years. Five young women did not use a condom and four female youth were below the age of 25.

### **Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 29 June 2009 **To Date:** 08 July 2009

This Behavioural Surveillance Survey targeting higher risk young people in the Vanimo Green District of Sandaun Province (West Sepik) was the first round of BSS research collected by the National Research Institute with this more hidden population. These higher risk young people were recruited from the 29<sup>th</sup> of June to the 29<sup>th</sup> of July 2009 through the use of Respondent Driven

Sampling (RDS) for a total sample size of 380 youth (237 male and 143 female youth). Young people recruited were between the ages of 15 and 29, who lived in Vanimo Green, were sexually active and who had had sex with more than one partner.

**Sample Size:** Number of survey respondents: 60

---

### **Interpretation of value in the context of the epidemic in PNG**

The NHS 2011-2015 noted the emergence of small but concerning evidence of injecting drug use in PNG, the extent of which is still unknown - PA.1 Cluster 1.3 Injecting practices, penile modification and other emerging transmission routes

*Recent behavioural research is showing some emerging practices in terms of injecting (drugs and penile injection), introduced penile modification practices and foreskin cutting both done within the context of initiation or less formally. The extent of injecting drug use is not yet known. As the risk of HIV transmission through sharing injecting equipment is far greater than it is through unprotected sex, efforts will be made to increase surveillance and research to understand the degree of these practices and prepare for the possibility of an increase in this behaviour.*

These two studies, which have small numbers still indicate grounds for concern, and for increased attention on the recommendation in the NHS 2011-2015 to increase surveillance and research to understand the degree and dynamics of these injecting practices.

There is a risk of migrant workers, who come from areas with higher IDU populations, injecting drugs by themselves and with Papua New Guineans while working in PNG in the LNG and logging industries. Cross border issues are also highlighted where young people have access to travel to Jayapura where there is greater access to IDU populations and to the availability of Heroin and other drugs for injecting.

### **Indicator changes compared with previous report**

No Values reported in prior reports

### **Challenges for indicator reporting improvement**

Survey's were undertaken based on the UNGASS requirements which did not have 1 month as the denominator. UNAIDS needs to be mindful of the implications of making these types of changes.

### **Recommendations for indicator reporting improvement**

## 2.3 People who inject drugs: Safe Injecting Practices

### Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected

#### What it Measures

It measures progress in preventing injecting drug use-associated HIV transmission

#### Rationale

Safer injecting and sexual practices among people who inject drugs are essential, even in countries where other modes of HIV transmission predominate, because: (i) the risk of HIV transmission from contaminated injecting equipment is extremely high; and (ii) people who inject drugs can spread HIV (e.g., through sexual transmission) to the wider population.

#### NHS 2011-2015 Priority Area 1: Impact of the NHS

##### Priority Area. 1. Prevention

##### Strategic Objectives. 1.4.3

Interventions are prepared to reduce the risk of HIV transmission from injecting drug use.

No Indicator:

#### Method of Measurement:

Special surveys including the Family Health International Behavioural Surveillance Survey for people who inject drugs.

#### Indicator Relevance:

Topic is of emerging relevance to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

No Value

---

#### Value of additional studies:

1.

In this additional study, of Vanimo higher risk youth, sixty young people reported injecting drugs. Of those 25 young men who reported injecting drugs in the last year that was not prescribed by a doctor, 11 or 44.0% reported using a needle or syringe that was used by someone else and not cleaned (unsterile) while 12 said they used sterile needle and syringe. Of those 11 who reported using unsterile needle and syringe, all were less than 25 years of age, and of those 12 that used sterile injecting equipment, 8 were less than 25 and 4 were over 25 years of age.

Thirty-five female youth reported injecting drugs not prescribed by the doctor in the last 12 months. Thirteen or 37.1% of female youth reported using a syringe and needle which was not used by someone else and cleaned (sterile) while 20 said they used unsterile injecting equipment. All the (13) young women who used sterile injecting equipment were below the age of 25 and of the 20 young women who reported using unsterile injecting equipment, 15 were the age of 25.

**Data Measurement Tool:**

Behavioural Surveillance Surveys Plan conducted by NRI

**From Date:** 29 June 2009 **To Date:** 08 July 2009

This Behavioural Surveillance Survey targeting higher risk young people in the Vanimo Green District of Sandaun Province (West Sepik) was the first round of BSS research collected by the National Research Institute with this more hidden population. These higher risk young people were recruited from the 29<sup>th</sup> of June to the 29<sup>th</sup> of July 2009 through the use of Respondent Driven Sampling (RDS) for a total sample size of 380 youth (237 male and 143 female youth). Young people recruited were between the ages of 15 and 29, who lived in Vanimo Green, were sexually active and who had had sex with more than one partner.

**Sample Size:** Number of survey respondents: 60

**2.**

In this study, three out of four or 75.0% of women exchanging sex who injected last month had used sterile injecting equipment; however these numbers are limited..

**Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 29 March 2010 **To Date:** 08 April 2010

Fifteen women who exchanged sex reported ever injecting drugs. This Behavioural Surveillance Survey targeting women exchanging sex in Mt. Hagen was the first round of BSS research collected by the National Research Institute with this more hidden population. These women were recruited from the 29<sup>th</sup> of March to the 8<sup>th</sup> of April, 2010 through the use of Respondent Driven Sampling (RDS) for a total sample size of 242 women who exchanged sex and who lived in different parts of Mt. Hagen and the Western Highlands. It must be noted that 42.6% of women did not know their age and this causes great limitations to age based indicators.

**Sample Size:** Number of survey respondents: 4

**The percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected**

<b>Number of women exchanging sex who injected last month and used a sterile</b>
--

injecting equipment		
Female		
<25	>+25	Total
3	0	3
<b>Number women exchanging sex who have injected in the last month</b>		
Female		
<25	>+25	Total
4	0	4
<b>Percentage of women exchanging sex who injected last month and used a sterile injecting equipment</b>		
Female		
<25	>+25	Total
75.0%	0.0%	75.0%

---

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

As noted in the 2.2 Indicator report above.

**Indicator changes compared with previous report**

No Values reported in prior reports

**Challenges for indicator reporting improvement**

As noted in the 2.2 Indicator report above

**Recommendations for indicator reporting improvement**

As noted in the 2.2 Indicator report above

## 2.4 HIV Testing in people who inject drugs

### Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results

#### What it Measures

It measures progress in implementing HIV testing and counselling among people who inject drugs

#### Rationale

In order to protect themselves and to prevent infecting others, it is important people who inject drugs to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment.

Note: Countries with generalized epidemics may also have a concentrated sub-epidemic among one or more key populations at higher-risk. If so, they should calculate and report this indicator for those populations.

#### NHS 2011-2015 Priority Area 1: Impact of the NHS

##### Priority Area. 1. Prevention

##### Strategic Objectives. 1.4.3

Interventions are prepared to reduce the risk of HIV transmission from injecting drug use.

No Indicator:

#### Method of Measurement:

Behavioural surveillance or other special surveys

#### Indicator Relevance:

Topic is of emerging relevance to PNG, the indicator is relevant and but data is not available.

#### Value of Indicator:

No Value

---

**Value of additional studies:** where the denominator is not the number of people who inject drugs who report having injected drugs and having had sexual intercourse in the last month

1.

In this study 44% of male youth and 31.4% female youth who had injected drugs had been tested for HIV during the last 12 months and knew their results.

#### Data Measurement Tool:

Behavioural Surveillance Surveys Plan conducted by NRI

**From Date:** 29 June 2009

**To Date:** 08 July 2009

This Behavioural Surveillance Survey targeting higher risk young people in the Vanimo Green District of Sandaun Province (West Sepik) was the first round of BSS research collected by the National Research Institute with this more hidden population. These higher risk young people were recruited from the 29<sup>th</sup> of June to the 29<sup>th</sup> of July 2009 through the use of Respondent Driven Sampling (RDS) for a total sample size of 380 youth (237 male and 143 female youth). Young people recruited were between the ages of 15 and 29, who lived in Vanimo Green, were sexually active and who had had sex with more than one partner.

**Sample Size:** Number of survey respondents: 60

The percentage of people who inject drugs who received and HIV test in the past 12 months and know their results

<b>Male youth</b>		
<b>Age disaggregation</b>		<b>Total</b>
<b>&lt; 25</b>	<b>25+</b>	
<b>Number of young men who inject drugs who have been tested for HIV during the last 12 months and know their result</b>		
9	2	11
<b>Total number of young men who inject drugs interviewed</b>		
21	4	25
<b>Percentage of young men who inject drugs who have been tested for HIV during the last 12 months and know their result</b>		
42.9%	50.0%	44.0%

<b>Female youth</b>		
<b>Age disaggregation</b>		<b>Total</b>
<b>&lt; 25</b>	<b>25+</b>	
<b>Number of young women who inject drugs who have been tested for HIV during the last 12 months and know their result</b>		
9	2	11
<b>Total number of young women who inject drugs interviewed</b>		
30	5	35
<b>Percentage of young women who inject drugs who have been tested for HIV during the last 12 months and know their result</b>		
30.0%	40.0%	31.4%

2.

In this study, 77.8% of women exchanging sex who have injected had been tested for HIV in the last 12 months and knew their results.

**Data Measurement Tool:**

Behavioural Surveillance Survey conducted by NRI

**From Date:** 29 March 2010

**To Date:** 08 April 2010

Fifteen women exchanging sex had ever injected and nine women who injected and tested for HIV in the last year could be calculated for this



indicator. This Behavioural Surveillance Survey targeting women exchanging sex in Mt. Hagen was the first round of BSS research collected by the National Research Institute with this more hidden population. These women were recruited from the 29<sup>th</sup> of March to the 8<sup>th</sup> of April, 2010 through the use of Respondent Driven Sampling (RDS) for a total sample size of 242 women who exchanged sex and who lived in different parts of Mt. Hagen and the Western Highlands. It must be noted that 42.6% of women did not know their age and this causes great limitations to age based indicators.

**Sample Size:** Number of survey respondents: 7

**The percentage of people who inject drugs who received an HIV test in the past 12 months and know their results**

<b>Number of women exchanging sex who have injected and have been tested for HIV in the last 12 months and know their result</b>		
<b>Female</b>		
<b>&lt;25</b>	<b>&gt;+25</b>	<b>Total</b>
6	1	7
<b>Number women exchanging sex who have injected in the last 12 months</b>		
<b>Female</b>		
<b>&lt;25</b>	<b>&gt;+25</b>	<b>Total</b>
8	1	9
<b>Percentage of women exchanging sex who have injected in the last 12 months and have been tested for HIV in the last 12 months and know their result</b>		
<b>Female</b>		
<b>&lt;25</b>	<b>&gt;+25</b>	<b>Total</b>
75.0%	100.0%	77.8%

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

As noted in the 2.2 Indicator report above

**Indicator changes compared with previous report**

No Values in previous reports.

**Challenges for indicator reporting improvement**

If PNG could provide the data without disaggregating for age or including an age category “don’t know” the figures would more accurately reflect the true number of injecting drug users.

**Recommendations for indicator reporting improvement**

As noted in the 2.2 Indicator report above

## 2.5 HIV Prevalence in people who inject drugs

### Percentage of people who inject drugs who are living with HIV

#### What it Measures

It measures progress on reducing HIV prevalence among people who inject drugs.

#### Rationale

People who inject drugs typically have the highest HIV prevalence in countries with either concentrated or generalized epidemics. In many cases, prevalence among these populations can be more than double the prevalence among the general population. Reducing prevalence among people who inject drugs is a critical measure of a national-level response to HIV.

#### NHS 2011-2015 Priority Area 1: Impact of the NHS

##### Priority Area. 1. Prevention

##### Strategic Objectives. 1.4.3

Interventions are prepared to reduce the risk of HIV transmission from injecting drug use.

No Indicator:

#### Method Of Measurement:

UNAIDS and WHO Working Group on Global HIV/AIDS and STI Surveillance: Guidelines among populations most at risk for HIV (WHO/UNAIDS, 2011)

#### Indicator Relevance:

Topic is of emerging relevance to PNG, the indicator is not relevant.

#### Value of Indicator:

No Value

*Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths*

- 3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission
- 3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth
- 3.3 Mother-to-child transmission of HIV (Modelled)

### 3.1 Prevention of Mother-to-Child Transmission

#### Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission

##### What it Measures

It measures progress in preventing mother-to-child transmission of HIV through the provision of antiretroviral drugs. This is one of the four main methods for the prevention of mother-to-child transmission, along with primary prevention of HIV for women of childbearing age, prevention of unintended pregnancies among women living with HIV, and appropriate treatment, care and support for mothers living with HIV..

This indicator allows countries to monitor the coverage with antiretroviral medicines of HIV-positive pregnant women to reduce the risk for transmission of HIV to infants. When disaggregated, this indicator can show increased access to more effective antiretroviral drug regimens for prevention of mother-to-child transmission of HIV in countries that are scaling up newer regimen categories. As the indicator measures antiretroviral drugs dispensed and not those consumed, it is not possible to determine adherence to the regimen in most cases. The postpartum regimen ('tail') to avoid transmission during breastfeeding and to reduce the mother's resistance to nevirapine are not captured by this indicator, even though they are recommended by WHO as standards of care for prevention of mother-to-child transmission of HIV. Because the tail is not included, the regimens below are not labelled with the standard names of Option A and B as described in WHO guidelines.

##### Rationale

The risk for mother-to-child transmission can be reduced significantly by the complementary approaches of providing antiretroviral drugs (as treatment or as prophylaxis) to the mother and antiretroviral prophylaxis to the infant and using safe delivery practices and safer infant feeding.

##### NHS 2011-2015

**Priority Area 2: Counselling, testing, Treatment, Care and Support.  
Strategic Objectives. 1.2.2**

	<b>Top 10 Intervention</b>
<b>Indicator No.9:</b>	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission.
<b>Purpose</b>	To assess progress in increasing the percentage of HIV positive pregnant women who receive ART to reduce mother-to-child HIV transmission.

##### Method of Measurement

For the numerator: national programme records aggregated from programme monitoring tools, such as patient registers and summary reporting forms.

**Indicator Relevance:**

Topic is relevant to PNG, the indicator is relevant and data is available.

**Value of Indicator:**

A total of 223 pregnant women have been registered as receiving antiretroviral (ARV) medicine for prevention of mother to child transmission of HIV, the estimated number of pregnant women needing this measure was 1809, therefore the coverage is estimated to be **12.3%**.

**Data Measurement Tool:**

Numerator from ART reporting

**From Date:** 01 January 2011                      **To Date:** 31 December 2011

The numerator for this indicator comes from ART reporting, based on these registers it is not possible to check if any single pregnant woman is receiving triple drug ARV regimen for prevention of mother to child transmission of HIV or for her own health. Moreover, it has to be noted that by the time this report is being compiled, around 80% of monthly reports from ART sites have been reported, so the final numbers might be higher than the current figure. From these 223 women, 11 were receiving nevirapine-only regimen, 16 the dual ARV regimen and the remaining triple ARV regimen. It has to be noted that the first two regimens are no longer part of the national guideline, however some few facilities are still providing them.

The denominator comes from the Estimation/Projection exercise conducted in 2011 based on HIV prevalence in ANC sites up to 2010. As ANC data for 2011 are not still complete, only the programme data, i.e. ART and PMTCT data were updated based on 2011 data.

**Sample Size:**

The estimated number of HIV positive pregnant women within the past 12 months: 1,809

---

**Value of other studies/records**

**1.a**

In this 2010 study, of the 134 pregnant women who were diagnosed HIV positive, 110 received ARVs to reduce the risk of mother to child HIV transmission.

**Data Measurement Tool:**

Programme records from Port Moresby General Hospital and Clinton Health Access Initiative PNG

**From Date:** 01 January 2010                      **To Date:** 31 December 2010

Total HIV positive women diagnosed in ANC in 2010 is 134. 24 women did

not receive ARV for various reasons.

**Sample Size:** Number of women who received ARVs: 110

**Number of HIV-positive pregnant women who received antiretroviral drugs during 2010 months to reduce the risk of mother-to-child transmission**

a) antiretroviral therapy for HIV-infected positive women eligible for treatment	b) maternal triple ARV prophylaxis	c) maternal AZT	d) Single-dose nevirapine only	Total
38	45	22	5	110

**From Date:** 01 January 2011 **To Date:** 31 December 2011

### 1.b

In 2011, of the 191 pregnant women who were diagnosed HIV positive in the Port Moresby General Hospital (PMGH) antenatal care clinic or were referred there for further care, 186 received ARVs to reduce the risk of mother to child HIV transmission.

Five of the women did not return for ART. Single doses for prophylaxis are no longer given at this clinic.

**Sample Size:** Number of women who received ARVs: 110

**Number of HIV-positive pregnant women who received antiretroviral drugs during 2011 months to reduce the risk of mother-to-child transmission**

a) antiretroviral therapy for HIV-infected positive women eligible for treatment	b) maternal triple ARV prophylaxis	c) maternal AZT	d) Single-dose nevirapine only	Total
90	96	0	0	186

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

NHS 2011-2015. PA.1. Cluster 1.2: Prevention of parent to child transmission of HIV

*PPTCT is vital for reducing the impact of HIV on children, families and communities throughout PNG. The aim is to provide a comprehensive range of services that will facilitate reducing primary HIV infection in women in the reproductive age group (15 to 49 years), preventing unintended pregnancies in women with HIV, preventing transmission during pregnancy, childbirth and*

*feeding and providing care and support for HIV infected women, children and families. For PPTCT to be effective, the male partners of pregnant women need to be actively involved at every stage and take personal measures to prevent transmission of HIV to their partners and children.*

There has been an extraordinary increase in PPTCT services and this Value shows strong progress on this Indicator in the last two years with the urban hospital based clinic setting providing remarkable targets for the rest of the country to follow.

#### **Indicator changes compared with previous report**

The Value for UNGASS 2008 was 3.5% and the denominator, 2848. For the UNGASS 2010 report the value was 11.1% with the denominator, 2,100 (estimated). GAR 2012 value is 12.3%; it does not demonstrate a significant increase in coverage of this prevention service.

#### **Challenges for indicator reporting improvement**

There are several challenges hampering quality of reporting against this indicator. Currently, data for the number of pregnant women receiving ARV for prevention of mother to child transmission of HIV is captured through ART reporting system, and that system only reports the number of women started on a treatment, so any possible drop out from the treatment is not being captured. Moreover, for women already on ART who become pregnant, there is no reporting system to capture them as part of the pregnant women receiving ARV. The third problem is that for the pregnant women who are diagnosed of living with HIV as part of the PPTCT programme and who are put on ART for their own health, it is unclear how they have been reported.

The above mentioned challenges are special to this indicator, however, it has been long recognized that quality, timeliness, and completeness of reports sent from facilities to the department of health still needs lot of improvement.

#### **Recommendations for indicator reporting improvement**

It is essential to be able to collect information on all pregnant women who receive ARV medicine, either for their own health or only as a preventive measure. Therefore, the NDoH has to revise the forms in a way to be able to report against this indicator which is an important indicator for monitoring the elimination of mother to child transmission of HIV.

## 3.2 Early Infant Diagnosis

### Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth

#### What it Measures

It measures progress in the extent to which infants born to HIV-positive women are tested within the first 2 months of life to determine their HIV status and eligibility for ART, disaggregated by test results

#### Rationale

Infants infected with HIV during pregnancy, delivery or early postpartum often die before they are recognized as having HIV infection. WHO recommends national programmes to establish the capacity to provide early virological testing of infants for HIV at 6 weeks, or as soon as possible thereafter to guide clinical decision-making at the earliest possible stage. HIV disease progression is rapid in children; they need to be put on treatment as early as possible because without early treatment almost 50% of children would be dead by the second year

#### NHS 2011-2015

**Priority Area 2: Counselling, testing, Treatment, Care and Support.  
Strategic Objectives. 2.2.2**

**Indicator No.33:** *Percentage of infants born to HIV infected women who are started on cotrimoxazole prophylaxis within two months of birth.*

**Purpose** To measure the coverage of cotrimoxaloe CTX prophylaxis for HIV exposed infants in line with international guidelines.

#### Method of Measurement

Early Infant Diagnosis (EID) testing laboratories for the numerator, and Spectrum estimates, central statistical offices, and/or sentinel surveillance for the denominator

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

**22.06%** of infants born to HIV-positive women received a virological test for HIV within 2 months of birth

#### Data Measurement Tool:

EID testing laboratories and Spectrum estimates



**From Date:** 01 January 2011 **To Date:** 31 December 2011

There are only two sites having PCR for virological diagnosis. Data comes from these two sites, one in Port Moresby and the other one in Goroka, Eastern Highlands Province. 399 infants received an HIV test within 2 months of birth, during the reporting period.

**Sample size:**

1,809 HIV-positive pregnant women giving birth in the last 12 months

---

**Value of other studies/records**

**1.a**

In this report, out of a total number of 841 PCR (EID/Virological) tests conducted in 2010, 316 infants born to HIV positive women received a virological (EID) test within 2 months of birth.

**Data Measurement Tool:**

Programme records from Port Moresby General Hospital and Clinton Health Access Initiative PNG. Early infant diagnosis collected from 53 sites in 13 provinces around PNG.

**From Date:** 01 January 2010 **To Date:** 31 December 2010

**Number of infants who received an HIV test within two months of birth, during 2010.**

316

**1.b.**

In this report, out of a total number of 687 PCR (EID/Virological) tests conducted in 2011, 339 infants born to HIV positive women received a virological (EID) test within 2 months of birth.

**From Date:** 01 January 2011 **To Date:** 31 December 2011

**Number of infants who received an HIV test within two months of birth, during 2011.**

339

---

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

NHS 2011-2015. PA.2. Cluster.2.2.: Paediatric treatment

*All HIV positive children must have access to quality paediatric ART, including care and support services. For children it is important to start treatment early to ensure better health outcomes. A key component of the NHS is to expand access to early infant diagnosis by testing all babies born to HIV positive mothers. The expansion of POC testing will also increase access for children in need of health care. Key components in the NHS include ensuring quality of paediatric ART, continuous supply of drugs and test kits, and training for health care providers. ART access for children will initially be expanded to*

*areas with the highest numbers of children in need of treatment.*

The GAR 2012 indicator Value of 22.06% is important to set against the additional reports from additional studies in the same period. The increase noted in the two reports (2010 and 2011) from the CHAI and PMGHPort Moresby General Hospital clinic programme records highlights the increase in the numbers of children receiving virological tests from 37% to 49% in one year. This sets a challenge for indicator reporting improvement for the rest of the country and on-going progress needs supported and closely monitored.

**Indicator changes compared with previous report**

This Indicator was not present in UNGASS 2008 or 2010.

**Challenges for indicator reporting improvement**

None

**Recommendations for indicator reporting improvement**

None

### 3.3 Mother-to-child transmission of HIV (modelled)

#### Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months

##### What it Measures

It measures progress towards eliminating mother-to-child HIV transmission.

##### Rationale

Efforts have been made to increase access to interventions that can significantly reduce mother-to-child transmission, including combination antiretroviral prophylactic and treatment regimens and strengthened infant-feeding counselling. It is important to assess the impact of PMTCT interventions in reducing new paediatric HIV infections through mother-to-child transmission.

The percentage of children who are HIV-positive should decrease as the coverage of interventions for PMTCT and the use of more effective regimens increases.

##### Method of Measurement

The mother-to-child transmission probability differs with the antiretroviral drug regimen received and infant-feeding practices. The transmission can be calculated by using the Spectrum model.

##### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and modelling is available.

##### Value of Indicator:

It is estimated that 640 cases of mother to child transmission of HIV among children 0 – 14 years old has happened in 2011, from an estimated total of 1809 HIV positive pregnant women (**35.4%**). It has to be noted, however, that if we only estimate the number of new infant HIV infection, the number is 479, which translates to **26.5%**, the difference between these two figures is mainly due to HIV transmission through breastfeeding.

##### Method of Measurement

Spectrum model

**From Date:** 01 January 2011

**To Date:** 31 December 2011

Data is based on the 2011 Estimation/Projection exercise, using prevalence data up to 2010 and updated 2011 programme data. For breastfeeding data, the DHS 2006 report has been used.

**Sample size:** The estimated number of HIV positive women who delivered in the previous 12 months is 1809.

*Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015*

- 4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy\*
- 4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

*\*Millennium Development Goals indicator*

## 4.1 HIV Treatment: Antiretroviral Therapy

### Percentage of eligible adults and children currently receiving antiretroviral therapy

#### What it Measures

Progress towards providing antiretroviral combination therapy to all people eligible for treatment.

#### Rationale

As the HIV pandemic matures, increasing numbers of people are reaching advanced stages of HIV infection. Antiretroviral therapy (ART) has been shown to reduce mortality amongst those infected and efforts are being made to make it more affordable within low- and middle-income countries. Antiretroviral combination therapy should always be provided in conjunction with broader care and support services including counselling for family caregivers.

#### NHS 2011-2015

#### Priority Area 2: Counselling, testing, Treatment, Care and Support.

#### Strategic Objectives. 2.1.1

#### Top 10 Intervention

#### Indicator No.16:

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

#### Purpose

**This measures the percentage of people with advanced HIV infection receiving ART.**

#### Method of Measurement

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

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

It is calculated that by the end of 2011 there were 9435 adults and children on antiretroviral therapy (ART), 4273 men and 5162 women. It is also estimated that by that time, a total of 15,406 adults (12,775) and children (2,271) were in need of ART, translated into a coverage figure of **61.2%**.

It has to be noted that because of the nature of ART reporting system in PNG, it is not possible to directly count the number of people on ART and the number has to be calculated through number of people started on treatment and the number of deaths and drop outs. As the last two figures are not currently reported age-disaggregated, it is not possible to report age disaggregated figures. In 2011, a total of 1981 adults and children were started on ART.

## Method of Measurement

ART Registers for numerators and Spectrum ART needs estimates

Data as of: 31 December 2011

The figure reported on the UA report 2011 was later on updated as more data became available, as reported in the 2010 surveillance report, 8522 adults and children were on ART by the end of 2010. FBOs provide around half of the ART across the country

### The sample size.

Estimated number of adults and children with advanced HIV infection is 15,406, 6758 males and 8288 females. 2271 are less than 15 years old and 12,775 are 15 and above.

Number of eligible adults and children on ART by the end of 2011		
Male	Female	Total
4273	5162	9435
Estimated number of adults and children needing ART by the end of 2011		
Male	Female	Total
6758	8288	15406
Percentage of eligible adults and children receiving ART by the end of 2011		
Male	Female	Total
63.2%	62.3%	62.7%

---

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

NHS 2011-2015. PA.2. Strategic priority 1: Scale-up HIV counselling and testing.

*Expanding access to and increasing uptake of HCT is fundamental to the achievement of the NHS goals. Equitable access to these services, regardless of gender, age, geographic location or sexual practice is both a moral and public health obligation. HCT is an important entry point to prevention and care, treatment and support services. The availability of HCT will be extended to all parts of the country. The priority is to make these services available at the local level in provinces and districts with the highest HIV prevalence.*

The need for increased access to ARTs for those diagnosed with HIV is a long standing priority for PNG. It is heartening to note the progress on the Indicator over the last two years has been significant. However it is always important to note that this measures those who are on ART of those who have been diagnosed and not the prevalence of HIV in PNG.

---

### Indicator changes compared with previous report

UNGASS 2008 Value was 23% for 2007. UNGASS 2010 Value reported for the end of 2008 was 66% of adults and children. The Value reported for the end of 2009 was 74.5%. The current figure of 62.7% is a reflection of a change in criteria for starting ART in PNG, including a CD4 count of less than 350, compared to the previous reports. Therefore, while the number of people living with HIV who are on ART has increased constantly in the past years, from 2011, the number of them eligible for the treatment has been increased disproportionately, meaning that to catch up with the previous coverage trends, the number of people on treatment has to follow a giant leap as well.

**Challenges for indicator reporting improvement**

None

**Recommendations for indicator reporting improvement**

None

## 4.2 Twelve-Month Retention on Antiretroviral Therapy

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

#### What it Measures

It measures progress in increasing survival among infected adults and children by maintaining them on antiretroviral therapy.

#### Rationale

One of the goals of any antiretroviral therapy programme is to increase survival among infected individuals. As antiretroviral therapy is scaled up in countries around the world, it is also important to understand why and how many people drop out of treatment programmes. These data can be used to demonstrate the effectiveness of those programmes and highlight obstacles to expanding and improving them.

#### NHS 2011-2015

**Priority Area 2: Counselling, testing, Treatment, Care and Support.  
Strategic Objectives. 2.1.0**

**Indicator No.18:** **Top 10 Intervention**  
Percentage of adults and children with HIV known to be on treatment at 12/24/36/48 months after initiation of antiretroviral therapy

**Purpose** To assess progress in increasing retention of PLHIV on ART and survival.

#### Method of Measurement

Programme monitoring tools; cohort/group analysis forms

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

**78.42%** of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy

1,083 is the number of adults and children who are still alive and on ART at 12 months after initiating treatment. In addition to 'alive and on ART', other outcomes at 12 months after initiating treatment are - 166 lost to follow up and 77 died.

#### Data measurement tool:

ART Patient Registers



**From Date:** 01 January 2010

**To Date:** 31 December 2011

Data is from six sites having a database compatible with the cohort-simulation

**The sample size.**

1,381 is the total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.

---

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

**Indicator changes compared with previous report**

The UNGASS 2010 Value was 82.1% for 2009. The UNGASS 2008 Value was 60.78%.

**Challenges for indicator reporting improvement**

**Recommendations for indicator reporting improvement**

*Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015*

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

## 5.1 Co-management of Tuberculosis and HIV Treatment

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

#### What it Measures

It measures progress in detecting and treating TB in people living with HIV

#### Rationale

Tuberculosis (TB) is a leading cause of morbidity and mortality in people living with HIV, including those on antiretroviral therapy. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international/national guidelines is essential for improving the quality and quantity of life for people living with HIV. A measure of the percentage of HIV-positive TB cases that access appropriate treatment for their TB and HIV is important.

#### NHS 2011-2015

#### Priority Area 2: Counselling, testing, Treatment, Care and Support.

#### Strategic Objectives. 2.1.3

#### Top 10 Intervention

#### Indicator No.17:

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

#### Purpose

This measures the percentage of HIV positive incident TB cases that received treatment for TB and HIV.

#### Method of Measurement

Facility antiretroviral therapy registers and reports; programme monitoring tools

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

**25.06%** is the percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV.

The number of adults with advanced HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting year is 208.

#### Data measurement tool:

ART Patient Registers and estimates from WHO Stop TB database.

**From Date:** 01 January 2011

**To Date:** 31 December 2011

It has to be noted that the numerator is from 2011 and WHO has only provided denominator for 2010, which has been used here. Moreover, as the denominator is not available in a disaggregated fashion, it is impossible to report the indicator in a disaggregated way.

**The sample size.**

The Estimated number of incident TB cases in people living with HIV is 830

---

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

**Indicator changes compared with previous report**

UNGASS 2010 Value was 127 in 2008 and 170 in 2009 with a percentage being reported for 2008 of 27.4%. The number of incident cases of TB in people living with HIV has increased from the 170 reported in 2009 however the 25.06% in 2010 who received treatment appears to be concerning and compared with the Value from 2008.

**Challenges for indicator reporting improvement**

**Recommendations for indicator reporting improvement**

*Target 6. Reach a significant level  
of annual global expenditure  
(between \$22 billion and \$24 billion)  
in low and middle-income countries*

**6.1 Domestic and international AIDS spending by  
categories and financing sources**

## 6.1 AIDS Spending

### Domestic and international AIDS spending by categories and financing sources

#### What it Measures

It measures how funds are spent at the national level and where those funds are sourced in an accurate and consistent manner.

#### Rationale

As the national and international response to AIDS continues to scale up, it is increasingly important to accurately track in detail: i) how funds are spent at the national level and ii) where the funds originate. The data are used to measure annual global HIV expenditures, which is an important component of Monitoring the 2011 Political Declaration on HIV/AIDS. In addition, the data help national-level decision-makers monitor the scope and effectiveness of their programmes. When aggregated across multiple countries, the data also help the international community evaluate the status of the global response. This piece of strategic information supports the coordination role of the National AIDS Authority in each country and provides the basis for resource allocation and improved strategic planning processes.

Since different countries can choose among different methodologies and tools to monitor the flow of AIDS funding – i.e. National AIDS Spending Assessments (NASA), AIDS sub-account of the National Health Accounts (NHA) and ad hoc Resource Flows Surveys – the National Funding Matrix includes a spreadsheet that allows financial data from any of these three methodologies to be easily entered, reviewed and reported.

#### NHS 2011-2015

#### Priority Area 3: System Strengthening.

#### Strategic Objectives. 2.3.4 & 3.2.4

**Indicator No.24:** Domestic and International AIDS spending by categories and financing sources

**Purpose** To collect accurate and consistent data on how funds are spent and where those funds are sourced.

#### Measurement Tool:

Primary tool/method: 1) National AIDS Spending Assessment (NASA)

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

National AIDS Spending Assessment (NASA).

2009	Total	Public sources			International sources							Private sources
					International Subtotal	Bilateral	Multilateral			All Other International	Private Subtotal	
							UN	Global Fund	Dev. Banks non-reimbursable			
ASC code	Grand Total	Public Subtotal	Central National	Sub-national	International Subtotal	Bilateral	UN	Global Fund	Dev. Banks non-reimbursable	Other multilateral	All Other International	Private Subtotal
<b>Grand Total</b>	<b>131,369,182</b>	<b>25,736,897</b>	<b>25,536,897</b>	<b>200,000</b>	<b>104,746,259</b>	<b>78,737,111</b>	<b>4,911,115</b>	<b>12,314,152</b>	<b>7,070,073</b>	<b>14,529</b>	<b>1,699,280</b>	<b>886,025</b>
<b>1. Prevention (sub-total)</b>	<b>34,025,764</b>	<b>1,219,993</b>	1,219,993	-	<b>31,958,874</b>	26,652,633	791,700	2,084,464	1,738,372	-	691,705	<b>846,897</b>
ASC.01.01 Communication for Social and behavioural change	7,222,144	1,021,655	1,021,655	-	6,200,489	5,168,891	-	351,397	155,270	-	524,931	-
ASC.01.02 Community mobilization	1,069,110	-	-	-	1,069,110	1,055,512	-	-	-	-	13,598	-
ASC.01.03 Voluntary counselling and testing (VCT)	1,911,028	1,141	1,141	-	1,909,887	797,055	-	728,074	288,211	-	96,547	-
ASC.01.04 Risk reduction for vulnerable and accessible populations	666,428	-	-	-	666,428	40,028	626,400	-	-	-	-	-
ASC.01.05 Prevention – youth in school	3,724,671	-	-	-	3,724,671	2,992,121	-	732,550	-	-	-	-
ASC.01.06 Prevention – youth out-of-school	23,900	-	-	-	23,900	23,900	-	-	-	-	-	-
ASC.01.07 Prevention of HIV transmission aimed at people living with HIV	35,357	500	500	-	34,857	34,857	-	-	-	-	-	-
ASC.01.08 Prevention programmes for sex workers and their clients	157,617	-	-	-	157,617	157,617	-	-	-	-	-	-
ASC.01.09 Programmes for men who have sex with men	440,248	-	-	-	440,248	440,248	-	-	-	-	-	-
ASC.01.11 Prevention programmes in the workplace	1,446,088	196,697	196,697	-	402,494	402,494	-	-	-	-	-	846,897
ASC.01.12 Condom social marketing	185,270	-	-	-	185,270	30,000	-	-	155,270	-	-	-
ASC.01.13 Public and commercial sector male condom provision	6,281,478	-	-	-	6,281,478	5,121,765	-	-	1,139,621	-	20,092	-
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	1,134,928	-	-	-	1,134,928	927,499	87,000	120,429	-	-	-	-
ASC.01.17 Prevention of mother-to-child transmission	1,755,628	-	-	-	1,755,628	1,603,614	-	152,014	-	-	-	-
ASC.01.98 Prevention activities not disaggregated by intervention	7,971,869	-	-	-	7,971,869	7,857,032	78,300	-	-	-	36,537	-
<b>2. Care and Treatment (sub-total)</b>	<b>9,797,903</b>	-	-	-	<b>9,797,903</b>	7,633,530	-	2,164,373	-	-	-	-
<b>2.01 Outpatient care</b>	<b>5,598,751</b>	-	-	-	<b>5,598,751</b>	3,434,378	-	2,164,373	-	-	-	-
ASC.02.01.01 Provider- initiated testing and counselling (PITC)	821,088	-	-	-	821,088	821,088	-	-	-	-	-	-
ASC.02.01.02 OI outpatient prophylaxis and treatment	480,947	-	-	-	480,947	-	-	480,947	-	-	-	-
ASC.02.01.03 Antiretroviral therapy	2,486,735	-	-	-	2,486,735	956,635	-	1,530,100	-	-	-	-
ASC.02.01.05 Specific HIV-related laboratory monitoring	153,326	-	-	-	153,326	-	-	153,326	-	-	-	-

ASC.02.01.09 Home-based care	1,656,655	-	-	-	1,656,655	1,656,655	-	-	-	-	-	-
<b>2.98 Care and treatment services not disaggregated by intervention</b>	<b>4,199,152</b>	-	-	-	<b>4,199,152</b>	4,199,152	-	-	-	-	-	-
<b>3. Orphans and Vulnerable Children (sub-total)</b>	<b>166,983</b>	-	-	-	<b>166,983</b>	109,563	57,420	-	-	-	-	-
ASC.03.98 OVC Services not disaggregated by intervention	166,983	-	-	-	166,983	109,563	57,420	-	-	-	-	-
<b>4. Program Management and Administration Strengthening (sub-total)</b>	<b>71,550,071</b>	<b>22,086,802</b>	21,886,802	200,000	<b>49,463,269</b>	36,090,864	3,848,320	3,882,850	4,685,566	14,529	941,140	-
ASC.04.01 Planning, coordination and programme management	34,748,011	4,029,520	4,029,520	-	30,718,491	26,167,800	3,437,142	548,260	56,045	14,529	494,715	-
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	8,164,802	-	-	-	8,164,802	5,828,466	12,087	2,324,249	-	-	-	-
ASC.04.03 Monitoring and evaluation	2,212,494	287,710	287,710	-	1,924,784	1,143,507	78,061	693,247	-	-	9,970	-
ASC.04.04 Operations research	10,044	-	-	-	10,044	-	-	10,044	-	-	-	-
ASC.04.05 Serological-surveillance (serosurveillance)	1,623,430	118,965	118,965	-	1,504,465	417,795	-	-	1,086,670	-	-	-
ASC.04.07 Drug supply systems	598,483	-	-	-	598,483	598,483	-	-	-	-	-	-
ASC.04.08 Information technology	26,130	-	-	-	26,130	26,130	-	-	-	-	-	-
ASC.04.10 Upgrading and construction of the infrastructure	7,543,732	1,088,297	888,297	200,000	6,455,435	1,848,048	321,030	307,051	3,542,851	-	436,455	-
ASC.04.98 Programme management and administration not disaggregated by type	16,619,945	16,562,310	16,562,310	-	57,635	57,635	-	-	-	-	-	-
ASC.04.99 Programme management and administration n.e.c	3,000	-	-	-	3,000	3,000	-	-	-	-	-	-
<b>5. Incentives for Human resources (sub-total)</b>	<b>8,922,115</b>	<b>264,458</b>	264,458	-	<b>8,657,657</b>	4,298,340	13,050	3,678,465	646,135	-	21,668	-
ASC.05.03 Training	8,922,115	264,458	264,458	-	8,657,657	4,298,340	13,050	3,678,465	646,135	-	21,668	-
<b>6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)</b>	<b>72,601</b>	-	-	-	<b>72,601</b>	72,601	-	-	-	-	-	-
ASC.06.04 HIV-specific income generation projects	72,601	-	-	-	72,601	72,601	-	-	-	-	-	-
<b>7. Enabling Environment (sub-total)</b>	<b>4,026,190</b>	<b>2,049,462</b>	2,049,462	-	<b>1,937,600</b>	1,288,216	100,617	504,000	-	-	44,767	<b>39,128</b>
ASC.07.01 Advocacy	2,615,649	2,018,270	2,018,270	-	597,379	161,363	100,617	335,399	-	-	-	-
ASC.07.02 Human rights programmes	29,460	-	-	-	29,460	29,460	-	-	-	-	-	-
ASC.07.03 AIDS-specific institutional development	880,297	-	-	-	880,297	835,530	-	-	-	-	44,767	-
ASC.07.04 AIDS-specific programmes focused on women	39,165	25,000	25,000	-	14,165	14,165	-	-	-	-	-	-
ASC.07.05 Programmes to reduce Gender Based Violence	43,947	-	-	-	43,947	43,947	-	-	-	-	-	-
ASC.07.98 Enabling environment not disaggregated by type	371,819	6,192	6,192	-	365,627	197,026	-	168,601	-	-	-	-
ASC.07.99 Enabling environment n.e.c.	45,853	-	-	-	6,725	6,725	-	-	-	-	-	<b>39,128</b>
<b>8. Research (sub-total)</b>	<b>2,807,554</b>	<b>116,182</b>	116,182	-	<b>2,691,372</b>	2,591,364	100,008	-	-	-	-	-



ASC.08.04 Social science research	100,008	-	-	-	100,008		100,008	-	-	-	-	-
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type	2,707,546	116,182	116,182	-	2,591,364	2,591,364	-	-	-	-	-	-

2010	ASC code	Grand Total	Public sources				International sources						
			Public Subtotal	Central National	Sub-national	All Other Public	International Subtotal	Bilateral	Multilateral			All Other International	
								UN	Global Fund	Dev. Banks non-reimbursable	Other multilateral		
	<b>Grand Total</b>	135,192,471	31,884,316	31,816,767	60,000	7,548	102,489,210	74,447,284	6,588,673	12,071,723	6,882,999	195,873	2,302,658
	<b>1. Prevention (sub-total)</b>	22,941,030	2,279,487	2,249,487	30,000	-	26,346,523	21,608,912	233,259	1,627,894	1,699,377	-	1,177,081
	ASC.01.01 Communication for social and behavioural change	6,357,256	220,544	220,544	-	-	6,136,712	5,079,970	121,942	601,817	117,992	-	214,991
	ASC.01.02 Community mobilization	3,001,459	113,000	113,000	-	-	2,888,459	2,564,780	-	282,532	-	-	41,147
	ASC.01.03 Voluntary counselling and testing (VCT)	1,254,859	329,840	299,840	30,000	-	925,019	492,188	-	261,750	43,564	-	127,517
	ASC.01.04 Risk-reduction for vulnerable and accessible populations	70,674	-	-	-	-	70,674	49,150	-	-	-	-	21,524
	ASC.01.05 Prevention – youth in school	445,625	124,782	124,782	-	-	320,843	320,843	-	-	-	-	-
	ASC.01.06 Prevention – youth out-of-school	33,200	-	-	-	-	33,200	20,650	12,550	-	-	-	-
	ASC.01.07 Prevention of HIV transmission aimed at people living with HIV	28,499	-	-	-	-	28,499	28,499	-	-	-	-	-
	ASC.01.08 Prevention programmes for sex workers and their clients	31,505	-	-	-	-	31,505	31,505	-	-	-	-	-
	ASC.01.09 Prevention programmes for men who have sex with men	344,420	-	-	-	-	344,420	344,420	-	-	-	-	-
	ASC.01.11 Prevention programmes in the workplace	1,886,507	459,251	459,251	-	-	754,979	754,979	-	-	-	-	-
	ASC.01.12 Condom social marketing	689,714	571,722	571,722	-	-	117,992	-	-	-	117,992	-	-
	ASC.01.13 Public and commercial sector male condom provision	2,675,020	-	-	-	-	2,675,020	944,141	-	-	1,419,829	-	311,050
	ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	1,147,299	396,348	396,348	-	-	750,951	381,309	45,967	323,675	-	-	-
	ASC.01.17 Prevention of mother-to-child transmission	1,461,397	28,000	28,000	-	-	1,433,397	1,222,477	52,800	158,120	-	-	-
	ASC.01.98 Prevention activities not disaggregated by intervention	9,870,853	36,000	36,000	-	-	9,834,853	9,374,001	-	-	-	-	460,852
	<b>2. Care and Treatment (sub-total)</b>	15,064,676	5,572,696	5,572,696	-	-	9,491,980	8,075,218	241,691	1,119,985	-	-	55,086

<b>2.01 Outpatient care</b>	<b>13,002,013</b>	<b>5,544,468</b>	<b>5,544,468</b>	-	-	<b>7,457,545</b>	<b>6,040,783</b>	<b>241,691</b>	<b>1,119,985</b>	-	-	<b>55,086</b>
ASC.02.01.01 Provider- initiated testing and counselling (PITC)	2,868,034	1,362,184	1,362,184	-	-	1,505,850	1,505,850	-	-	-	-	-
ASC.02.01.02 OI outpatient prophylaxis and treatment	611,578	397,074	397,074	-	-	214,504	-	-	214,504	-	-	-
ASC.02.01.03 Antiretroviral therapy	6,548,207	3,480,843	3,480,843	-	-	3,067,364	2,219,138	105,426	742,800	-	-	-
ASC.02.01.05 Specific HIV-related laboratory monitoring	315,548	2,000	2,000	-	-	313,548	15,244	136,265	162,039	-	-	-
ASC.02.01.09 Home-based care	2,658,646	302,367	302,367	-	-	2,356,279	2,300,551	-	642	-	-	55,086
<b>ASC.02.98 Care and treatment services not disaggregated by intervention</b>	<b>2,062,663</b>	<b>28,228</b>	<b>28,228</b>	-	-	<b>2,034,435</b>	<b>2,034,435</b>	-	-	-	-	-
<b>3. Orphans and Vulnerable Children (sub-total)</b>	<b>5,245</b>											
ASC.03.98 OVC Services not disaggregated by intervention	5,245	-	-	-	-	5,245	5,245	-	-	-	-	-
<b>4. Program Management and Administration Strengthening (sub-total)</b>	<b>77,114,245</b>	<b>21,801,468</b>	<b>21,801,468</b>	-	-	<b>55,310,478</b>	<b>36,357,898</b>	<b>5,058,076</b>	<b>7,843,424</b>	<b>4,934,991</b>	<b>45,597</b>	<b>1,070,491</b>
ASC.04.01 Planning, coordination and programme management	37,351,643	4,866,125	4,866,125	-	-	32,483,218	21,107,244	4,228,037	6,236,712	209,793	45,597	655,835
ASC.04.02 Administration and transaction costs associated with managing and disbursing funds	9,087,369	447,598	447,598	-	-	8,639,771	8,635,051	3,633	100	987	-	-
ASC.04.03 Monitoring and evaluation	3,070,807	105,411	105,411	-	-	2,965,396	1,107,632	105,089	1,519,471	-	-	233,204
ASC.04.04 Operations research	37,528	30,000	30,000	-	-	7,528	4,448	-	-	-	-	3,080
ASC.04.05 Serological-surveillance (serosurveillance)	1,498,433	835,126	835,126	-	-	663,307	-	-	-	663,307	-	-
ASC.04.07 Drug supply systems	3,266,455	-	-	-	-	3,266,455	3,262,002	-	4,453	-	-	-
ASC.04.08 Information technology	31,700	-	-	-	-	31,700	22,460	9,240	-	-	-	-
ASC.04.10 Upgrading and constructon of infrastructure	7,600,431	532,250	532,250	-	-	7,068,181	2,207,945	538,272	82,688	4,060,904	-	178,372
ASC.04.98 Programme management and administration not disaggregated by type	15,169,879	14,984,958	14,984,958	-	-	184,921	11,116	173,805	-	-	-	-
<b>5. Incentives for Human resources (sub-total)</b>	<b>8,186,455</b>	<b>466,374</b>	<b>466,374</b>	-	-	<b>7,720,081</b>	<b>5,559,911</b>	<b>702,569</b>	<b>1,243,070</b>	<b>214,531</b>	-	-
ASC.05.03 Training	8,186,455	466,374	466,374	-	-	7,720,081	5,559,911	702,569	1,243,070	214,531	-	-
<b>6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)</b>	<b>11,000</b>	<b>11,000</b>	<b>11,000</b>	-	-	-	-	-	-	-	-	-
ASC.06.04 HIV-specific income generation projects	11,000	11,000	11,000	-	-	-	-	-	-	-	-	-
<b>7. Enabling Environment (sub-total)</b>	<b>4,177,931</b>	<b>1,594,161</b>	<b>1,556,613</b>	<b>30,000</b>	<b>7,548</b>	<b>2,439,401</b>	<b>1,672,596</b>	<b>345,078</b>	<b>237,350</b>	<b>34,100</b>	<b>150,276</b>	-
ASC.07.01 Advocacy	1,820,815	1,258,524	1,220,976	30,000	7,548	451,902	55,090	309,911	52,800	34,100	-	-
ASC.07.02 Human rights programmes	2,278	-	-	-	-	2,278	2,278	-	-	-	-	-

ASC.07.03 AIDS-specific institutional development	1,231,785	57,000	57,000	-	-	1,174,785	1,174,785	-	-	-	-	-
ASC.07.04 AIDS-specific programmes focused on women	188,443	3,000	3,000	-	-	185,443	-	35,167	-	-	150,276	-
ASC.07.05 Programmes to reduce Gender Based Violence	208,219	5,000	5,000	-	-	203,219	203,219	-	-	-	-	-
ASC.07.98 Enabling environment not disaggregated by type	692,411	270,637	270,637	-	-	421,774	237,224	-	184,550	-	-	-
ASC.07.99 Enabling environment n.e.c.	33,980	-	-	-	-	-	-	-	-	-	-	-
<b>8. Research (sub-total)</b>	<b>1,334,632</b>	<b>159,129</b>	<b>159,129</b>	<b>-</b>	<b>-</b>	<b>1,175,503</b>	<b>1,167,503</b>	<b>8,000</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>
ASC.08.98 HIV and AIDS-related research activities not disaggregated by type	1,334,632	159,129	159,129	-	-	1,175,503	1,167,503	8,000	-	-	-	-

## *7. Additional: Critical Enablers and Synergies with Development Sectors*

- 7.1 National Commitments and Policy Instrument (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)
- 7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months
- 7.3 Current school attendance among orphans and non-orphans aged 10–14\*
- 7.4 Proportion of the poorest households who received external economic support in the last 3 months

*\*Millennium Development Goals indicator*

## 7.1 Government HIV and AIDS Policies

### National Commitments and Policy Instrument (NCPI)

#### What it Measures

It measures progress in the development and implementation of national-level HIV and AIDS policies, strategies and laws.

#### Rationale

This indicator tracks progress made in implementing the laws, regulations and policies necessary for an effective response to HIV.

#### NHS 2011-2015

**Priority Area 3: System Strengthening.  
Strategic Objectives. 2.3.4 & 3.2.4**

**Indicator No.25:** National Composite Policy Index (NCPI) (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and M&E)

**Purpose** To assess progress in the development and implementation of national level HIV and AIDS policies and laws.

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is available.

#### Value of Indicator:

NCPI – see Annex I.

---

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

The NHS 2011-2015 states that the NCPI is cross cutting across a number of Priority Areas and SOs with express reference to PA.1. Cluster 2.4.2 and PA.3. SO 2.5.4

#### Indicator changes compared with previous report

In comparing the NCPI for UNGASS 2010 and the NCPI for GAR 2012 it is worth noting that there were time constraints in the process in 2010, which led there to being a reduced opportunity to have stakeholder input into the NCPI data at a consensus workshop. There also appears to be some confusion on the degree of progress/status of the response in the two prior NCPIs. They all appear to be stating the same responses which would indicate no progress, even though the evidence is clear that there are significant increases on the indicators over the two year period of GAR 2012.

The GAR 2012 process enabled key stakeholders to review and validate the

responses to ensure greater accuracy. This will be of value to the GAR 2014.

### **Challenges for indicator reporting improvement**

There may need to be guidance on the critical number necessary for a useful and representative sample of key stakeholders for the NCPI. The risk is that the interviewee size increases each NCPI, which will increase the complexity and effort involved in both collection and analysis.

### **Recommendations for indicator reporting improvement**

The tools provided by the GAR Guidelines did cause some confusion as 'final' formats of the NCPI template were not in fact the 'final' as represented in the GAR Guidelines which was not available in a non-pdf.

## 7.2 Prevalence of Recent Intimate Partner Violence

**Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.**

### What it Measures

It measures progress in reducing prevalence of intimate partner violence against women (as an outcome itself and as a proxy for gender inequality).

An intimate partner is defined as a cohabiting partner, whether or not they had been married at the time. The violence could have occurred after they had separated.

### Rationale

Globally, and particularly in sub-Saharan Africa, the observed high rates of HIV infection in women have brought into sharp focus the problem of violence against women. There is growing recognition that women and girls' risk of, and vulnerability to, HIV infection is shaped by deep-rooted and pervasive gender inequalities - violence against them in particular. Studies conducted in many countries indicate that a substantial proportion of women have experienced violence in some form or another at some point in their life. Studies from Rwanda, Tanzania, and South Africa show up to three-fold increases in risk of HIV among women who have experienced violence compared to those who have not.<sup>19</sup>

### NHS 2011-2015

#### Priority Area. 3. System Strengthening

#### Top 10 Intervention

#### PA.1. Cluster 2.1. Gender-related vulnerability

No Indicator:

### Method of Measurement

Population based surveys that are already being used within countries, such as WHO Multi-country surveys, DHS/AIS (domestic violence module),<sup>20</sup> International Violence Against Women Surveys (IVAWS).

### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is not available. Submitting other data as relevant

<sup>19</sup> <http://www.who.int/gender/violence/en/yawinformationbrief.pdf>

<sup>20</sup> The questions asked in the DHS module on domestic violence and the WHO multi-country study on domestic violence and women's health are slightly different. However, the estimates produced from either methodology are comparable.

**Value of Indicator**

No value

**Value of other studies:**

1.

In this additional study 30.59% those female sex workers who currently have or ever had an intimate partner, report experiencing physical or sexual violence by at least one of those partners in the past 12 months.

**Data Measurement Tool:**

Cross Sectional Survey conducted by FHI 360

**From Date:** November 22 2010 **To Date:** December 18 2010

In late 2010, USAID funded FHI to conduct a Cross Sectional Survey among MSM and women in Port Moresby, Papua New Guinea. Respondent driven sampling (RDS) was used to survey 585 participants in November and December 2010. In total, 585 participants (302 MSM and 283 women) were surveyed during the USAID/FHI survey. Though the MSM and FSW study was conducted at the same time by the same investigators the two study populations were investigated separately.

**Sample Size:** Number of female survey respondents: 170

Total women surveyed aged 15-49 who currently have or had an intimate partner

MALE				FEMALE				MALE & FEMALE			
15-	20-	25-	All	15-	20-	25-49	All	15-	20-24	25-49	All
16	48	83	147	37	64	69	170	53	112	152	317

Women aged 15-49 who currently have or ever had an intimate partner, who report experiencing physical or sexual violence by at least one of those partners in the past 12 months

MALE				FEMALE				MALE & FEMALE			
15-	20-	25-	All	15-	20-	25-49	All	15-	20-24	25-49	All
3	11	31	45	8	23	21	52	11	34	52	97

Indicator

MALE				FEMALE				MALE & FEMALE			
15-	20-	25-	All	15-	20-	25-49	All	15-	20-24	25-	All



18.7	22.9	37.3	30.6	21.6	35.9	30.43	30.59	20.7	30.36	34.	30.60%
------	------	------	------	------	------	-------	-------	------	-------	-----	--------

### **Interpretation of value in the context of the epidemic in PNG**

The NHS 2011-2015 in PA.1. has clearly identified gender based violence as a major factor in HIV vulnerability. Cluster 2.1: Gender-related vulnerability

*Gender inequality is a key factor in vulnerability to HIV in PNG. The NHS will comprehensively address gender vulnerability as a fundamental part of HIV prevention.*

*Gender-related vulnerability is the result of social and cultural attitudes, practices and beliefs that disempower people, especially women and girls, and prevents them from accessing services and resources which could protect them from HIV. The roles, relationships and cultures that contribute to what it means to be a boy, girl, teenager, woman, man or transgendered person have a great effect on the epidemic. Customs such as bride price, inheritance and polygamy contribute to power imbalances and sexual dynamics that increase the vulnerability of women. Efforts will be made to address the deeper factors that make people vulnerable to HIV: political, legal, economic, educational, religious and cultural.*

*Gender-based violence and sexual violence are endemic in PNG and are a major factor in HIV vulnerability. Interventions which reduce physical and sexual violence against women and girls, and which support survivors of violence will be urgently scaled-up.*

It is crucial that GBV has been recognised as a key factor for HIV transmission in this NHS 2011-2015. More research is necessary to provide documentary evidence of the extent of the GBV so that progress on the SOs under this Cluster 2.1. can be monitored.

### **Indicator changes compared with previous report**

This Indicator was not present in the UNGASS 2010 or 2008.

### **Challenges for indicator reporting improvement**

The GAR description of intimate partner provided by the GAR does not include clients. This can cause some confusion in behavioural surveys for sex workers/exchange of sex as intimate can also denote sexually intimate.

### **Recommendations for indicator reporting improvement**

None

### 7.3 Orphans School Attendance

#### **Current school attendance among orphans and non-orphans (10–14 years old, primary school age, secondary school age)**

##### **What it Measures**

It measures progress towards preventing relative disadvantage in school attendance among orphans versus non-orphans.

The indicator is split up in two parts so comparisons can be made between orphans and non orphans:

Part A: current school attendance rate of orphans aged 10-14 primary school age, secondary school age

Part B: current school attendance rate of children aged 10–14 primary school age, secondary school age both of whose parents are alive and who live with at least one parent

##### **Rationale**

AIDS deaths in adults occur just at the time in their lives when they are forming families and bringing up children. Orphanhood is frequently accompanied by prejudice and increased poverty, factors that can jeopardize children's chances of completing school education and may lead to the adoption of survival strategies that increase vulnerability to HIV. It is important therefore to monitor the extent to which AIDS support programmes succeed in securing the educational opportunities of orphaned children.

##### **NHS 2011-2015**

##### **Priority Area. 1. Prevention**

##### **Cluster. 2.3 – Strategic Objectives 2.3.1-2.3.5**

Vulnerability of Children.

No Indicator:

##### **Method of Measurement**

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

##### **Indicator Relevance:**

Topic is relevant to PNG, the indicator is relevant but data is not available.

##### **Value of Indicator:**

No value

---

##### **Interpretation of value in the context of the epidemic in PNG**

##### **Indicator changes compared with previous report**

The UNGASS 2010 report was the same as that supplied for UNGASS 2008. The Value was 75% however the measurement tool was not as stipulated by

the UNGASS Indicator.

**Challenges for indicator reporting improvement**

There are significant challenges for PNG in collecting this data. Noting also the definition of orphans and vulnerable children used for the NHS 2011-2015 does not match that used by the GAR 2012 guidelines,

**Recommendations for indicator reporting improvement**

None

## 7.4 External Economic Support to the poorest households

### Proportion of the poorest households who received external economic support in the last 3 months

#### What it Measures

It measures progress in providing external economic support to poorest households affected by HIV and AIDS.

#### Rationale

Economic support (with a focus on social assistance and livelihoods assistance) to poor and HIV-affected households remains a high priority in many comprehensive care and support programs. This indicator reflects the growing international commitment to HIV-sensitive social protection. It recognizes that the household should be the primary unit of analysis since many of the care and support services are directed to the household level. However, household data should be disaggregated to track whether or not households have orphans or an HIV-positive person. Tracking coverage of households with orphans and within the poorest quintile remains a developmental priority.

#### NHS 2011-2015

**Priority Area. 2. Counselling testing, treatment, care and support  
Cluster. 2.4 – Community Support. SO 2.4.2.**

No Indicator:

#### Method of measurement:

Population-based surveys such as Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other nationally representative survey

#### Indicator Relevance:

Topic is relevant to PNG, the indicator is relevant and data is not available.

#### Value of Indicator:

No value

---

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

The NHS 2011-2015 notes the relevance of income support for PLHIV in PA.2. Cluster 2.4: Community and family support.

*The growing number of orphans and vulnerable children, people living with HIV and households requiring income support and assistance highlights the need for action, particularly for community driven responses. Efforts will focus on understanding and mitigating the impact of HIV on households and communities, using a wide range of interventions and addressing stigma and discrimination.*

**Indicator changes compared with previous report**

This Indicator was not present in UNGASS 2010 or 2008.

**Challenges for indicator reporting improvement**

**Recommendations for indicator reporting improvement**

## IV. Best practices

### **a) Best practice on the process in developing the multi-sectorial National HIV and AIDS Strategy 2011-2015. (By N. Moiya)**

#### **Introduction:**

PNG's response to the HIV epidemic was guided by the National Strategic Plan (NSP) 2006 – 2010. Accompanying the NSP were 'subsidiary' plans (the national HIV Prevention Strategy (NHPS) and the national Gender Policy and Plan) to assist with implementation of the NSP. The NSP was replaced by the National HIV and AIDS Strategy (NHS), 2011-2015. The GAR report period spans both the end of the NSP (2010) and the start of the NHS (2011).

Most significantly for the development of the NHS 2011-2015 is the alignment of a number of key national strategies timelines. National strategies and plans on gender, MTDPs, Vision 2020, the National Health Strategy – were all mid development with the same strategic timeframes, as those developing the NHS 2011-2015

#### **The NHS process:**

The government took ownership of the development of the new strategic response by initiating early development in 2009 through establishing the NHS Steering Committee (NHSSC) chaired by the NACS Director. It established a multi-sectoral sub committee the 'NHS Core group' (NHSCG) which facilitated a process of comprehensive consultations and collected data from the various stakeholders around the country to feed into the new NHS development. Women, MSM and PLHIV were on the NHSCG and the NHSSC.

The NHSCG undertook the following activities to fulfil its mandate-  
Consultation:

- Three national level workshops were held in the early stages of 2010. The first one was to set the stage and approve a road map and two others after that to bring together all critical stakeholders to review and comment on the two drafts of the NHS respectively.
- Four regional workshops were conducted. The first two were to collect information and data from the regional level of the response and the second two held prior to the two national workshops were to review the NHS drafts for comments from a regional and provincial perspective.
- CSOs, FBOs and the private sector were invited to all of the above workshops and in addition there were specific focus group consultations included: three rural settings, two youth representative groups, PLHIV organisations, MSM groups, sex workers group including transgender and a private sector group. Women were consulted at the provincial level. Prisoners were missed out due to a prison breakout at the time.
- A newspaper advertisement was also put out for the public to make inputs into developing the NHS which did draw responses from the public.

- Guidelines were developed and given to the stakeholders for them to hold organisational meetings/workshops to make collective inputs into the NHS.

**Resourcing:**

The government, via the NACS, met transport, DSA and personal expense costs for participants. This resourcing was crucial to enable effective participation in PNG where geographic challenges for travel are significant. The budget included the cost of hiring national and international technical experts.

**Drafting process:**

1. The first two drafts were submitted to the NHSSC and the NAC for their comments and input
2. It was then sent back to the NHSCG to work on it further through the various working groups and the Technical Support Team (TST).
  - a. The TST was established, consisting of an international consultant as team leader and five other technically competent national and non-national experts.
    - i. The TST was responsible for synthesising the information collected by the NHSCG, undertake desk reviews of available research and local information as evidence to develop the strategy, synthesise the feedback from the drafts and feed them into the actual write up of the NHS.
    - ii. The TST also formed various technical working groups (gender, GIPA, VCT, etc) as required to assist them in collecting expert opinions for the three priority areas of the NHS.
  - b. The working groups included women, PLHIV, MSM, and female sex workers.
3. All the relevant laws and other national and sectoral policies and strategies were integrated into the NHS. These included:
  - a. Legislation: HAMP Act 2003, NAC Act 1997 (amended 1999), Lukautim Pikinini Act 2009.
  - b. Government of PNG strategies: PNG Development Strategic Plan 2010-2030, National Gender Policy and Plan on HIV and AIDS 2006-2010, HIV and AIDS Policy for the National Education System 2005-2010, Protection Care and Support for Children Vulnerable to Violence, Abuse, Exploitation and Neglect in the Context of the HIV Epidemic in PNG 2008-2011.
  - c. NAC policies: National Research Agenda for HIV and AIDS IN PNG 2008-2013), Strengthening PNG's Decentralised Response to HIV and AIDS 2009, National HIV Prevention Strategy 2010-2015 (NHSP).
  - d. Most significantly a number of national related strategies and plans were being developed concurrently and effort was made to ensure that the NHS and the other strategies/plans were compatible, coherent and consistent. This included:

- i. The development of: Vision 2050, the Medium Term Development Plan 2011-2015, the National Policy for Gender Equality 2011-2015, the National Health Plan 2011-2020, Transport policy
4. Guiding Principles of the NHS: Key additions to the principles of the NSP were Gender Equality and the GIPA which are integrated through the NHS.
5. International obligations and declaration: The NHS development process added the Convention for the Elimination of Discrimination Against Women, Convention of the Rights of the Child and the PNG-Australia Partnership for Development 2010.

The highly consultative process produced a strategic document that has been considered the best National HIV Strategies in the Asia Pacific region with high levels of support report by CSOs, FBOs, NGOs, government and private sector alike.

#### **The NHS Structure:**

The NHS itself is the main overarching framework under which the national multi-sectoral response to the HIV epidemic is to be undertaken by all sectors from 2011-2015. The NHS has three complimentary documents to facilitate its implementation.

1. The NHS Implementation Plan is a bridging document to assist the implementers to align their annual activity plans to the NHS Priority Areas as well as align their plans to the Monitoring and Evaluation framework of the NHS. It has a list of broad activity areas under which the implementers can develop their relevant activities.
2. The NHS Monitoring and Evaluation Framework (M&EF) highlights the overall national indicators under each of the NHS priority areas. It was envisaged that by stakeholders (NGOs, CBOs and government sectors) aligning their activities under the major activity areas, the local activities will contribute to progress on the national indicators in the NHS M&E framework.
3. The NHS Users' Guide is in two languages (Tok Pisin and English) to assist the implementers to translate the NHS to their local setting for their activity plans.

*“• More comprehensive and yet very simple to understand.*

*• Development of the user guides that goes with it makes a lot more easier to use.*

*• Most stakeholders find it easier to understand” 2012 NCPI respondent No.33. AI.*

#### **NHS, an integrated plan**

The subsidiary policies and plans developed to meet identified gaps in the NSP are now all integrated fully within the NHS. This means that all programs and activities have gender and GIPA as part of the programs rather their being 'retrofitted' as an afterthought. Therefore all the indicators relating to gender and GIPA now become NHS indicators. This adheres to and fulfils the "three ones principle" of one national plan (NHS), one national coordinating



body (NACS) and one national M&E framework (NHS M&EF).

### **NHS Guiding Principles**

The consultation process directly shaped the development of the founding principles that guide the implementation of the NHS. The drafting process enabled a full stakeholder 'buy in' of the agreed principles. This process thus enables a degree of accountability by the stakeholders in a shared commitment to work harmoniously with each other, within the guiding principles, in order to mitigate the spread of HIV in PNG.

*"Main streaming in the way it's done. Gender part of it included. Discussions involving churches raised objections on issues of contention on things like condom. The a) & b) component of it. But NHS has balanced all concerns or areas (Care, Treatment, Counselling)". 2012 NCPI respondent No.28. AI.2*

These are the 15 guiding principles of the NHS:

1. Human Rights are respected
2. Gender is always integrated into the HIV response
3. Greater Involvement of people living with HIV
4. Community participation and mobilisation
5. Empowerment
6. Leadership
7. Evidence-Informed approaches and prioritisation
8. Cultural practices
9. Religion
10. Flexibility and responsiveness
11. Accountability
12. Capacity
13. Systems strengthening
14. Partnership and collaboration
15. Sustainability and self- reliance

---

### **NHS 2011-2015: Priority Area 2. Counselling, treatment, care and support**

*Strategic Priority 2: Expand treatment, care and support services. Cluster 2.4: Community Support. Strategic Objective: 2.4.11 Innovative community based approaches to care and treatment adherence are supported, evaluated and shared*

#### **b) Case Management Teams with key PLHIV members, Bolster ART Adherence and Reduce Mortality in Port Moresby**

## **Introduction**

In January 2008, with support from the the National Department of Health, the United States Agency for International Development Regional Development Mission Asia (USAID/RDMA), and the Australian Agency for International Development, FHI 360 PNG started the Continuum of Prevention to Care and Treatment (CoPCT) model in the National Capital District of PNG

Case Management Teams as part of CoPCT program is presented as a 'Best Practice' within this GAR 2012 report because of evidence of significant progress within the reporting period. FHI360 PNG ensured the CoPCT approach was aligned with the National HIV and AIDS Strategic Plan NHS 2011-2015 and has delivered progress against the PA 1: Prevention, PA 2: Counselling, Treatment, Care and Support and the PA 3: Systems Strengthening. Core to the model is the linking, coordinating, and consolidation of prevention, care, treatment, and support services for people living with HIV (PLHIV), it also strengthens clinical and community services which are fundamental in the provision of comprehensive HIV care.

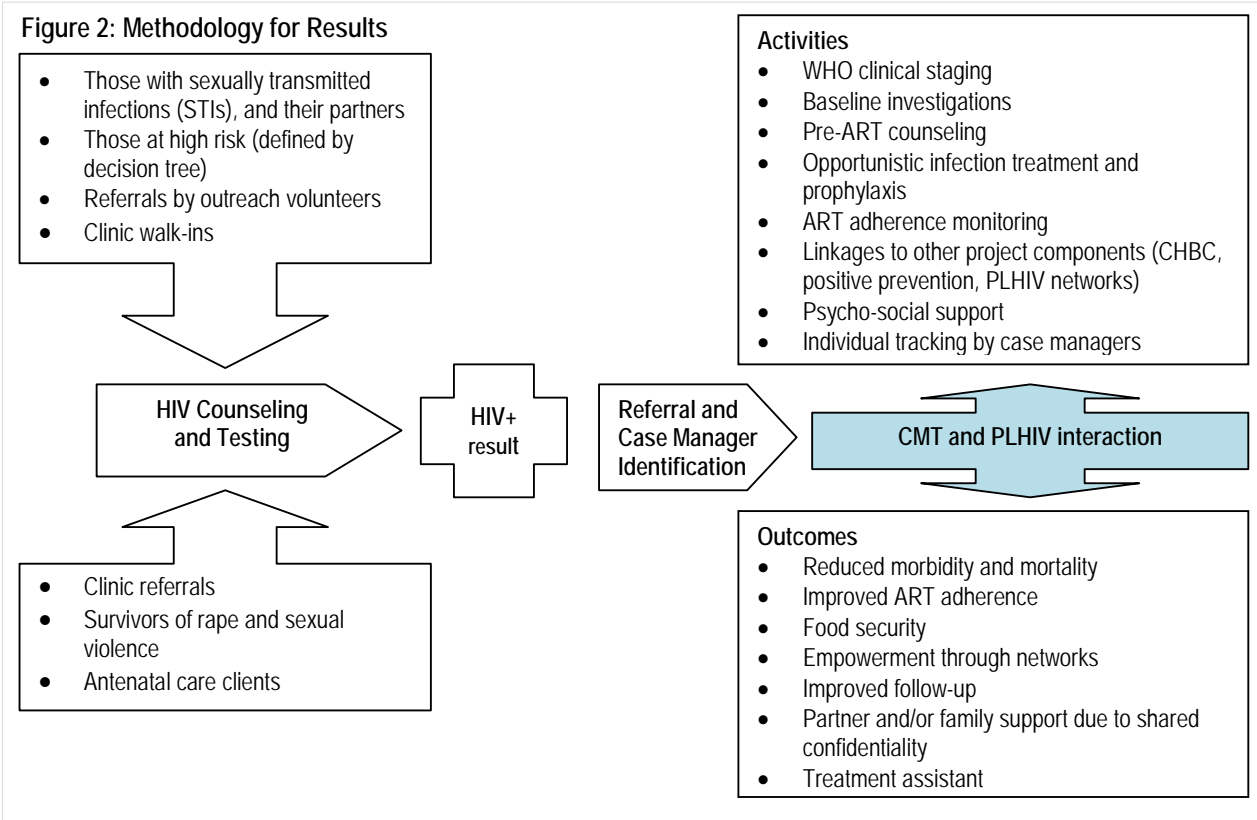
Stigma and discrimination are significant barriers for those at risk of, or living with HIV resulting in gaps in program and support services. The CoPCT model is addressing this through a coordinated system of care that integrates PLHIV both as recipients and providers of the care which links individuals, communities, and health service providers at provincial and national levels to ensure better health outcomes.

## **Case Management Teams**

The CoPCT model in PNG uses case management teams (CMT) to deliver care, treatment, and support to PLHIV and most-at-risk populations (MARPs). In PNG, MARPs include female sex workers, men who have sex with men and transgender individuals. CMTs were recognized as critical to the implementation of CoPCT in PNG, which faces multiple challenges including a weak health system and complicated mobility patterns into urban areas. CMTs are made up of doctors, nurses, and case managers who together address psycho-social needs, provide crisis support and adherence counseling (particularly important in PNG), positive prevention information and tracking for those lost to follow-up. Compared to a traditional health systems strengthening approach, which focuses on building provider capacity, the CoPCT model spreads the roles and responsibilities for care amongst a wider cadre of providers including those from the targeted communities. Most significantly, PLHIV as case managers enhances the ability of CMT to support and understand the issues faced by PLHIV. It also helps address stigma and discrimination amongst health care providers within the health system.

Acknowledging the special needs of at-risk and vulnerable populations, the project focused on providing community outreach, counseling and testing services to the MARPs and PLHIV. HIV testing functions as an entry point to CoPCT and CMTs are critical to improved health outcomes (see Figure 2).

**Figure 2: Methodology for Results**



Upon HIV diagnosis, PLHIV are linked to CMTs who lead them through pre-ART counseling, baseline tests, opportunistic infection treatment and prophylaxis. They are also linked with community home-based care programs (CHBC), and introduced to PLHIV support groups which are an important support system. The PLHIV support groups call themselves *Kirap bung wantaim*, which in Pidgin means 'stand, rise, and work together.' CMTs ensure that PLHIV patients are followed-up at regular intervals through home and clinic visits, and -- among those on antiretroviral therapy (ART) -- monitored for adherence. Adherence support within the CoPCT model involves trained counselors, adherence plans, and a treatment assistant who is someone living in the household of the PLHIV patient. Every PLHIV patient is encouraged to form a special bond with their case manager, some of whom are also PLHIV. Clinicians and counselors are also sensitized around issues specific to PLHIV including how to reduce stigma and discrimination. As a component of the CoPCT, CMTs filled a critical gap towards ensuring care, treatment and support.

### Achievements

In total, 184 PLHIV clients have been followed for 3.8 years. Only 27.1 % were originally from the National Capital District. The remainder came from other provinces, following typical urban migration patterns. Females make up 64.5% of these patients, with an average age of 30.3 years, while male client ages averaged 37.8 years. At baseline, 51.1% of clients were classified as WHO Stage 3 or 4. The average CD4 at baseline (in 2008) was 179.8 cells/mm<sup>3</sup>, compared to 270.6 cells/mm<sup>3</sup> in other years (p=0.880).

CMTs classified the risk behaviors of 168 of the 184 clients and found that 31.6% were female sex workers, 31.0% were high risk females, 32.1% were high risk males, and 3.6% were men who have sex with men. Over the project period, 122 PLHIV clients initiated ART. The mean period of follow-up was 369 days, with an average 38

days between clinical visits. From first to last visit, 95% adherence to ART increased from 58.8% to 75.1% (p=0.027). Mortality rates decreased from 56.5 per 100 person years (PY) in 2008 to 20.5 per 100 PY in 2009, 13.6 per 100 PY in 2010, and 6.8 per 100 PY in 2011 (Hazard Rate= 0.1, p<0.001). Factors contributing to mortality were found in multivariate regression to be the year 2008 compared to other years (p=0.001), less than 95% adherence (p=0.001), WHO stage 3 or 4 (p=0.054) and not being from National Capital District (p=0.094).

### **Learning**

The PNG experience provides valuable lessons in operationalizing CMTs in resource-limited settings.

1. Late WHO stages and low CD 4 counts at baseline result in very high mortality rates which demoralized teams in the first year of implementation.
2. Adherence to ART is dependent upon many social issues including high mobility, lack of housing, irregular employment, food insecurity, and a breakdown in social structures due to urbanization. CMTs are helpful in addressing some of these barriers to ART adherence.
3. Using PLHIV staff as part of the CMTs reduces the loss to follow-up, increases adherence, provides needed social support, and reduces mortality in urban settings.
4. Mortality amongst PLHIV patients can be reduced through early diagnosis, good ART adherence and addressing the needs of MARPs including female sex workers.

### **Acknowledgements**

The best practice would not have been possible without dedicated efforts from our implementing partners, Hope Worldwide- Helvim Bilong Yumi Project, PLHIV support groups, case manager's and clinical staff

Contact person as below

**Shiv Nair** | Country Director | PNG Country Office  
Unit 3, Sec 33, Steamships Compound, Waigani, Port Moresby  
PO Box 447, NCD, Papua New Guinea  
O: 675.323.0966 | [snair@fhipng.org](mailto:snair@fhipng.org) | FHI 360 Facebook FHI is now FHI 360. Visit us at [www.fhi360.org](http://www.fhi360.org)

---

## **Priority Area 3: System Strengthening**

*Strategic Priority 2: Strengthen the enabling environment for the national HIV response. Cluster 2.2. Leadership. Strategic Objective: 2.3.1. Effective strategies and programs*

### **c) Transformational Leadership –Unexpected results generated**

#### **Introduction**

HIV and AIDS remains one of the health and development challenges of this century. There have been diverse and creative responses to the pandemic and many lessons have been learned. Innovative approaches have been employed to address HIV, resulting in longer-term impacts that have tackled

other underlying development challenges including poverty, climate change, health, and gender inequalities. In Papua New Guinea, UNDP and the National AIDS Council Secretariat (NACS) have been playing a significant role in strengthening the leadership and advocacy capacity through Transformational Leadership Capacity Development (TLPD) to address underlying drivers of the HIV epidemic.

### **Methodology**

The TLPD is conducted with a series of 3 workshops with planned breakthrough initiatives in between the workshops. These workshops are aimed at enabling participants to discuss the major factors influencing the spread of the epidemic and learn new strategies to tackle them. Each participant is encouraged to go through a process of self-assessment, self-reliance and personal initiative. Neuroscience research confirms that the pathways to decision making are the same for everyone regardless of education or socio-economic status. People can be moved to positive action if they feel a sense of hope or have a stake in the future. UNDP and NACS's response to the epidemic is aimed at enabling people to envision a better future for themselves and communities, and to take steps to achieve their goals.

This overview highlights results from TLPD 2011 that focused on women initially then, in a second group, specifically on HIV positive women. This best practice reports on the HIV positive women who went through the leadership development training, and how their lives as well as their communities were changed.

### **SECOND TLPD GROUP 2011: Focused specifically on HIV positive women**

The overall aim of this leadership development programme for 43 HIV positive women was to develop their capacity to advocate for interventions that are tailored towards addressing their needs and rights directly as defined by them. In addition, the training programme enhanced knowledge and greater understanding of the epidemic dynamics and how to stitch initiatives that effectively address the challenges posed by HIV on them. As highlighted above in the methodology, after 12 months of the programme implementation, the following were some of the key results:

1. At least 16 HIV positive women, out of the 43, accessed micro credit schemes and established small income generating projects which have significantly improved not only their livelihood, but also in terms of supporting education for their children, access to basic health services, including treatment. Other women who did not have access to credit schemes, are now engaged mainly in agriculture/gardening and while others have secured themselves jobs with either NGOs or companies and means of improving their health.
2. In terms of advocacy and community level sensitization on issues related to stigma, discrimination and representation in decision making, a few women have

been engaging community leaders, groups, and networks into advocacy and sensitization programmes. Women in this category shared experiences with the group on how communities are now engaging them in community planning and decision making processes, as well as addressing legal cases where women have been thrown out of their homes “when husband died of HIV”. At least three women have been assisted with legal services to reclaim their marital property/ houses through community leaders.

3. At policy level, a selected group of 11 HIV positive women from this programme are actively engaging and influencing the development of the Social Protection Policy for PNG. They are advocating and acting as a resource for the inclusion of HIV positive people as one of the key target groups. Discussions are ongoing on this, and whilst not yet formal it is highly probable that as a result HIV Positive people, will be mainstreamed/GIPA in the policy.

***For details, contact:***

*Peterson Magoola  
Program Specialist, HIV  
UNDP PNG  
PO Box 1041,  
Port Moresby, NCD  
Papua New Guinea  
Tel +675 321 2877  
[Peterson.magoola@undp.org](mailto:Peterson.magoola@undp.org)*

# Major challenges and remedial actions

## NASA – challenges for the resourcing of the national response

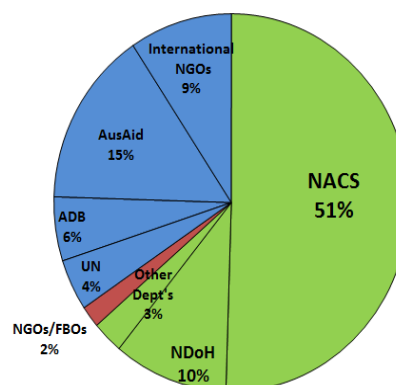
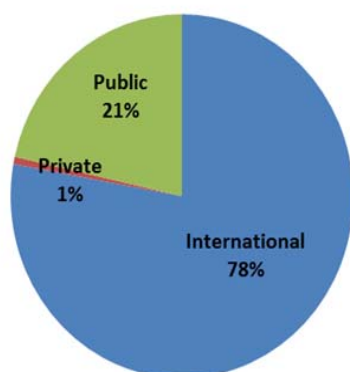
The conclusion from the NASA report provides three powerful challenges to the national response in PNG.

1. Change the heavy reliance on international donors for programme delivery

National Government provides less share of total funding but manages more funds

Who provides the money

Who manages the money



**National Government is responsible for managing 55% of all HIV funds**



Figure 3: NASA report: presentation 15 March 2012

2. Spend more of the funds on service delivery and less on the management of the response.

## AIDS Spending Categories, 2009 and 2010

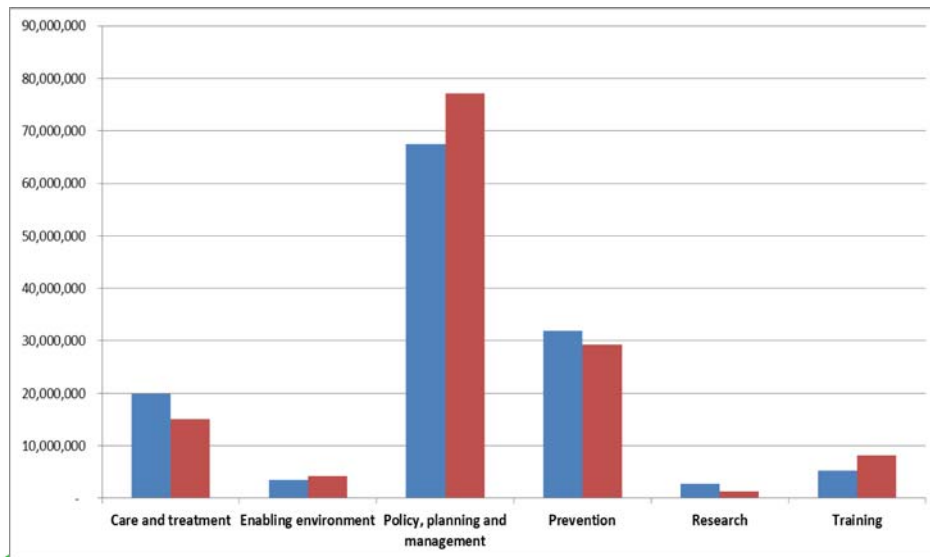


Figure 4: NASA report: presentation 15 March 2012

3. More funds should be allocated to prevention among the more at-risk populations and treatment, care and support services, in accordance with the NHS 2011-2015 (see figure 5).

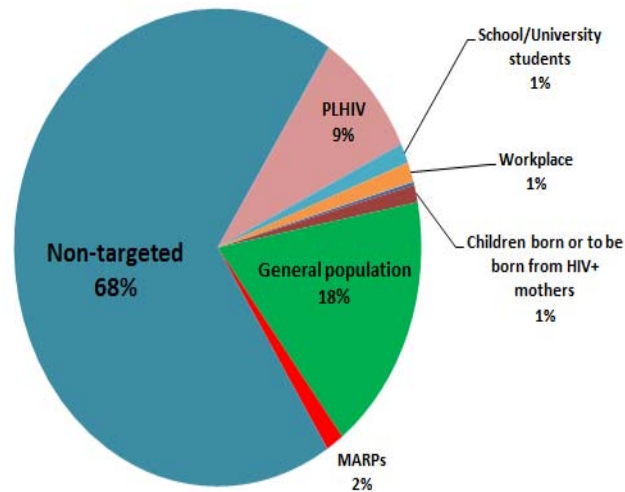
Another challenge is to make sure there is a second NASA exercise as planned in 2014. This will provide an invaluable tool in assessing progress on the NHS 2011-2015, three years into its time frame.

A related challenge, linked to the NASA 2012 results, is the need to complete the NHS 2011-2015 costing exercise.

*“It has been extremely challenging to develop a budget for the NHS 2011-2015. A costing exercise was started with civil society involved but never completed. CSO are concerned that the NHS 2011-2015 does not have a budgeted annual cost”. NCPI respondent. PART B.I.*



## Beneficiary populations reached, 2009-2010



- Policy, management, training & research takes almost 70%
- MARP's-targeting interventions represent only 2% of the response



Figure 5: NASA report: Presentation 15 March 2012

### A. Progress made on key challenges reported 2010 Country Progress Report

This section of the GAR 2012 reports on progress on key challenges reported in the UNGASS 2010, which covers the 2008-2009 period of the National HIV and AIDS Strategic Plan 2006-2010 (NSP). Progress reported on the key challenges has been clustered under the NHS 2011-2015 priority areas.

#### Prevention (PA.1)

#### Key Challenges 2010

- Key lessons learned include the need to identify and prioritise those people at high risk

Progress:

The NHS 2011-2015 has integrated the issues for the more at risk populations (MARPS) in PNG throughout the three Priority areas. The working definition of the MARPs in PNG is, as at 2010 when the NHS 2011-2015 was drafted.

*In PNG, more-at-risk populations include: women and men involved in sex work and transactional sex, men who have sex with men, migrant workers, enclave workers, prisoners and mobile men with money (such as public servants, police, politicians, landowners, cash crop buyers and sellers, transport sector workers, and business men)<sup>21</sup>.*

The NHS 2011-2015 also ensured this more at risk population group is in the Top 10 interventions. Under PA.1.

*Develop and scale-up targeted HIV and STI combination prevention interventions for more-at-risk populations (MARPs)<sup>22</sup>*

The *National Research Agenda for HIV and AIDS in PNG (2008-2013)* alongside the NHS 2011-2015's increased focus has resulted in an increase in research on marginalised and more at risk populations. This has provided very valuable data on the risk behaviours of sex workers, women and men who exchange sex, mobile populations, young people at higher risk, economic enclave workers and MSM.

- **geographical priority areas for prevention programming; and the need for research on sexual practices to inform interventions;**

#### **Progress**

The NHS 2011-2015 incorporated the policy *Strengthening PNG's Decentralised Response to HIV and AIDS (2009)* and there is clear evidence of growth in capacity and effectiveness of the PACS and the District AIDS Councils (DACs). However there is inadequate information on the geographical priority areas as the information is limited.

The IBBS is expected to help PNG define these geographical priority areas based on HIV prevalence alongside improvement in coordination of the data collection from provinces to NDoH.

It has been a challenge that there has not been a general population based survey that has included sexual practices in this period. The IBBS is also expected to increase knowledge on the sexual practices from a general population-based approach to inform interventions.

- **the need to maintain consistent condom supplies and understand that condom distribution does not equal condom promotion;**

#### **Progress:**

The transfer of responsibility for distribution of condoms to BAHA has reduced the concerns about inconsistency of supply and 'stock outs' of condoms. This has included the warehousing of condoms at a province level.

- **the need for strategies to address stigma and discrimination when**

---

<sup>21</sup> NHS 2011-2015: Glossary. Page 62.

<sup>22</sup> NHS 2011-2015: Section 2: Page 6.

## **working with vulnerable groups**

### **Progress:**

Igat Hope Inc. successfully advocated for inclusion of Stigma and Discrimination into the NHS 2011-2015 (PA.3. Cluster 2.5). It has also been partnering on the People Living with Stigma Index since 2010.

## **Treatment, testing, care and support (PA.2)**

### **Key Challenges 2010**

#### **HIV Counselling and Testing / Testing, treatment, care and support (PA.2)**

- **quality of service delivery in all sites, including ensuring that all services are user friendly and welcoming of all clients;**

### **Progress**

The introduction and implementation of VCT guidelines are being used as a means of quality assurance. There has been an increase in the quality accreditation of sites.

- **to expand HCT beyond fixed stand alone VCT facilities to include mobile testing; and to increase the coverage of HCT at the local government level in rural areas.**

### **Progress**

Up to 80 HCT sites with prescribers now available including rural areas and the number are still increasing.

#### **Community & Family Support/ Testing, treatment, care and support (PA.2)**

- **The growing number of orphans and vulnerable children,**

### **Progress**

The Lukautim Pikinini Act 2009 signalled the need to focus more attention on the needs and vulnerabilities of orphans and vulnerable children in the context of HIV. The NHS 2011-2015 responded with a section on programming to reduce the vulnerabilities of children affected/infected by HIV (PA.1. Cluster 2.3). The training on the Lukautim Pikinini Act 2009 has begun in this GAR 2012 period and includes churches working at community level. This has progressed to try and guide communities on their role in care protection and support of any vulnerable child.

- **people living with HIV and households requiring income support and assistance highlights the need for new areas of support, particularly for community driven responses. Efforts need to focus on mitigating the impact of HIV on households and communities;**

### **Progress**

There has not been any strategic change or progress in this area. Social and economic support is provided by charities and church led organisations. There are small grants to assist some NGOs and FBOs to assist PLHIV with

economic needs (i.e. HIV related work).

- **the role of sorcery and other traditional beliefs;**

#### **Progress**

It is not clear what programmes and interventions have been initiated or progressed in this area.

## **System Strengthening (PA.3)**

### **Key Challenges 2010**

#### **GIPA – The greater involvement of PLHIV / PA.3. Systems Strengthening. Cluster 2.2 Greater involvement of PLHIV**

- **The meaningful involvement of PLHIV will strengthen the national response.**

#### **Progress**

Igat Hope Inc. reports significant progress in this area, most evident at a national level. PLHIV are becoming involved in service delivery (FHI 360 CoPTC reported in IV. Best Practice section). PLHIV are

*“GIPA- it’s past the ad hoc involvement at a national level and more meaningful and systematic”. Igat Hope Inc. representative at the Consensus Workshop, 23 March 2012.*

In the **NCPI 2012** the Part B respondents scored the extent to which civil society sector representation in HIV efforts were inclusive of diverse organisations (e.g. PLHIV, sex workers and FBOs). The score given was 4 with 5 being the highest.

- **Strengthening the role of HIV positive people and PLHIV groups is an important and necessary remedial action and will be addressed in the NHS.**

#### **Progress**

There has been significant growth in PLHIV organisations since the UNGASS 2010 was reported (March 2010) including Igat Hope Inc. becoming a national organisation. There are challenges that have become pressing as a result of the growth of established and emerging PLHIV organisations at the provincial and district level. As a result the capacity of Igat Hope, as a recent national organisation, to meet these growing needs and expectations has become challenging. For meaningful engagement of a marginalised population greater investment is necessary in capacity development, at all levels of PLHIV network or organisations. This has not been understood or not a priority for resourcing in 2010 and 2011.

*“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”. NCPI Respondent.*

*Part B.I.*

### **Gender / PA.3. System Strengthening: Cluster 2.1. gender**

- **There is a need to create multi stakeholder partnerships which to develop gender sensitive responses in areas of health, justice, education, economic and social studies.**

#### **Progress**

Progress is unclear in this area. NACS has appointed a Gender and Special Interests Officer who has overarching responsibility for building partnerships and networks, however a more institutional commitment is necessary to achieve progress on this challenge.

- **Support is needed for programs which motivate men and boys to actively participate in prevention including setting up clinics for men and boys.**

#### **Progress**

There have been a few small initiatives in this area. For example, COMPASS - Clinical Outreach, Men's Program, Advocacy and Sexual Health Service Strengthening in Lae, Madang province funded by AusAID. The aim is to educate and encourage men to take responsibility for their own sexual and reproductive health, as well as to be better partners in intimate relationships. This is in recognition of the key role that men play in contributing to the empowerment of women, and the improvement of sexual and reproductive health for all

- **Research needs to be conducted to better understand male and female perceptions of sex, violence, sexual practices and how this links to men's notions of masculinity and desire.**

#### **Progress**

There have not been any significant research studies in this area.

- **Male leaders who can advocate on behalf of gender equality need to be identified and supported.**

#### **Progress**

There has not been any specific progress in this area.

### **Leadership / PA.3. Systems Strengthening. Cluster 2.3**

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

#### **Progress**

Political leadership at a higher level has continued to deteriorate. However the new Special HIV Parliamentary committee chairperson is more visible and there are exceptions with the Minister for Health attended the United Nation's General Assembly meeting and gave a speech on HIV/AIDS and the Former Minister for Community Development speaking at the Nation Convention of

Human Rights and at PNG National Parliament promoting the a Bill that decriminalises the sodomy and prostitution. At a Provincial level there have been reports of greater engagement with particular reference made to Mr Powes Parkop, the NCD Governor, talks about HIV on media, has taken an initiative to take an HIV test publicly, has allocated K500,00 for the NCD response to support Mobile VCT clinics and he visits the VCT clinics.

- **The leadership role of men and women living with and affected by HIV needs to be strengthened.**

#### **Progress**

In 2011 NACS and UNDP introduced the Transformational Leadership Development Programme that had one group for women and one specifically for HIV positive women. The best practice case study at IV in the GAR Report describes the success of the PLHIV group.

- **Male and female community leaders and elders need to be engaged as agents of change.**

#### **Progress**

Progress is less clear at this level. Not so much on whether activities are occurring but on whether the data has been collected to report on them.

- **The role of leaders in the public and private sectors as champions for effective HIV prevention needs to be strengthened.**

#### **Progress**

Improvements at the departmental level are reported with an extensive list of examples provided by the Law and Justice sector as an example. *'The Chief Ombudsman hosted World AIDS day activities at the Ombudsman Commission 2010, 2011. The Ombudsman Commission has included HIV as a funded line item in the 2012 annual plan. The Ombudsman Commission funded one Commissioner and the Cross Cutting Issues Coordinator to attend the XVIII International AIDS Conference in Vienna 2010 and have committed to funding one commissioner, the Manager HR and the CCI Coordinator to attend the XIX International AIDS Conference in Washington 2012. The RPNGC Assistant Commissioner Human Resources hosted World AIDS day Activities at police head quarters, 2011. The RPNGC Assistant Commissioner Human Resources participated in the Asia and Pacific Regional Consultation on HIV and Sex Work in Thailand, October 2010'. NCPI respondent. Part A.II.*

- **All leaders, particularly religious leaders need to promote accurate, consistent and mutually reinforcing prevention messages that are in line with Government of PNG (GoPNG) strategies and policies.**

#### **Progress**

Church leadership has significantly increased its involvement in this period through the development of the Church Alliance in 2010.

### **Capacity / PA.3. Systems Strengthening. Cluster 3.1**

- **Current approaches to capacity building will need to be overhauled.**

**Training, particularly one-off training programs have become a vehicle for “capacity building” but little consideration is given to establishing minimum competency standards for training participants.**

- **In addition lack of training follow-up, including on-the-job technical support has been lacking.**

#### **Progress**

Capacity development initiatives, often provided by donors, and how they are implemented are not easily monitored or reported in detail For example on to whether there were competency standards established and assessed.

### **Research, Surveillance, M&E / PA.3. Systems Strengthening. Cluster 1.1**

- **There should be an emphasis on operational research especially at service delivery points.**
- **The country’s rich cultural diversity requires both quantitative and qualitative research with a variety of methods, approaches, localities and scale to provide the background for developing relevant responses for specific populations in specific contexts.**

#### **Progress**

The planned Integrated Bio-Behavioural Survey (IBSS) was launched on September 2011 so is yet to provide a representatively sampled national survey that collects bio-behavioural data.

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

#### **Progress**

Data management is still a challenge. The surveillance unit at NDoH is understaffed and suffered a loss in budgets and staff in 2011. There is a lack of coordination between M&E staff and Provincial Health Officers at provinces

## **B. Challenges faced throughout the reporting period (2010-2011) that hindered the national response, in general, and the progress towards achieving targets**

- **NACS restructuring**

The process of restructuring for NACS was challenging and at times

unpopular. Whilst it must be noted that the NHS 2011-2015 consultation (see case study in the IV Best practice) was extremely well done, not surprisingly the capacity to plan, coordinate and lead the implementation of the first year for the NHS 2011-2015 in 2011 was compromised.

- **GFATM Round 4 ending**

The GFATM round 4 grant ended mid 2010 and there was a great deal of uncertainty and disquiet on what was to replace the support provided. The GoPNG stepping in and taking on the full cost of ARVs was welcomed as important leadership and the success of the Round 10 application offered some reassurance.

- **No costing of the NHS 2011-2015**

Perhaps as a result of the capacity issues with NACS during restructuring but the costing exercise was not completed and many in the NCPI referred to this as a significant impediment for effective implementation of the NHS 2011-2015 by many partners.

- **ART actual and perceived stock outs**

Whilst it was good news that the government took on the resourcing of the country's ARVs there have been regular 'crisis' in 2010 and 2011 where there was either actual or perceived 'stock out's of the medications. The resulting urgent activities to locate new stocks or to explain the error in perception, have had a negative impact on the trust in the ARV supply system.

- **Decentralisation – reaching the rural areas**

Whilst the reach of the national response has extended further into rural areas in both prevention and care and treatment (VCTs, HCTs, DACS and PLHIV support organisations) the infrastructure and capacity issues have understandably escalated in complexity and at the same time faced increased expectations and newly identified need.

- **Political instability and leadership waning at national level**

The lack of high level leadership, as noted in the UNGASS 2010 report, has deteriorated further by the change in political leadership of the government in mid 2011. The subsequent ruling of that change's legal status and the resulting confusion and uncertainty for PNG that has continued into 2012.

- **Growth in PLHIV organisations at province and district levels and capacity to support the extending network for I-gat Hope as a national organisation**

This has been commented on in other sections of this report but sustaining a network of support through periods of growth is a challenge and if not resourced well the sense of 'neglect' and frustration felt by network members can damage key organisational relationships and slow down progress.

- **NDoH restructuring and capacity of surveillance Unit**

A significant number of NCPI respondents, from both government agencies and the CSOs commented on the disruption and subsequent loss of key staff in the Surveillance Unit at the NDoH. The impact of this issue of capacity has



been felt in the timing and extent of this GAR 2012 report with programme data arriving exceptionally late for incorporated within the GAR report.

- **Limited research funds**

Smaller grants were available and supportive of MARPS sub population research in this period. However funds were not available for larger general population based studies. With IBBS there are serious concerns that there will not be any additional funds for smaller MARPs targeted research.

## **C Concrete Remedial Actions That Are Planned To Ensure Achievement Of Agreed Targets.**

*“The dynamics of involvement has changed significantly over the last two years, a very short period of time. It is not just international voices being heard, but Papua New Guineans are influencing decisions. NHS using “our” language. Greater ownership of Papua New Guineans”. Consensus Workshop participant. March 23 2012.*

The following remedial actions proposed have been drawn from the NCPI respondents and the Consensus Workshop participants held at NACS, Port Moresby, on 22 and 23 March 2012.

### **PA.1. Prevention**

#### **Strategic priority 1: Reduce the risks of HIV transmission**

##### **Cluster 1.1: Sexual transmission of HIV and other STIs**

1. In view of higher HIV prevalence for those involved in sex work/transactional sex and MSM populations - scale up prevention programmes and support for those who do the services delivery to these populations
2. Prevention programs moving from awareness to social, structural, and behavioural change. More holistic approach. Not just condom distribution.
3. Ensure integration of prevention interventions for anal sex into HIV prevention programmes. There is a challenge of addressing condom use and anal sex in heterosexual relationships in programme development, prevalent but taboo to speak about, however HIV wins if anal sex is too embarrassing to talk about.
4. Private-public partnerships to build demand for condoms among the sexually active.

##### **Cluster 1.4: Injecting practices, penile modification and other emerging transmission routes**

5. More research on penile modification and inclusion in NHS. Better understanding on male circumcision and penile modification.

6. IDUs- Emerging concern. Need research to better understand and programs to reach them to reduce their risks.

## **Strategic priority 2: Address factors that contribute to HIV vulnerability**

### **Cluster 2.1: Gender-related vulnerability**

7. PNG needs more services to address GBV. Working with perpetrators and survivors.
8. Violence among sexual minorities: need more research on the violence within the more at risk communities: women and men who engage in transactional sex, transgendered people, and MSM (FHI BSS and Askim na Save) within the gendered context.
9. High levels of acceptance of gender-based violence among the population at large.
10. Need to better understand GBV in PNG and possible relationship between GBV and HIV/STI. Use existing data and new research to help inform and evaluate the impact of programs and policy changes.

### **Cluster 2.4: Vulnerability of more-at-risk populations**

11. Better understand and respond to higher risk populations along PNG borders.

### **Cluster 2.5: Drugs and alcohol**

12. Alcohol use, remittances, and other social drivers being better understood.

## **PA.2. Testing, Treatment, Care and Support**

### **Strategic priority 1: Scale-up HIV counselling and testing**

#### **Cluster 1.1: HIV counselling and testing**

1. Increase couple HIV counselling and testing through promotion, social media and peer support initiatives like FHI 360 CoPCT.
2. Rural access – consider coordinating and funding transport to get to VCTs
3. Increase access to testing through rolling out of the point of care diagnosis with a better grip on quality of testing,
4. increasing access to ART, with more laboratory backup, especially with CD4 counting and emphasis on quality of care,
5. Eliminating actual or perceived stock outs
6. More PICT in TB and STI patients.
7. Invest on the PPTCT through increasing access to maternal and child health services and PPTCT mainstreaming. The number of pregnant women tested has not increase much, PPTCT coverage has increased slightly, ANC coverage is around 60% of all pregnancies.

## Strategic priority 2: Expand treatment, care & support services

### Cluster 2.1: Treatment

8. Stock-outs. Better systems and communication to track medicine (ARVs, OI treatments and STIs) and inform the public on what is available and where. Use the PLHIV networks to communicate what is going on. Estimate need based on prevalence data. Monitor supply chain, strengthen checks and balances. Forensics on supply chain. More supervision, follow up, and public reporting.
9. Training for health workers in utilising available ARTs and communicating with patients
10. MARPS:
  - i. Access to health services for MARPS,
  - ii. Support for psycho-social for MARPS?
  - iii. Weak ability to address mental health issues

### Cluster 2.4: Community and family support

11. Clear direction and strategy should be developed for hospice and palliative care – could be led by the Church Alliance and or Community Leaders (provided meets needs of MARPS)
12. Scale up home based care using similar programme as FHI Community home-based care in Madang and NCD
13. Increase Orphans, Vulnerable Children programs that are consistent with Melanesian cultural values. Church, family, and community structures exist and can be harnessed to deliver care and support services and would be more sustainable. Prioritize a larger scale response and use current models i.e. Churches in Chimbu Province- pays for kids to go to school and House of Claire in Lae with Mission House- working with OVCs

## PA.3. Strengthening Systems

### Strategic priority 1: Improve strategic information systems

#### Cluster 1.1: Monitoring, evaluation and surveillance

1. Costing of NHS MUST be completed. Recommendations from NASA process should be implemented in the NHS costing.
2. Annual NACS report should report publically against the NHS, the M&E framework, and its spending against the costed plan.
3. Encourage international NGOs and CSO with donor funding to send data to both their funders and the NDoH Surveillance Unit.
4. Consider technical support options including sharing staff to reduce impact of high M & E staff turnover in CSOs
5. Plan and provide adequate notice so that short notice is not the reason for why data is not collected.
6. Regular refresher training for donor recipients and partners on the data reporting system for PNG. This could include a 'sharing best practice' component to improve quality of reporting and support across

institutions and organisations.

**Cluster 1.2: Bio-behavioural research and Cluster 1.3: Social, behavioural and operational research**

7. NACS Research Advisory Committee to run an annual training on Harmonisation of GAR and NHS 2011-2015 Indicator use in research in PNG (as done in 2010).
8. More Research into the risk behaviours of:
  - i. 'monied' men and women
    - a. unemployed youth in respect to numbers of sexual partners, engagement in transactional sex, and condom use.
    - b. Men who have multiple partners of which some are transactional (men with money).
    - c. Mobile men with money
    - d. Female clients of male sex workers/ transactional sex
  - ii. Transactional sex becoming younger. Evidence emerging about inter-generational sex and young people engaging in transactional sex i.e. Sugar mamas and papas.
  - iii. Female, male, and transgender partners of MARPs
  - iv. Anal sex risk behaviours are in the IBBS to understand what role it has in the general population and what interface, if any, with S & RH.

**Strategic priority 2: Strengthen the enabling environment for the national HIV response**

**Cluster 2.1: Gender**

9. National Council of Women should receive support for capacity and HIV sector partners be encouraged to partner with NCW.

**Cluster 2.3: Leadership**

10. NACS to take on an advocacy role to promote best practices at the provincial and national level among developmental partners.
11. Youth Alliance to be supported through capacity assistance to play a greater role in the response.
12. Political leadership to take more responsibility on national response to HIV. For example the Special Parliamentary Commission on HIV to organize a 'Session on the floor' of Parliament.
13. Churches to continue partner with other civil society organizations. Help de-stigmatise condom use by promoting the multiple benefits of condom use (i.e. Supporting birth spacing). Church Alliance to involve other CSO partners in discussions and CSOs to involve Church Alliance in their forums.

**Cluster 2.4: Legal environment**

14. Resubmit the proposal to decriminalise sodomy and sex work- led by the Minister for Health and HIV.

## **Strategic priority 3: Strengthen organisational and human capacity for coordinating and implementing the National HIV and AIDS Strategy**

### **Cluster 3.1: Capacity building**

15. Develop ways to support partners from all parts of the HIV sector to share support services and resources (technical support, specialized services) with each other.
16. Invest more in technical assistance and effective models for capacity development and less on policy development
17. NACS to track status of mainstreaming HIV into strategies, policies and programmes in other departments and non HIV specific services and programs.

### **Cluster 3.2: Decentralisation**

18. Improve systems to deliver funding and technical support on the provincial level. Set up a system to track the decentralization process.

## VI. Support from PNG's development partners

### Key support received from PNG's development partners

The importance and role of the development partners is described in the NHS 2011-2015:

*Key development partners include AusAID, UNAIDS, ADB, EU, UNICEF, UNDP, WHO, World Bank, USAID, and NZAID. These partners are actively involved in the planning of activities and services and directly and indirectly fund providers, agencies and organisations. The Development Partners Forum (DPF) is the mechanism for donors to coordinate their collective contributions to the response in order to reduce the burden on GoPNG in having to coordinate with each donor individually. It allows the NAC and the NACS to communicate with the development partners at single forum. This enables development partners to discuss and negotiate priorities, determine donor contributions to PNG, strive to eliminate duplication and promote application of resources according to needs. Development partners have direct relationships with NAC, NACS, NDoH and the Country Coordinating Mechanism (CCM). (NHS 2011-2015 page 58)*

The support to PNG from Australia is through the PNG-Australia HIV and AIDS Program, called "Sanap Wantaim" (Standing Together). The other major bilateral and multilateral development partners continue to be the United States Agency for International Development (USAID), New Zealand's International Aid and Development Agency (NZAID), the Asian Development Bank (ADB), the Global Fund to fight AIDS, TB and Malaria (GFATM), and the UN system. The World Bank, the British High Commission and the European Union are also engaged in supporting the PNG response.

The GFATM round four grant (granted 2005) came to an end in August 2010. There was significant uncertainty on how key areas of support provided by the GFATM round four grant (particularly on funding the ARV budget) would be able to continue after the grant come to an end. It was particularly important to note that the GoPNG took on the full budget for the supply of ARVs from mid 2010 and has continued to guarantee the supply of ARVs since that date.

The news of the successful round ten GFATM application in 2010 was particularly important as a sign of progress, in light of the failure of the round nine application to pass the technical review panel.

The recent 2012 National AIDS Spending Assessment (NASA) has highlighted the high levels of support provided by the development partners to the national response to HIV in PNG.

Year	Financing source	Total (PGK)	%
2009	International	104,746,259	80%
	Private	886,025	1%
	Public	25,489,768	19%
<b>2009 Total</b>		<b>131,122,052</b>	
2010	International	102,489,210	76%
	Private	818,945	1%
	Public	31,807,186	24%
<b>2010 Total</b>		<b>135,115,341</b>	
<b>Grand Total</b>		<b>266,237,393</b>	<b>100%</b>

**Figure 8: Presentation of NASA 2012 on 15 March 2012**

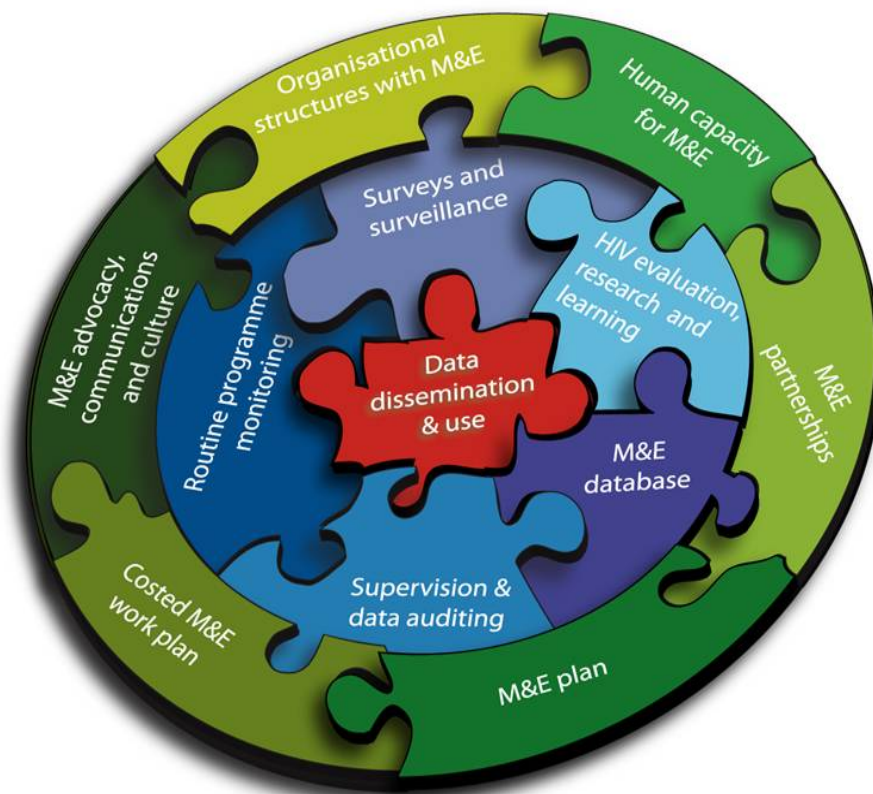
In the 2009-2010 period of the NASA undertaken in March 2012, the Government of Australia is the single largest source of the HIV response in PNG, representing 69% of the international funds and 53% of the overall HIV response. The share financed by the Global Fund comprises 9% of the total country's spending, followed by UN agencies which provide 5% of the response.

The support from other development partners is channelled through programs which are developed in consultation with national partners and GoPNG, and are in alignment with the NHS 2011-2015. An example of the development partners commitment to supporting the NHS 2011-2015 is the Joint UN Team on HIV and AIDS, working as part of the UN's *Delivering as One*, adapting their 5 year strategic planning cycle to fit into the NHS timeframe and aligning it's 2012-2015 Strategic Plan with the NHS 2011-2015 Priority areas.

## Monitoring and Evaluation Environment in Papua New Guinea

The National Monitoring and Evaluation (M&E) System in Papua New Guinea is guided by the “third ones” of the “three ones principles” of having one national M&E system which is linked to the National HIV and AIDS Strategy 2011-2015 (NHS). The NHS and the accompanying NHS Implementation Framework sees M&E as an integral part of the NHS and can be found in many parts of the strategic objectives and major activities areas but is specifically addressed in Priority area 3, Systems Strengthening.

Like any fully functional national M&E system, it is comprised of the 12 components of: (1) Organizational Structure for HIV M&E functions, (2) Human resource capacity for HIV M&E, (3) Partnership to plan, coordinate and manage the HIV M&E system, (4) National multi-sectoral HIV M&E Plan, (5) Annual costed national HIV M&E work plan, (6) Advocacy and communication culture for HIV M&E, (7) Routine HIV program monitoring, (8) Surveys and surveillance, (9) National and sub-national databases, (10) supportive supervision and data auditing, (11) HIV evaluation and research, (12) Data dissemination and use. These 12 components should be integrated with each other following the three tiers of “People, partnership & planning”, “Collecting, verifying and analyzing data”, and “Using data for decision making” as depicted below.



The

National M&E System in PNG therefore integrates these 12 components of a fully functional national HIV M&E system. These are:

- 1. Organizational Structure for HIV M&E Function**



The three (3) main structures with the HIV M&E functions in Papua New Guinea are:

- a. The Intelligent, Monitoring & Evaluation (IME) Branch at the National AIDS Council Secretariat
- b. The Surveillance Unit with the National STI and HIV and AIDS Program with the National Department of Health
- c. The Surveillance and M&E Unit with the National Health Information System (NHIS) with the National Department of Health.

The Provincial Monitoring, Evaluation and Surveillance Team (ProMEST) at the sub-national level which is made up of technical officers such as the Provincial HIV M&E Officer and HIV Response Coordinator from the Provincial AIDS Committee Secretariat (PACS), the Provincial Health Information Officer (PHIO), Provincial Disease Control Officer (PDCO), and the Director-Medical Services from the Provincial Health Office and Provincial Hospital, is the main structure that performs the M&E function.

The Research Coordination Unit (RCU) at the National AIDS Council Secretariat is the main coordinating body for all HIV related research in the country.

Steps have been taken to ensure regular and meaningful communication between the coordinating bodies which is currently a major challenge. One of this is the integration of the M&E Technical Working Group (METWG) and the Surveillance Technical Working Group (STWG) into one technical working group which is now called the Strategic Information Technical Working Group (SITWG).

## **2. Human Resources Capacity for HIV M&E**

The NACS has successfully completed its organizational restructure and has now created positions in its Intelligent, Monitoring & Evaluation (IME) Branch and has recruited two (2) M&E Officers, two (2) Surveillance Officers and a Manager. At the provincial level, additional positions have been created with the Provincial AIDS Committees to cater for a Provincial M&E Officer for the 20 provinces.

The NDoH STI, HIV and AIDS Program has recently been restructured as part of the NDoH organizational restructure, which saw an increase in staff capacity with the aim of increasing its capacity to strengthen the STI, HIV and AIDS surveillance and M&E at the national and sub-national level. The new STI, HIV and AIDS Program comprised of the Surveillance, Care & Treatment, VCT/HCCT components is managed by the Program Manager and has four Regional Technical Officers, four Regional Medical Officers, and two Technical Officers.

Continuous short and long term capacity building of staff involved in M&E at the

national and sub-national levels is critical to ensure quality monitoring outcomes. Although development partners have invested heavily in this area, a more coordinated approach to capacity development within the national M&E framework is required and needs to be higher priority for stakeholders, especially development partners.

### **3. Partnership to Plan, coordinate and manage the HIV M&E system**

At the highest level, the National Monitoring & Evaluation Oversight Committee (NOC) has been established as of 2010 and became operational by 2011. The key task for the NOC is to provide an oversight on all HIV M&E activities among all stakeholders at national and sub-national level and mobilize resources for monitoring & evaluation activities where necessary. The NOC reports to the NHS 2011-2012 Steering Committee which is a sub-committee of the National AIDS Council (NAC) of Papua New Guinea.

Also at the technical level there used to be a Surveillance Technical Working Group (STWG) that exist at the NDoH which is responsible for providing coordinated technical oversight for all STI, HIV and AIDS data collection and management requirements, guidelines, and procedures. And at the NACS, there used to be a Monitoring & Evaluation Technical Working Group (METWG) that also provides technical support to the IME Branch.

However, the NOC in its 1<sup>st</sup> Quarter meeting of 2012 has now resolved to have only one integrated technical working group following the recommendation from the M&E Systems Strengthening workshop held in July 2011. The new multi-sectoral technical working group called the Strategy Information Technical Working Group is co-chaired by NACS and NDoH and comprises representatives from NDoH, NACS, PNGIMR, PNGNRI, Catholic AIDS Programme, Anglicare Stop AIDS, NCD PACS, Family Health International (FHI360), Oil Search Health Foundation (GFATM HIV Grant Principal Recipient), University of Papua New Guinea (UPNG), Australian Agency for International Development (AusAID), World Health Organization (WHO), Joint United Nations Development Programme (UNAIDS), Voluntary Services Organization (VSO), and the United States Centre for Diseases Control and Prevention (US CDC).

The key challenge for the HIV and AIDS M&E System in this area is to ensure adequate coordination at both higher and technical levels and ensure provision of necessary M&E support to ProMEST at the sub-national levels.

### **4. National multi-sectoral HIV M&E Plan**

The new National M&E Framework 2011-2015 is seen as one of the achievements of the National Strategic Plan (NHS) for HIV/AIDS 2011-2015 as it forms the overarching M&E framework that formed the basis for monitoring of the HIV response. The new M&E framework is in alignment with the NHS 2011-2015.

The main challenge will be the actual implementation of the NHS and to ensure the M&E framework is target driven and realistic enough to adequately monitor the trends in HIV and its associated risk behaviours to enable a better response. Another important challenge is for the M&E plan to embrace, to the extent possible, all the reporting commitments of PNG and for the development partners to limit their reporting requirements to the national HIV M&E plan.

## **5. Annual costed national HIV M&E work plan**

There has never been fully costed M&E Work plan, although annual work plans has been developed. In addition to costing a work plan, the main challenge will be to mobilize resources based on that costed work plan and to effectively use them to archive M&E targets. The HIV-STI Surveillance Plan 2007-2010 was costed and this facilitated resource mobilization for its implementation.

## **6. Advocacy and communications culture for HIV M&E**

There is an increasing receptiveness to the incorporation on M&E into HIV programming. The new NHS places a strong emphasis on communication of strategic information as the basis for evidence informed interventions in its three priority areas.

## **7. Routine HIV program monitoring**

The ProMEST mechanism is now improving since the recruitment of the Provincial M&E Officers by NACS at the PACS in all the provinces since mid 2011. One of the core responsibilities of the Provincial M&E Officer is to provide secretariat support to the ProMEST. About 12 out of the 20 ProMEST are fully functional while others are now working to update their membership composition. The four Regional Technical Officers recruited under the new NDoH structure will also coordinate and strengthen ProMEST activities at the sub-national level.

One of the overall challenges for routine HIV program monitoring is the existence of parallel reporting system by big NGOs, CBOs & FBOs to parent organization direct, hence bypassing the ProMEST mechanism which means that their data is not captured at the sub-national level.

## **8. Surveys and surveillance**

NDoH is responsible for national coordination of all surveillance activities for STI and HIV. Its core mandates includes:

1. Routine surveillance of STI, HIV and AIDS through case reporting
2. Development of estimates and projections for HIV and AIDS, with assistance of a panel of experts or core working group.

3. Conducting annual sentinel surveys of STI clients, antenatal care (ANC) clients and tuberculosis (TB) patients.
4. Conducting behavioural surveillance surveys (BSS)

NDOH works in partnership with the National Research Institute (NRI) has designed and conducted behavioural surveys. Two rounds of BSS have been conducted between 2006-2011 at various sites targeting key-affected-populations (KAPs) such as youths, sex workers, economic enclave's workers and truck drivers.

An integrated bio-behavioural survey among general population is being planned for 2012.

One of the main challenges in the surveillance and program monitoring is to ensure that quality, accuracy and timely surveillance strategic information is generated to guide planning and timely evidence based intervention. Also a significant challenge is limited surveillance of KAPs by either NDoH or other institutions which limits comprehensive programming targeting these groups.

To address some of the challenges and update the surveillance plan with the requirements from the NHS M&E framework, a new surveillance plan has been developed to cover the NHS M&E framework period, the first three years of the plan was also budgeted.

In 2011, the HIV surveillance unit at NDoH faced serious management and capacity problems as the Asian Development Bank (ADB) ended its technical support to the unit as the life cycle of their project with NDoH on HIV prevention in economic enclaves ended and simultaneously NDoH restructuring process affected that unit. This has resulted in de-capacitating of the unit and almost halting of most of the unit's activities in the second half of 2011.

Following these problems and as availability of funds also became another problem for HIV surveillance, the implementation of the surveillance plan has been halted, the partnership between NDoH and NRI will not continue and the provision of external technical support to the unit is being revised. At the same time, a new structure for the unit has been revised and it is expected that the positions will be filled shortly.

## 9. National and sub-national databases

With technical and financial support from development partners, the IME Branch of NACS has developed and rolled out M&E Toolkits at the national and sub-national level. The M&E Toolkit includes:

- **Stakeholders Database** – managed at the provincial level, data is disaggregated by districts and manages records by organization type, program areas and target populations.
- **Stakeholder Reporting Database** – Data is normally inputted quarterly to monitor stakeholders reporting to PACS

- **Condom & IEC Database** – Records numbers of condoms received from PACS as well as other sources and also distributed by stakeholders.
- **HIV/AIDS Reports Database** – Quarterly program Reports received from implementing agencies is entered into this database quarterly.
- **HIV/AIDS Training Database** – All trainings done in the province is entered by stakeholders which is disaggregated by district and LLG level. It also captured information on the type of training and the target population by sex and age groups.
- **PACS News Letter Template** – is a template ready for them to use as a way of information dissemination. The newsletters also contain guided statements to assist them in compiling them.
- **Annual / Bi-annual M&E Report template** – This template contain detail information from all the 5 databases. This report can be used to report to the provincial government, NACS, development partners, etc annually.

The NDoH also manages ART, HIV/AIDS Case notification, Monthly testing, and Sentinel Surveillance databases respectively while the Research Coordination Unit (RCU) of NACS manages database on all HIV/AIDS researches.

The major challenges are the alignment of all HIV and AIDS data from all sources, and make them available to all partners for use.

## **10. Supportive supervision and data auditing**

NACS policy is to decentralize many M&E and surveillance functions to the provinces, including the relocation of resources, delegation of power, infrastructure support and local capacity building. Implementing this policy faces many challenges. There are ongoing issues related to the quality management of data coming from the provinces. Specific data quality assurance and control mentoring programs for staff are required, especially the ProMEST which is the structure at the sub-national level to ordinate data collection, management, analysis and reporting.

The NDoH Surveillance Unit, with the assistance of WHO and United States Centre for Disease's regional program, is currently piloting quality assurance and data quality improvement tools.

## **11. HIV evaluation and research**

A prioritized National HIV/AIDS Research Agenda (2008-2013) was launched in 2008. In addition, the NACS RCU conducted a thorough and systematic review of 62 studies carried out or published in 2007 and 2008 and synthesized findings in a published report.

A national Research Advisory Committee (RAC) has been established and is functioning to ensure ethical design and implementation of HIV and AIDS research and compatibility of research with the *HIV and AIDS Management and Prevention Act, 2003* (HAMP). The RAC is comprised of members from all research and academic institutions, NGOs, CBOs, donor organizations, NDoH as well as representation of People Living with HIV And AIDS (PLHIV).

The Independent Review Group (IRG) also contributes to ongoing M&E of PNG's national HIV response. This is a group of inter-disciplinary international experts engaged by NACS, with funding support from AusAID and the United Nations (UN). The IRG carried out regular assessment of progress in implementing various aspects of the national response and publishes reports of its findings.

The Aus AID-funded *Strengthening HIV Social Research Capacity in Papua New Guinea Project* is a collaboration between IMR and the National Centre in HIV Social Research at the University of New South Wales. The project is contributing to capacity building in terms of HIV social research in PNG. It is designed to position social research as a central component of the evidence base for effective, sustainable response to the HIV epidemic through a cadetship program and dissemination of findings.

The main challenge is the translation of research into the day-to-day practices of services providers. Additionally, operational research is not being conducted by either service providers or researchers.

## **12. Data dissemination and use**

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

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

## **ANNEX 1:**

### **Consultation/preparation process for the PNG 2012 Global AIDS Progress Report.**

#### ***A. Leadership and Overview***

The Intelligence, Cross Cutting and Monitoring and Evaluation (ICME) Unit of the National AIDS Council Secretariat in partnership with the HIV/STI Surveillance Unit of the National Department of Health facilitated the process for 2012 Global AIDS Progress Report with the major technical support provided by the Joint United National Programme on HIV (UNAIDS).

The PNG 2012 Global AIDS Report is the result of wide consultation and finalisation of available National Commitment on Policy Instrument (NCPI) information, program data and behaviour and knowledge information generated from the national response activities between 2010 and 2011.

The amount of leadership provided for the production of the 2012 GAR report was enormous especially with the budget support. It was almost to 100 % support by the National AIDS Council Secretariat apart from the support provided by the UNAIDS PNG office for the hire of consultant.

#### ***B. Process***

##### ***Establishment of the 2012 GAR Desk:***

National AIDS Council Secretariat in its efforts to get the process off the ground established a coordinator's desk who took up the major responsibility of ensuring the logistical and administrative support was provided. A Work Plan and budget were developed to guide and support the process. With the assistance of the UNAIDS technical Adviser the Coordinator, the Country GAR Focal person conducted the process effectively.

Biggest Budget allocation was provided by the GoPNG through the national Coordinating body, the National AIDS Council Secretariat. All activities were funded through the budget allocation except for the hire of consultant which was paid by the UNAIDS PNG office.

A thirty one (31) member Core Working Group was formed by representatives from government, private sectors, Non-Government Organisation (NGOs) and Faith Base Organisation (FBOs) and Donor Core working partners to oversee the process taken. Terms of reference was developed for the Core working group which gave them the mandate to review and do changes to guide the process successfully.

Biweekly meetings were held since November 2011 – January 2012 then shifted to weekly meetings to update members on the progress of the process and meet deadlines. All members shared responsibilities of resolving issues that arose and reported back during each meeting to update members. (Refer to member listing)

### **C. Data collection Process**

An indicators matrix was developed and shared amongst the Core Working Group members showing data sources, types of studies and programs conducted which could generate respective indicators data. The template made it easier for identification of data sources which lead to collection of data. NCPI data was collected using standard NCPI survey forms which were used during interviews. Data collected on these forms were later transferred to electronic templates for record keeping and analysis.

Respective check lists were developed to monitor the level of data collection for respective indicators and the NCPI interviewers. This process allowed us to understand the coverage of reporting.

### **II. Data management**

All data collected were on hard copy forms that were then transcribed and stored in the electronic reporting templates issued by UNAIDS especially for NCPI, NASA and other survey and program indicators. Daily back of data entries were done on flash drives to ensure data was safe and secured

### **Data Analysis**

i) **NCPI data analysis** was undertaken by the consultant and involved the collation of all NCPI interviews into a master form in Excel and an analysis of the results. Two components of the process resulted in a late analysis of all of the interview data.

a) All but three of the interviews were individually transcribed from the hard copy used by the interviewers. Three were self-completed in the e-form. The transcribed e-interviews were entered into individual Excel spread sheets and saved by interviewee name and date of interview. This process took up to 3 hours per interview. The consultant then needed to transfer the data from each interviewee's answers into a master collated form, this also took up to 3 hours per interview and was, in effect, double handing.

b) For reasons explained elsewhere the interviews were still taking place up until mid March with the last self completed interview submitted on 19 March.

The draft results as at 14 March were shared for feedback with the CWG at that weekly meeting. The complete but still draft NCPI was shared for comment with the CWG on the 21 March and then presented to the Consensus Workshop on the 22 & 23 March. The feedback and corrections were made by 26 March and the final NCPI was sent to the CWG.

ii) **GAR Indicators report.** The majority of the data for the GAR Indicators that were survey based was provided to the consultant at the CWG meeting on the 14 March. Further surveys and changes to those provided were received up until 22 March. The CWG did not receive a draft of the Indicators report before the 22 March as the programme data was not available until March 22.

The interpretation of the Values in the PNG context, comparison with prior reports and comment on improvements for the indicators were primarily



supplied by the participants at the Consensus Workshop on 22 and 23 March with some additional changes supplied by members of the CWG.

#### **Data Verification:**

National HIV program implementers were called to a one-day meeting to verify the data collected. Key national level organisations that have more facilities operating at sub national and district levels were invited to attend this meeting where comparison of surveillance and other program data from facility levels and National Department of Health (NDOH) national databases was conducted as a means of verification.

#### **PLHIV involvement:**

##### **Involvement of a PLHIV is a priority in national activities and as such**

Igat Hope, a nationally owned non-government organisation comprising and representing PLHIV was involved in the GAR 2012. They took part in the NCPI survey as well as having a representation in the 2012 GAR Core Working Group.

#### **Consultation Process.**

**PNG 2012 GAR process began in late November 2011. Soon after the guidelines were received a core working group was established where biweekly meetings were called to get the process began. The Core Working group was chaired by two officials, the Deputy Directors of the National AIDS Council Secretariat and the Director of National Department of Health Disease Control Branch. This arrangement was entertained to allow both Global AIDS and Universal Access Progress Report (UAR) processes to be monitored.**

**Evidence of both groups regular meetings are kept in meeting minutes.**

#### **Finalisation of the 2012 Global AIDS Progress Report**

**Finally a two (2) day national consensus building workshop was held inviting almost 100 stakeholders who attended to reach consensus on the report. Representatives from both the Government and private sectors, NGOs, FBOs, CBO and for the first also had authorities from the Government sectors at sub national and district levels of the country attended to contribute to the report.**

**The report was presented for audiences views where final consensus on key issues relating to the report were reached. Issues raised were discussed and amendments done.**

#### **Technical support:**

The National Core Working Group is made up of very senior technical officers from Government, Private, NGOs, FBOs, and Donor partners who basically provided the technical support to all aspects of the processes taken, reviewing and advising on how the working team should be moving on with the process.

Major assistance was provided by the UNAIDS and NACS for respective organisations data collection and UNAIDS provided consultancy with the

training and the report writing.

### **Participation.**

**There was high level of representation and participation by the key organisations both for government and private sectors, NGOs and FBOs operating in the country.**

**The final meeting having almost to 100 participants gives the indications of the willingness of stakeholders to participate in this Governments commitment.**

### **Financial Support**

This was the first time PNG governments through National AIDS Secretariat showed their full ownership of the activity. Funding aspect of the report was fully supported by the National AIDS Council Secretariat while UNAIDS only assisted in the hire of consultant. This is a new approach taken comparing to the two previous reports where UNAIDS and other partners were more involved in funding than NACS.

### **Key Challenges and Issues**

- *PNG financial system turnovers affected the flow of work.*
- *Interviewers for NCPI survey were hired unemployed people who found new jobs created vacancies where new recruits and trainings were done again led to loss of time.*
- *Sub national level participation is difficult to supervise which led to only two provinces out of the seven provinces who had the training participated in data collection.*
- *Understanding of Global AIDS Report and Universal Access Reports indicators are yet to be well understood, unless so they can be monitored well by respective organisations.*
- *NCPI survey form is too long for the interviewees. Most interviewees are heads of organisations and program managers who have no time to spend in participating in this very lengthy 1 and a half to two hours interview. Most complained or they only participated in one or two parts of the Part A or Part B only.*

### **Lessons learned.**

#### **Key lesson learned in this round of exercise are:**

- 2012 GAR process has given more confidence to the national team and has allowed further capacity building.
- National Research institutions are more aware of the survey indicators that they should be generating in their knowledge and behaviours surveys.
- The NCPI component of the Global AIDS Report required more time

therefore should be implemented at least 4 months earlier.

.

## ANNEX 2.

### COUNTRY: PAPUA NEW GUINEA

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

---

Postal address:

National AIDS Council Secretariat, P.O.Box 134, BOROKO, National Capital District, 111, Papua New Guinea

---

---

Tel: \_\_\_+ (675) 3236161

---

Fax: \_\_+ (675) 3231619\_\_\_\_\_

Email: \_\_agnes.gege@nacs.org.png\_\_\_\_\_

---

Date of submission:

---

---

## NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)

### DATA GATHERING AND VALIDATION PROCESS

**Describe the process used for NCPI data gathering and validation:**

#### **Sample Selection and Sample Size**

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 Strategic Plan 2006-2010 and the National HIV and AIDS Strategy 2011 - 2015. There are 28 respondents from the government sector and 22 from the CSOs, bi-lateral and UN organisations.

#### **Notice, invitation and consent**

The Director of the National AIDS Council (national coordinating body) sent out letters to the senior staff of each participating organisation in December 2011. The letter advised them of the purpose of the survey and encouraged/invited their organisation to be involved. Each interviewer was supplied with a copy of the letter of invitation and the interviewee was provided with a copy.

#### **Building capacity of interviewers**

The GAR Core Working Group conducted NCPI interviewer training over a three-day period in December 2011. For the first the participants were drawn from the recently appointed M& E officers in the Provincial government and Provincial AIDS Committee offices. For the majority this was the first time they had conducted a survey of this nature and more importantly, with senior staff and government officials of high standing. Of the 11 trained, only 2 were involved in the interviewing in 2010. Of the 11 trained 2 were unable to continue and a further two were recruited to replace them.

#### **Data Collection**

53 interviews were conducted 30 of the government sector and 23 from the CSOs, bi-lateral and UN organisations. This is 12 more than the 39 interviews in 2010 NCPI and 22 more than the 19 in the 2008 NCPI report. However 1 of the government sector data forms was duplicated/overwritten during transcribing with another so of the two, only one was entered. One CSO survey form and one government survey form arrived after the NCPI was completed so were not included. This NCPI is based on 28 government sector interviews and 22 from the CSOs, bi-lateral and UN organisations, a total of 50.

#### **Data Collection Methods**

Face to face interviews and two self-administered surveys. Of those that provided the time of interview the majority (27) were completed between 1 ½ and 3 hours, with the next cluster between ½ hour and 1 ½ hours (18). There were as one interview over 4 hours.

**Survey Implementation Period**

The survey was implemented between January and 16 March 2012. This NCPI included three provinces as well as national stakeholders. The provinces were: Western Highlands Province, Morobe Province and Central Province.

**Data Management**

The survey data was collected in hard copy and manually entered in a specially formatted Excel worksheet template of the survey. The 51 individual Excel sheets of data were then entered into one master file for analysis. Analysis was done using Excel and discussions with the Core Working Group.

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

The format and quality of the raw data was discussed with the GAR Core Working Group on 14 March. The first draft NCPI was presented to the GCWG on 21 March where discussions were had on areas of the NCPI to gain consensus. The revised NCPI v2 was and then presented to the stakeholders in a 2 day Consensus Workshop, on 22 and 23rd March. The workshop recommendations for change were implemented and the final NCPI was entered into the on line tool between 26th and 30th March 2012.

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

There were clearly some answers that indicated a poor understanding of the questions emphasis and syntax. It is important to note that whilst many of the respondents are fluent in English, the complexity and technical language of some of the questions posed some difficulty, particularly, when the comfort levels of some interviewers were not at an optimum level due to this being their first NCPI involvement.

This was evident when interviewers and interviewees persevered with a question that actually had no sense in English. There was the one typo error in the survey template that was printed for interviewers use - AI 1.3 'IF NO explain how key populations were *indentured*?' however the actual word in the GAR guidelines document is *identified*. This question was thus rendered unusable and the answers, whilst well intentioned, did not relate to the question.

**Regional/Provincial participants**

This is the first NCPI in PNG that interviewed Provincial stakeholders (three Provinces). A number of respondents were not familiar with national policies and strategies and tended to answer from the perspective of the Provincial issues.

**Percentages and Multiple Choice**

Consensus was more difficult where the questions asked respondents to provide a percentage without there being a range offered as a multiple choice. This resulted, in some cases, with over 15 different answers. The Core Working Group overrode the answers with the correct answer for the country.

**High Level AIDS Review June 2011/Political Declaration on AIDS 2011.**

The High Level AIDS Review June 2011 has not been comprehensively followed up in PNG and as the NHS 2011-2015 was just into it's first year when the 2011 Declaration was made there were no changes made in 2011 to the NHS 2011-2015 or the budget allocation for 2012.

The NCPI question assumed knowledge of the AIDS Review June 2011 rather than asking if the Declaration was known to the respondents. The majority answered that NHS 2011-2015 and the national HIV budget were changed accordingly. However, on enquiry, many assumed the question was about the Declarations of Commitment on HIV/AIDS 2001 and Political Declaration on HIV/AIDS 2006.

### Entry error

Two forms provided the exact same data where an error had occurred during transcribing from the handwritten forms. There was not time to re-enter the additional data. Investigation was undertaken to match the responses to the role and one was discarded.

### Overview of participation

Whilst a number of surveys comprised very limited data, primarily just answering the binary questions and not providing any commentary, explanations or brief notes, overall respondents were conscientious in their participation and provided thoughtful and informed answers where they could. As this is the third NCPI for PNG, and the first including some of the Provinces, there is growing data sets for comparative analysis and trend analysis emerging for PNG.

## NCPI Respondents

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

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

	Organization	Names/Positions	Respondents to Part A [indicate which parts each respondent was queried on]					
			A.I	A.II	A.III	A.IV	A.V	A.VI
1	Central Province Administration-Community Development: Kwikila	Ms Tawa Gebia & Ms Rolyne Raka/No job title provided.	✓	✓	✓	✓		
2	National Planning, Monitoring & Evaluation Department.	Ms Amanda. Kikalia/ Senior Programme Officer	✓	✓	✓	✓	✓	✓
3	National AIDS Council Secretariat	Dr Moale Kariko/ Deputy Director – Care, Treatment &	✓	✓	✓	✓	✓	

		Support						
4	PNG Christian Leaders Alliance on HIV ( PNG Churches Alliance)*	Mr Eddie Kekea/ National Coordinator	✓	✓	✓	✓	✓	✓
5	National Department of Finance	Mr Andrew Saige/ Assistant Secretary	✓	✓	✓	✓	✓	✓
6	National AIDS Council Secretariat	Ms Julie Airi/ Manager, Behaviour Research Information, Prevention Division	✓	✓	✓	✓	✓	✓
7	Central Province Administration – Health Division: Kwikila Hospital	Mr Richard Oaeke/ Officer in Charge- Health Sector		✓	✓	✓	✓	✓
8	National AIDS Council Secretariat	Mr Moses Kaigu/ Manager Policy & Planning	✓	✓	✓	✓		
9	Central Province Administration – District Administrator - Rigo	Mr Iobo Lalai/ Deputy Administrator	✓	✓	✓	✓		
10	Rigo District Admin-Education Section	Mr Weseley Satu/ District Elementary Coordinator	✓	✓	✓	✓	✓	✓
11	NCD Provincial AIDS Council Secretariat	Doreen Nadile/ HIV Technical Officer				✓		
12	PNG Sexual Health Society	Dr John Millan/Director	✓	✓	✓	✓	✓	✓
13	National Department of Health	Dr Paison Dakulala/Deputy Secretary of Health-National Standards	✓	✓			✓	
14	National Central District - Provincial AIDS Council Secretariat	Mr Isu Aluvula/ HIV AIDS Response Coordinator	✓					
15	National Department of Health	Mr Sibank Vivaldo Bieb/Manager Disease Control & Surveillance	✓	✓				
16	Morobe Provincial AIDS Council	Ms Joan Ganoka/ - HIV AIDS Response Coordinator	✓	✓	✓	✓		
17	Morobe Province -Provincial Health Office-Division of	Mr Micah Yawin/Acting Provincial Health	✓	✓	✓	✓	✓	✓



	Health							
18	Community Development Morobe Admin.	Mr Kiun Kimbing/A/Provincial Program Advisor	✓	✓	✓	✓	✓	✓
19	National AIDS Council Secretariat	Mr Philip Tapo/ Deputy Director - Prevention	✓	✓	✓	✓		
20	Port Moresby General Hospital - Heduru HIV Clinic	Sister Opina/ Sister in Charge	✓	✓	✓	✓		
21	National AIDS Council Secretariat	Mr Valentine Tangoh/ Regional Manager - Momase	✓	✓	✓	✓	✓	
22	National AIDS Council Secretariat	Mr Wep Kanawi/ CSM. OBE Director	✓	✓				
23	Western Highlands Province- Provincial AIDS Council Secretariat**	Mr Joshua Meninga/ HIV Response Coordinator	✓	✓	✓	✓		✓
24	Western Highlands Province- Provincial Health Authority	Mr Philip Talpat/ Acting Director – Public Health	✓	✓	✓	✓	✓	✓
25	Western Highlands Province – Provincial Administration	Mr Pym Mamandi/ Deputy Administrator – Corporate Services	✓	✓	✓	✓		✓
26	Western Highlands Province – Community Development	Mrs Regina Kanza/ Women’s Coordinator: NGO, FBO & CBO Affairs	✓	✓	✓	✓		✓
27	PNG Australia Law & Justice Partnership (PALJP)	Ms Joanne Robinson/ L&J Sector Cross Cutting Issues Activity Management Team: Sector Coordinating Mechanism	✓	✓	✓	✓	✓	✓
28	National AIDS Council Secretariat	Ms Angelsula Jogamup/ Southern Region Manager	✓	✓		✓		
29	NDoH - HIV Prevention & Care in Rural Development	Kel Browne/ Deputy Project Manager			✓		✓	

\* The interviewee was not from the government sector and completed the Part A survey in error. The Core Working Group noted the experience of the respondent and decided to keep the data as it was

of value.

\*\* Did not use as duplicated in no.25. Data showed answer was from Provincial government source.

**Key respondents missing from Part A (present in prior NCPI reports)**

National government as opposed to provincial government respondents – National Department of Transport, National Department of Education (undertaken but received after NCPI completion), HIV Parliamentarians Committee, National Department of Community Development, National Volunteer services, PNG Defence Force, PNG National Sports Federation

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

	Organization	Names/Positions	Respondents To Part B [Indicate Which Parts Each Respondent Was Queried On]				
			B.I	B.II	B.III	B.IV	B.V
1	FHI 360	Mr William Yeka/Senior Technical Officer - M&E	✓	✓			
2	ADRA SED	Ms Becky Sambak/Project Manager	✓	✓	✓	✓	✓
3	Hope Worldwide PNG	Mr Jonah Kuman/ HIV Programme Manager	✓	✓	✓	✓	✓
4	Business Association against HIV and AIDS (BAHA)	Ms Carolyn Bunemiga/ Director	✓	✓	✓	✓	✓
5	National Research Institute	Dr Holly Buchanan Haruwafu / Mr Ray Frank Associate Researcher Behaviourial Surveillance	✓	✓	✓	✓	✓
6	Anglicare StopAIDS	Mr Heni Meke/National Director	✓	✓	✓	✓	✓
7	PNG Sustainable Development Program Ltd	Ms Jennifer Krimbu & Ms Jacklyn Esseo/Senior Program Officer HIV & AIDS	✓	✓	✓	✓	✓
8	PNG Alliance of Civil Society Organisations (PACSO)	Mr John Kerari/Chairman	✓	✓	✓	✓	✓

9	Save The Children (Poro Support)	Ms Lydia Seta & Mr Jonathan Wala/ Acting Project Manager & M& E Officer	✓	✓	✓	✓	✓
10	Japanese International Cooperation Agency/JICA	Mr Taniguchi/Program Officer	✓	✓	✓	✓	✓
11	USAID	Ms Jennifer Erie/Health Officer	✓	✓	✓	✓	✓
12	National Catholic AIDS Office	Sr Tarsicia Hunoff/Director	✓	✓	✓	✓	✓
13	Baptist Union of PNG	Mr Michael Pasaga/HIV AIDS Project Manager	✓	✓	✓	✓	✓
14	UNAIDS PNG	Dr Ali Feizzadeh/M & E Advisor			✓	✓	✓
15	Sanap Wantaim: PNG Australian HIV Programme (AUSAid)	Dr Ninkama Moiya/ Medical Advisor	✓	✓	✓	✓	✓
16	PNG: International Development Law Organisation (IDLO)	Lydia Karre/ Legal Officer		✓	✓		
17	UNAIDS PNG	Maria Nepal/ Partnership Social Mobilisation Advisor	✓				
18	UNAIDS PNG	Stewart Watson/ Country Coordinator		✓	✓		
19	UNICEF	Christi Morf/Chief HIV/AIDS	✓	✓	✓	✓	✓
20	Igat Hope (PNG) Incorporated	Annie McPherson/ Executive Director	✓	✓			
21	World Vision	Lucy Jaro/Project Coordinator – HIV Section	✓	✓	✓	✓	
22	WHO	Dr Fabian Ndenzako/HIV AIDS Programme Director	✓	✓	✓	✓	✓

**Key respondents missing, including some of those in prior NCPI reports,**

UNDP, UN Women, UNFPA, UNESCO, Clinton Foundation (arrived after closing date for entry), Tingim Laip, Susu Mamas, National Council of Women, Salvation Army, Apostolic AIDS Association, Care International, Friends Frangipani, Friends Foundation, Nambawan

**NATIONAL COMMITMENTS AND POLICY INSTRUMENT  
(NCPI)**

**PART A**

[to be administered to government officials]

**I. STRATEGIC PLAN**

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

(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry)

<b>Yes</b>	
------------	--

*IF YES*, what was the period covered [write in]:

<b>2011-2015</b>
------------------

***IF YES***, briefly describe key developments/modifications between the current national strategy and the prior one.

***IF NO or NOT APPLICABLE***, briefly explain why.

*YES: Summary of comments from respondents.*

- New one: multisectoral. Integration of services. Old one: Standalone & a multitude of strategies that did not work.
- It is addressing all sectors of societies and aspects of development as a cross cutting issue ..... It's a way forward for Multisectoral and Intersectoral participation.
- The previous strategy was not clear in terms of developing plans and activity at community based level, however, the new NHS has clear priorities and can easily be aligned with community based organizations activities and programs
- The new plan has three priority areas. Whilst the old one had seven (7) areas.
- The new plan has a clear "10 Must Do" task and also has the M&E plan. It also has the Implementation Framework.
- Having these Frameworks (*M & E and Implementation*) make it much easier to focus our resources and energy to specific areas of the new plan

*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?**

Name of government ministries or agencies [write in]:

1 ) National AIDS Council is the legally mandated authority to coordinate multi -
---

sectorial strategy (NAC ACT 1997 amended 1999).

The following government departments are on the National AIDS Council as stipulated by the NAC ACT 1997 (amended 1999).

2 ) Frontline government agencies –

a ) Nat Planning

b ) NDOH

c ) Department of Education

d ) Department of Provincial/Local Level Government

e ) Department of Labour

f ) Department of Agriculture

g ) Department of Works

i ) Department of DPM.

All have developed HIV intervention programs.

*Note: However this was not well know/understood by the respondents. Only 9 of the 22 respondents replied correctly. Most reported NDoH had overall responsibility and were not aware of NACS' legally mandated role.*

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

SECTORS	Included in Strategy		Earmarked Budget	
<i>Education</i>	Yes		Yes	
<i>Health</i>	Yes		Yes	
<i>Labour</i>	Yes		Yes	
<i>Military/Police</i>	Yes		Yes	
<i>Transportation</i>	Yes			No
<i>Women</i>			Yes	
<i>Young People</i>	Yes		Yes	
<i>Other [write in]:</i>				
Agriculture (3)	Yes		Yes	
Mining and Petroleum (2)	Yes		Yes	
Law & Justice (1)	Yes		Yes	
Trade & Commerce/Business (1)	Yes		Yes	
Non Sector comments (5)				

***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?***

*There was one sector where the majority of respondents reported a No.*

*Note: However the comments also provided information that suggested that the source of the Departments HIV specific budget for may, was not from the re-current budgets but from development budgets which were sourced from NACS or donor partners.*

*Respondent's comment:*

- Transport is part of Govt service plan but it has no budget - its HIV is catered for under partnership arrangements. Agriculture, Trade and Industry fall under the same category.
- When there is no adequate budget funding from the Department's own

development budget, it is through grant applications to NACS or donor development partners. E.g. UNICEF . The national Department can also request funding from District Level Governments or other Departments such as Health.

- Corporate sector departments have their own plans but HIV budgets are supported by National AIDS Council Secretariat (NACS), National Department of Health (NDoH) and DONOR partners to budget for implementation.

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

<b>KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS</b>		
<i>Men who have sex with men</i>	Yes	
<i>Mobile populations</i>	Yes	
<i>Orphans and other vulnerable children</i>	Yes	
<i>People with disabilities</i>		No
<i>People who inject drugs</i>	Yes	
<i>Sex workers</i>	Yes	
<i>Transgendered people</i>		No
<i>Women and girls</i>	Yes	
<i>Young women/young men</i>	Yes	
<i>Other specific vulnerable subpopulations<sup>23</sup></i>	Yes	
<b>SETTINGS</b>		
<i>Prisons</i>	Yes	
<i>Schools</i>	Yes	
<i>Workplace</i>	Yes	
<b>CROSS-CUTTING ISSUES</b>		
<i>Addressing stigma and discrimination</i>	Yes	
<i>Gender empowerment and/or gender equality</i>	Yes	
<i>HIV and poverty</i>		No
<i>Human rights protection</i>	Yes	
<i>Involvement of people living with HIV</i>	Yes	

***IF NO, explain how key populations were identified?***

*Note: There was a typo error in this question. Indentured not **identified**. The answers do not relate to the question re identification so cannot be used to inform how the key populations are identified.*

*The answer/explanations related to the 1.3 table selections.*

*Consensus comments on the 1.3 table selections:*

HIV and Poverty as a cross cutting issue is not in the NHS 2011-2015 despite the majority reporting that it was.

<sup>23</sup> Other specific vulnerable populations other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners and refugees)

The NHS 2011-2015 does refer to injecting drug use users as an identified MARP within 'Injecting practices'. (PA.1. SO.1. Cluster 1.4). 8 respondents reported it does not.

However the NHS 2011-2015 does not refer to disability as a Key Population yet 17 of 22 (77%) respondents reported it did. Only one expressly commented that it was absent.

One respondent stated 'these populations are not in PNG' but then went on to correctly identify key affected populations for 1.4

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

KEY POPULATIONS
Men and women aged 15 – 59 with concurrent sexual relationships and multiple partners, male & female sex workers; pregnant women – mother to child; TB clients; STI clients; adults & children living with HIV; young men & women; vulnerable children; health workers; MSM; transgender; people who practice penile modification, tattooing and scarification; injecting drug users; women who experience gender based family /sexual violence; in and out of school youth; uniformed services, prisoners, mobile populations - economic enclaves.

***1.5. Does the multisectoral strategy include an operational plan?***

Yes	
-----	--

***1.6. Does the multisectoral strategy or operational plan include:***

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

***1.7. Has the country ensured "full involvement and participation" of civil society\* in the development of the multisectoral strategy?***

Active involvement		
--------------------	--	--

\* Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

**IF ACTIVE INVOLVEMENT**, briefly explain how this was organised:

*Respondents Comments*

- Led by NACS: Through multi-sectoral teams including (CSOs, FBOs and biltalera) & grouped up in thematic areas. They met together & discussed how to implement the multi-sectoral plan.
- Consultative meetings were conducted involving all partners including civil societies from NGOs, FBOs and government sectors involved with HIV programs
- Much, much wider consultation with Civil Society and community as compared to NSP.

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

Yes		
-----	--	--

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

Yes, all partners		
-------------------	--	--

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

*Note: High number of “Yes all’s on this answer. However other answers indicated a lack of knowledge on whether the development partners included international NGOs. One noted that they are required to but not sure whether they had in fact done so. Respondents Comment who had ‘some’:*

- Alignment has been done in word but not in deed. Programs & funds usually channelled to small organisations.
- Some agencies have their international obligations to full and therefore conduct themselves differently e.g.: Tingim Laip may not fulfil the national setup or program.

**2. Has the country integrated HIV into its general development plans such as in:**

Yes		
-----	--	--

- (a) **National Development Plan;**
- (b) **Common Country Assessment / UN Development Assistance Framework;**
- (c) **Poverty Reduction Strategy; and a**
- (d) **Sector-wide approach?**

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



<b>SPECIFIC DEVELOPMENT PLANS</b>			
<i>Common Country Assessment/UN Development Assistance Framework</i>	<b>Yes</b>		
<i>National Development Plan</i>	<b>Yes</b>		
<i>Poverty Reduction Strategy</i>	<b>Yes</b>		
<i>Sector-wide approach</i>	<b>Yes</b>		
<i>Other [write in]:</i>			
Health (1)	<b>Yes</b>		
Education (1)	<b>Yes</b>		
Mining (1)	<b>Yes</b>		
Transport(1)	<b>Yes</b>		
Defence(1)	<b>Yes</b>		
Provincial Extension Plan (1)	<b>Yes</b>		
Vision 2050 (1)	<b>Yes</b>		
M & E Plan (1)	<b>Yes</b>		

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

<b>HIV-RELATED AREA INCLUDED IN PLAN(S)</b>		
<i>HIV impact alleviation</i>		<b>No</b>
<i>Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support</i>	<b>Yes</b>	
<i>Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support</i>	<b>Yes</b>	
<i>Reduction of stigma and discrimination</i>	<b>Yes</b>	
<i>Treatment, care, and support (including social security or other schemes)</i>		<b>No</b>
<i>Women’s economic empowerment (e.g. access to credit, access to land, training)</i>	<b>Yes</b>	
<i>Other[write in below]:</i>		
<i>Maternal and infants (1)</i>	<b>Yes</b>	
<i>Research &amp; IBSS (1)</i>	<b>Yes</b>	
<i>M &amp; E Surveillance (1)</i>		
<i>Leadership (1)</i>		
<i>Community Development (1)</i>		
<i>The last 3 ‘other’ were listed without a Yes/No indicated.</i>		

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

**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? Inconclusive**

	<b>No</b>	
--	-----------	--

NA

LOW					HIGH
	1	2	3	4	5

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

Yes	
-----	--

**5. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2011?**

	No
--	----

**5.1. Have the national strategy and national HIV budget been revised accordingly?**

	No
--	----

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

Estimates of Current and Future Needs		
---------------------------------------	--	--

**5.4. 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?**

*A lack of clarity from respondents on the status of country wide/national monitoring of HIV programmes. Consensus corrected the answers to report the actual situation*

**Briefly explain how this information is used:**

Answers indicate that there is knowledge on how 'information' is used but not on how THIS information is used as it is not collected/monitored.  
 Respondents Comment:  
 Very useful for national and Provincial Development plans, the HIV, HEALTH and other sectoral plans to develop appropriate strategy and allocate resources wisely

(c) *Is coverage monitored by geographical area?*

Yes	
-----	--

**IF YES, at which geographical levels (provincial, district, other)?**  
 Coverage is monitored in four regions at provincial levels. Most of these Provinces are reporting by districts. Provinces reporting by LLGs reporting to NACS.

**Briefly explain how this information is used:**  
*Respondents comments:*  
 Information collected and dated to keep track of the level of diagnosed/trends in the level of HIV and STIs.  
 The information provides a picture of compliance of adherence to using condoms, numbers accessing VCT sites, to assess resource capacity, identify needs and weaknesses (programs/infrastructure/provincial services/communities).  
 Information used for monitoring, planning and budgeting for annual activities.

**5.5. Has the country developed a plan to strengthen health systems?**

	No
--	----

**Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:**  
*Respondents comments:*  
 Looking at the whole system to assist people & not concentrate on ART & condoms only.  
 Upgrading of infrastructures has lead to improvement & reopening of sections of health facilities for VHIV testing and treatment. Training of health staff on treatment and care and support. Improvement with procuring of logistics such as testing kits.

**6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in the HIV programmes in 2011?**

Very Poor										Excellent
0	1	2	3	4	5	6	7	<b>8</b>	9	10

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

*Respondents comments:*

- School children increasingly becoming aware of HIV/AIDS through school (curriculums). All schools receiving basic HIV education,
- Community taking bigger role in preventing HIV from spreading in their communities
- Access to ART increase: 70 – 80)% of PNGeans are on the ART: ART rollout to the most remote districts
- Increase number of VCT sites and ART sites
- Establishment of District AIDS committees in the country
- Leadership Development Framework introduced.
- Increased focus on gender equality.
- Improvement in a the breakdown of stigma & discrimination – more people are coming to be tested
- Development of the multi-sectoral NHS 2011-2015. The only country in South - East Asia who has developed a multi - sectoral strategy plan for HIV.
- Aligning government plans - Improved planning process with stakeholders.
- 2011 Annual planning for the NHS 2011-2015 - (there were two strategic planning workshops for the four regions (1 workshop conducted for two regions, 2 staff & key stakeholders involved) followed up by two strategic planning workshops to enable better written submissions for budget assistance through the Government of PNG budgetary system.
- Round 10 Global Fund securing over \$500 000 USD to support implementing the new NHS plans.

**What challenges remain in this area:***Respondents comments:*

- The LNG boom – migrants, miners in enclaves
- Older men with young women
- Sex work explosion
- Having to detect new HIV infections, challenges, re how people receive HIV information.
- ART resistance/ treatment failure
- Infrastructure, health care centres are run down, technology lacking e.g.; CD4 Count machine, sustaining this machines and replacing them.
- Effective management and utilization of resources. Coordination because of too many stakeholder and monitoring and evaluation.
- Implementation of policies and plans. To date the sector response has not been driven by a formal analysis of the needs and context.
- No Impact Evaluation: The sector and its agencies do not have a comprehensive understanding of how HIV&AIDS, could be affecting the achievement of their goals, objectives and programmes. There is not a detailed understanding of how the work practices of the sector and agencies could be causing or contributing to the spread of HIV.
- Very little recurrent budget is allocated to HIV & AIDS activities and programs, these are almost exclusively funded by development (donor) funds or externally sourced from organizations such as NACS.
- Need to improve on the reporting + maintain government and donor partners confidence + support as well as our stakeholders.
- Human Resources, replace ageing work force. Refresher courses for trained health staff
- Medical Research - more research needed to drive clinical interventions on HIV/AIDS. E.g.: HIV or TB vice versa to be diagnosed properly and treated accordingly.
- Better alignment of development & donor partner programs to the national response
- HIV is shifting in towards the rural areas. The level of discrimination and stigma in the rural communities, families is high. Capacity building for the rural health sector including everybody (Community, Churches etc.)
- Provinces don't see the importance in HIV programmes. There is a lack of commitment as they think it is just for the National AIDS Council to worry about. Ownership of response at local levels. Resourcing of local response by local authorities
- Work still needs to be done on leadership & ownership of HIV/AIDS. Needs proactive advocacy from leaders on HIV/AIDS. Politicians need to be role models for cross-cutting issues (take responsibility e.g. politicians have one wife & not two or three wives).
- Donor funders withdrawing.
- Government to continue support for proactive prevention/investment from donor partners
- Inconsistency between initial budget estimates and the actual allocation of resources. More equitable distribution of resources
- There should be better policies in place for capacity development and transfer

of knowledge to people engage in the national response.

---

---

## II. POLITICAL SUPPORT AND LEADERSHIP

Strong political support includes: government and political leaders who regularly speak out about HIV/AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

**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?**

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

Yes	
-----	--

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

*Respondents comments:*

*Nationally*

- The current & past Ministers for Health have spoken that HIV/AIDS poses a development challenge for PNG and have all stated support for NACS
- Minister for Health attended the United Nation's General Assembly meeting and gave a speech on HIV/AIDS. At the WAD 2011 the NDoH Secretary, Minister & staff participated wearing T' Shirts (zero tolerance) for HIV/AIDS.

- Former Minister for Community Development speaking at the Nation Convention of Human Rights and at PNG National Parliament promoting the a Bill that decriminalises the sodomy and prostitution.
- Special political leaders and parliament committees attended international conferences on HIV/AIDS to reaffirm HIV/AIDS as a developmental issue in PNG & the country's effort towards minimising impact towards HIV/AIDS.
- We've had ministers taking part in most of our workshops and forums while giving speeches.

*Provinces. e.g. NCD Governor*

Mr Powes Parkop, the NCD Governor, talks about HIV on media, has taken an initiative to take an HIV test publicly, has allocated K500,00 for the NCD response to support Mobile VCT clinics and he visits the VCT clinics.

*Sector leadership e.g. Law and Justice*

The Chief Ombudsman hosted World AIDS day activities at the Ombudsman Commission 2010, 2011. The Ombudsman Commission has included HIV as a funded line item in the 2012 annual plan. The Ombudsman Commission funded one Commissioner and the Cross Cutting Issues Coordinator to attend the XVIII International AIDS Conference in Vienna 2010 and have committed to funding one commissioner, the Manager HR and the CCI Coordinator to attend the XIX International AIDS Conference in Washington 2012. The RPNGC Assistant Commissioner Human Resources hosted World AIDS day Activities at police head quarters, 2011. The RPNGC Assistant Commissioner Human Resources participated in the Asia and Pacific Regional Consultation on HIV and Sex Work in Thailand, October 2010.

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

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

<b>IF YES, does the national multisectoral HIV coordination body:</b>		
<i>Have terms of reference?</i>	<b>Yes</b>	
<i>Have active government leadership and participation?</i>	<b>Yes</b>	
<i>Have an official chair person?</i>	<b>Yes</b>	
<i>IF YES, what is his/her name and position title?</i>		
Sir Peter Barter (acting Chair of National AIDS Council )		
<i>Have a defined membership?</i>	<b>Yes</b>	
<i>IF YES, how many members?</i>		
22 said yes but only 1 gave the correct number of 19		

<b>Yes</b>	
------------	--

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

<i>Include civil society representatives?</i>	<b>Yes</b>	
<i>IF YES, how many?</i>		
22 said yes but only 5 gave an answer ranging from 3-4 representatives		
<i>Include people living with HIV?</i>	<b>Yes</b>	
<i>IF YES, how many?</i>		
20 said yes, 11 of 14 gave correct number = 1		
<i>Include the private sector?</i>	<b>Yes</b>	
<i>Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?</i>	<b>Yes</b>	

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

<b>Yes</b>		
------------	--	--



**What challenges remain in this area:**

**IF YES, briefly describe the main achievements:**

*Note: respondents comments were both on the mechanisms and the achievements.*

The mechanisms are:

a) BAHA - Business Coalition against HIV. b) PACSO - For NGOs and CSOs c) Government sectors d) Provincial AIDs Committees (10 are for each province ) e) Church Alliance.

- Through the NAC membership which is multi-sectoral & includes representation from all sectors. Two of these NGO mechanisms are on the National AIDS Council and all of the key government sectors/departments.

The achievements are:

- Got NHS 2011-2015 2011-2015 in place
- Increased number of stakeholders from 50 to 200
- Decentralized HIV response to provincial down to districts & LLGs
- Increased HIV in schools including Sensitized teachers to teaching HIV/AIDS
- Private enterprise is now putting in or implementing HIV workplace policies
- Increase in HIV Budget from 2009

*Respondents comments:*

- There needs to be formal or consolidated linkages in terms of coordination between BAHA, PACSO, Church Leaders Alliance, Youth Alliance, Igat Hope Inc and Govt Sector coordination groups and NACS. NACS need to continue strengthening these umbrella corporations. Reason being so that their leaders would work with NACS. It helps filter the process of policy change/formulation and as well as providing resources down to the people.
- Regularity of treatment & elimination of stock-outs of ART.
- Funding and Duplication of activities/programmes.
- Political & Leadership - consistency regarding promises and commitment. E.g.: Politicians may talk one day about HIV and the next day they do not.
- A greater involvement of the private sector in provinces & in economic enclaves by government officers.
- Better alignment with aid donors & development partners

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

**5. What kind of support does the National HIV Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?** 44%

<i>Capacity-building</i>	Yes	
<i>Coordination with other implementing partners</i>	Yes	
<i>Information on priority needs</i>	Yes	
<i>Procurement and distribution of medications or other supplies</i>	Yes	
<i>Technical guidance</i>	Yes	
<i>Other [write in below]: Funding</i>	Yes	
	Yes	
<i>Monitoring and Surveillance , Statistics and data, income generation, resource mobilisation, home based care, research capacity, alignment with UN, Province, NGO plans, planning and budgeting, logistics, Training, Information sharing.</i>		

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

**Yes**

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

<b>IF YES, name and describe how the policies / laws were amended</b>
<i>This question poses problems by merging laws with policies. Some replied on the basis of the Laws = No and others on Policies = yes.</i>
Yes: <ul style="list-style-type: none"> <li>The recent National Education Plan has now captured HIV Curriculum in Education unlike the previous one. In the Schools: they have integrated HIV study into the curriculum.</li> <li>Amendment to General Orders to amend HIV workplace policies. Developed templates for workplace policies for private enterprise</li> </ul>
No: <ul style="list-style-type: none"> <li>Changes to the laws on sodomy and prostitution were talked about and a Bill but it was not passed.</li> </ul>
<b>Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:</b>
<i>The comments relate to Laws that are inconsistent not so much on the policies.</i> <i>Respondents comments:</i> <ul style="list-style-type: none"> <li>Old national laws being inconsistent with modern laws on human rights including HIV</li> </ul>

- Provincial policies being inconsistent with the HAMP ACT
- Laws being inconsistent with the HAMP ACT (Women not expressly protected)
- Laws not consistent with human rights (e.g. Laws on sodomy & prostitution)

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

<b>Very Poor</b>										<b>Excel lent</b>
0	1	2	3	4	5	6	7	8	9	10

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

*Respondents comments:*

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

**What challenges remain in this area:**

*Respondents comments:*

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

programs.

- Taking ownership of HIV at all levels. Develop policies geared towards, targeting population, specific catchment area- LLG, Wards.

### 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? Circle yes if the policy specifies any of the following key populations and vulnerable groups:***

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

***1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?***

**Yes**

***IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:***

a) The Constitution (S55) guarantees all citizens the same rights, privileges, obligations and duties irrespective of sex. However, freedom from discrimination is not a guaranteed right as the constitution provides that Customary law is part of the underlying law of PNG.

*The following is the correct legal situation but other comments made it clear that MSM and sex workers do not believe they are protected by the Constitution.*

There is no legal guarantee of non discrimination on the grounds of sex. The Constitution provides that citizens have the right to freedom of assembly which theoretically would include associations of MSM, sex workers, and transgendered people. The Constitution provides that citizens have the right to freedom of movement which would theoretically apply to MSM, sex workers and transgendered people.

b) The Discriminatory Practices Act 1963 prohibits discrimination on the basis of colour, race or ethnic, tribal or national origin.

c) The Lukautim Pikinini Act protects and promotes the rights and wellbeing of all children regardless of gender and protects children from all forms of violence, abuse, neglect, exploitation and discrimination.

d) Criminal Code (Sexual Offences and Crimes Against Children) Act 2003.

e) The Juvenile Court Act 1997, specifically provides human rights protection for young offenders aged between 10 and 18 years old.

f) The Police Juvenile Policy and Protocols provide a tool for dealing with juveniles in conflict with the law.

g) The Correctional Services Act 1975 sets out the legal requirements for duty of care to prisoners.

**Briefly explain what mechanisms are in place to ensure these laws are implemented:**

*There are the following formal complaints processes using the following mechanisms however the Consensus Workshop noted that this information is not common knowledge and that there are many obstacles to accessing these mechanisms for those experiencing discrimination:*

a) through the Village Court System,

b) The Office of the Public Solicitor and the PNG Development Law Association provide legal aid services,

c) the National Court Human Rights Track which provides a fast track process for redressing human rights violations and allows people to submit complaints related to human rights violations including HIV&AIDS directly to the national court without having to go through the police or engage lawyers.

d) If the discrimination has been caused by the police, complaints can be made to The Commissioner, The RPNGC Internal Investigation Unit or the Ombudsman Commission

e) For employment related discrimination complaints can be lodged with Department of Labour & Industrial Relations, Public services commission or the PNG Trade Union Congress

f) complaints related to discrimination by public figures, politicians, leaders and LLG leaders can be lodged with the Ombudsman Commission

g) The Ombudsman Commission is mandated to monitor places of detention

h) Within the Law & Justice Sector all organizations with the exception of the OPP and OPS have endorsed HIV&AIDS Workplace policies which prohibit

discrimination on the basis of perceived or actual HIV status.

i) Within the Law & Justice sector all organizations with the exception of OPP and OPS have endorsed EEO Policies which prohibit discrimination on the basis of gender. Some organizations such as NJS and RPNGC specifically prohibit discrimination on the basis of sexual orientation, religion and gender.

j) The RPNGC HIV/AIDS workplace policy acknowledges women, children, young people, drug users, sex workers, men who have sex with men, workers in the informal economy, people with disabilities and highly mobile workers as groups particularly vulnerable to HIV with which the police come into frequent contact. The policy commits the police to service as positive role models to these groups, promote understanding and provide information related to HIV.

k) The Correctional Services HIV/AIDS workplace policy covers all CS personnel, their dependants and all prisoners. It commits to banning mandatory testing, encouraging voluntary testing, providing HIV education and awareness programs, VCT, treatment and care services and condoms being available to all staff and prisoners.

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

*Most of the answers related to HIV and very few on human rights or anti discrimination against MARPs.*

*The Consensus workshop noted that whether HIV based or discrimination experienced by MARPs or women the reality is accessing the correct process is very difficult due to the obstacles.*

*Respondents comments:*

- The National Court Human Rights Track was launched in July 2011.
- For Human Rights - Currently difficult to implement and enforce, because the HAMP ACT was implemented with little involvement of law enforcement agencies.
- Some agencies are not familiar with HAMP ACT or current legislation that protects human rights and they have not applied them appropriately to date.

**2. Does the country have laws, regulations or policies that present obstacles<sup>24</sup> to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?**

Yes	
-----	--

<b>IF YES, for which key populations and vulnerable groups?</b>		
<i>People living with HIV</i>		<b>No</b>
<i>Men who have sex with men</i>	<b>Yes</b>	
<i>Migrants/mobile populations</i>	<b>Yes</b>	
<i>Orphans and other vulnerable children</i>		<b>No</b>

<sup>24</sup> These are not necessarily HIV-specific policies or laws. They include policies, laws or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: “laws that criminalize same sex relationships”, “laws that criminalize possession of condoms or drug paraphernalia”; “loitering laws”; “laws that preclude importation of generic medicines”; “policies that preclude distribution or possession of condoms in prisons”; “policies that preclude non-citizens from accessing ART”; “criminalization of HIV transmission and exposure”, “inheritance laws/rights for women”, “laws that prohibit provision of sexual and reproductive health information and services to young people”, etc.

<i>People with disabilities</i>		<b>No</b>
<i>People who inject drugs</i>	<b>Yes</b>	
<i>Prison inmates</i>	<b>Yes</b>	
<i>Sex workers</i>	<b>Yes</b>	
<i>Transgendered people</i>	<b>Yes</b>	
<i>Women and girls</i>		<b>No</b>
<i>Young women/young men</i>		<b>No</b>
<i>Other specific vulnerable populations<sup>25</sup> [write in below]:</i>	Yes	
GBV and SV – the policies such as ‘Fight fee’ and the need for a police report before clinical care and support for rape survivors impact on Women, girls and transgender		

**Briefly describe the content of these laws, regulations or policies:**

The Criminal Code sections 210, 212 retain the offences of sodomy and indecent dealings between males. The Summary Offences Act makes it illegal to solicit or live off the earnings of prostitution. Living off the earnings of prostitution also applies to the sex worker.

*Note: A number of views expressed that show support for discriminatory laws. “Sex Work is "illegal"- refer to the bible. Says divorce, being unfaithful, it's not okay to re - marry " - More sex partners = rubbish."1. "The PNG constitution reflects the natural law (men who have sex with women only )."6.*

**Briefly comment on how they pose barriers:**

*Respondents comments:*

- The discriminatory Laws and policies devalue the human rights of FSW & MSM.They go underground, they cannot access care, services and commodities such as condoms.
- Enforcing the laws on the key affected population such as the MSM, PLHIV, and FSW will provide obstacles to effective implementation of HIV programs and drive the affected population underground making them hard to reach. Health concern - HIV work with concerned populations as such can be compromised and seen as legally breaking the law.
- Police brutality/Extra – judicial action by police,
- Harassment of perpetrators & and harassment of those who care for the victims
- Health providers concerns - HIV work with concerned populations, the Health providers can be legally compromised and seen as legally breaking the law.
- The ‘Fight fee’ and need for police report for survivors of rape are obstacles for women and girls

<sup>25</sup> Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

## 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	
-----	--

<i>IF YES, what key messages are explicitly promoted?</i>		
<i>Abstain from injecting drugs</i>		<b>No</b>
<i>Avoid commercial sex</i>		<b>No</b>
<i>Avoid inter-generational sex</i>	Yes	
<i>Be faithful</i>	Yes	
<i>Be sexually abstinent</i>	Yes	
<i>Delay sexual debut</i>	Yes	
<i>Engage in safe(r) sex</i>	Yes	
<i>Fight against violence against women</i>	Yes	
<i>Greater acceptance and involvement of people living with HIV</i>	Yes	
<i>Greater involvement of men in reproductive health programmes</i>	Yes	
<i>Know your HIV status</i>	Yes	
<i>Males to get circumcised under medical supervision</i>		<b>No</b>
<i>Prevent mother-to-child transmission of HIV</i>	Yes	
<i>Promote greater equality between men and women</i>	Yes	
<i>Reduce the number of sexual partners</i>	Yes	
<i>Use clean needles and syringes</i>		<b>No</b>
<i>Use condoms consistently</i>	Yes	
<i>Other [write in below]:</i>		

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

Yes	
-----	--

Yes	
-----	--



**2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?**

**2.1. Is HIV education part of the curriculum in:**

<i>Primary schools?</i>	Yes	
<i>Secondary schools?</i>	Yes	
<i>Teacher training?</i>	Yes	

**2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?**

Yes	
-----	--

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

Yes	
-----	--

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

Yes	
-----	--

<b>Briefly describe the content of this policy or strategy:</b>
<p>As in the NHS 2011-2015.</p> <p>Strategic priority 1: Reduce the risks of HIV transmission</p> <p>1.1: Sexual transmission of HIV and other STIs</p> <p>1.2: Prevention of parent to child transmission of HIV</p> <p>1.3: Transmission of HIV in health care settings</p> <p>1.4: Injecting practices, penile modification and other emerging transmission routes</p> <p>Strategic priority 2: Address factors that contribute to HIV vulnerability</p> <p>2.1: Gender-related vulnerability</p> <p>2.2: Vulnerability of young people</p> <p>2.3: Vulnerability of children</p> <p>2.4: Vulnerability of more-at-risk populations</p> <p>2.5: Drugs and alcohol</p> <p>Strategic priority 3: Create supportive and safe environments for HIV prevention</p> <p>3.1: National and local social and cultural events</p> <p>3.2: HIV prevention in the workplace and in economic enclaves</p> <p><i>Note: The majority of respondents did not answer the question correctly by referring to their own organisations policies or policies that did not refer to MARPs</i></p>

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

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

	IDU <sup>26</sup>	MSM <sup>27</sup>	Sex workers	Customers of Sex Workers	Prison inmates	Other populations <sup>28</sup> [Youth pop'n] (1)
<i>Condom promotion</i>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Drug substitution therapy</i>						
<i>HIV testing and counselling</i>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Needle &amp; syringe exchange</i>						
<i>Reproductive health, including sexually transmitted infections prevention and treatment</i>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Stigma and discrimination reduction</i>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Targeted information on risk reduction and HIV education</i>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Vulnerability reduction (e.g.</i>						

26 IDU = People who inject drugs

27 MSM=men who have sex with men

28 Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners, and refugees)

income generation)							
--------------------	--	--	--	--	--	--	--

**3.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate policy efforts in support of HIV prevention in 2011?**

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

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

*Respondents comments:*

- Most significant has been the development of the NHS, and the development of the Implementation Framework and the M&E framework.
- Almost 80% of people who need treatment have access to facilities.
- In 2001, as a result of the NHS 2011-2015 focus - Greater emphasis on gender equality, addressing gender based violence and making men and boys to be responsible partners.
- Increase in condoms distributed.
- More integration of HIV & STIs.
- There's been a scale - up of prevention efforts for specified target groups including all of the sub - populations (PLHIV, FSW, MSM, TG, Prisoners, women, girls and youths )

**What challenges remain in this area:**

*Respondents comments:*

- Challenge in educating people in rural areas, especially in the young population.
- Main streaming of gender equality.
- Advocacy for increased use of both male and female condom.
- Discussion and decision on male circumcision as a national preventative measure.
- Realistic inclusion of key affected population in preventative efforts.
- Geographical constraints prevent delivering these messages,
- Cultural Barriers to reaching MARPs. Need to strengthen MARPs groups.
- Strengthen the Monitoring and Evaluation of HIV programs.
- Lack of quality assurance processes -needs to be strengthened through M&E.

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

Yes	
-----	--

**IF YES, how were these specific needs determined?**

*Note, the majority of respondents referred to consultations and workshops as the means for identifying the needs for HIV prevention programmes.*

Through the bio behavioural surveys, and other means of research and from experience, lessons learnt and international best practice the country utilised these sources to develop the National HIV Strategy and prioritise prevention.

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

#### **4.1. To what extent has HIV prevention been implemented?**

<b>The majority of people in need have access to...</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>	<b>N/A</b>
<i>Blood safety</i>	4	<b>3</b>	2	1	N/A
<i>Condom promotion</i>	4	<b>3</b>	2	1	N/A
<i>Harm reduction for people who inject drugs</i>	4	3	2	<b>1</b>	N/A
<i>HIV prevention for out-of-school young people</i>	4	<b>3</b>	2	1	N/A
<i>HIV prevention in the workplace</i>	4	<b>3</b>	2	1	N/A
<i>HIV testing and counselling</i>	4	<b>3</b>	2	1	N/A
<i>IEC<sup>29</sup> on risk reduction</i>	4	<b>3</b>	2	1	N/A
<i>IEC on stigma and discrimination reduction</i>	4	<b>3</b>	2	1	N/A
<i>Prevention of mother-to-child transmission of HIV</i>	4	<b>3</b>	2	1	N/A
<i>Prevention for people living with HIV</i>	4	<b>3</b>	2	1	N/A
<i>Reproductive health services including sexually transmitted infections prevention and treatment</i>	4	3	<b>2</b>	1	N/A
<i>Risk reduction for intimate partners of any of the above three key populations</i>	4	3	<b>2</b>	1	N/A
<i>Risk reduction for men who have sex with men</i>	4	3	<b>2</b>	1	N/A
<i>Risk reduction for sex workers</i>	4	3	<b>2</b>	1	N/A

<i>School-based HIV education for young people</i>	4	<b>3</b>	2	1	N/A
<i>Universal precautions in health care settings</i>	4	<b>3</b>	2	1	N/A
<i>Other[write in]: Treatment, care and support (1)</i>	4	<b>3</b>	2	1	N/A

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

Very Poor											Excellent
	0	1	2	3	4	5	<b>6</b>	7	8	9	
<b>Since 2009, what have been key achievements in this area:</b>											
<i>Respondents Comments:</i>											
<ul style="list-style-type: none"> <li>• Recognition and prioritization for youth and young people is happening and is critical,</li> <li>• The recognition and understanding of the impact of gender inequality in families and communities to the spread of HIV be increased,</li> <li>• Inclusion of members of key affected populations. For instance, getting FSW as part of two technical working groups to decide for themselves.</li> <li>• Policies for IEC materials for children.</li> <li>• VCT policy guidelines used for quality assurance</li> <li>• Antenatal testing has increased in the clinics.</li> <li>• Screening of blood products now available.</li> <li>• NGO/FBOs taking responsibility to produce and distribute IEC materials.</li> <li>• More private organizations have developed their own workplace policies.</li> <li>• NGOs/CSOs beginning to align activities with the NHS prevention strategies.</li> <li>• There are now 4 out of 20 prison locations that are able to provide Voluntary Counselling and Testing to prisoners.</li> <li>• Correctional Services have successfully accessed development budget funding for 2012 to establish primary health care services in all prisons, which integrate HIV prevention and care.</li> </ul>											
<b>What challenges remain in this area:</b>											

*Respondents comments:*

- Need to sustain HIV programs & projects in communities for key affected populations.
- The prevention tool has to be brought down to the remote areas with the change in the trend of infection form the urban to the rural areas
- Effective implementation of preventive strategy
- Continuous funding.
- Health workers need to treat the sex workers on non judging and supportive ways.
- High level of discrimination and stigma in the churches.
- To date the sectors response to HIV has not been driven by a formal analysis of the needs and context. The sector and its agencies do not have a comprehensive understanding of how HIV&AIDS, could be affecting the achievement of their goals, objectives and programmes.

---

---

## V. TREATMENT, CARE AND SUPPORT

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

Yes	
-----	--

***If YES, Briefly identify the elements and what has been prioritized:***

*Respondents comments:*

- HIV counselling and testing should be made available where possible in the districts, provinces and wards.
- Upgrading and increasing the number of testing sites.
- Integration of HIVs, STIs and TB testing and treatment.
- There is a continuum of care from the home through to provincial hospital with the use and engagement of auxiliary staff, volunteers and organisations such as churches, community care providers, Pastors and Priests, community herbalist so that there is a range of treatment from the house to the hospital for person living with HIV/AIDS.
- Ensure a continuous procurement and supply of OI - Opportunist infections and ARV medications

**Briefly identify how HIV treatment, care and support services are being scaled-up?**

*Respondents comments:*

- Training conducted to health officers on ART and PICT.
- Improvement of facilities to do PICT, storage of blood sample and improved filing system.

- Increased funding and improvement to care and support centres to take in HIV positive persons for psychosocial care and support.

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

The majority of people in need have access to...	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
	<i>Antiretroviral therapy</i>	4	3	2	1
<i>ART for TB patients</i>	4	3	2	1	N/A
<i>Cotrimoxazole prophylaxis in people living with HIV</i>	4	3	2	1	N/A
<i>Early infant diagnosis</i>	4	3	2	1	N/A
<i>HIV care and support in the workplace (including alternative working arrangements)</i>	4	3	2	1	N/A
<i>HIV testing and counselling for people with TB</i>	4	3	2	1	N/A
<i>HIV treatment services in the workplace or treatment referral systems through the workplace</i>	4	3	2	1	N/A
<i>Nutritional care</i>	4	3	2	1	N/A
<i>Paediatric AIDS treatment</i>	4	3	2	1	N/A
<i>Post-delivery ART provision to women</i>	4	3	2	1	N/A
<i>Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)</i>	4	3	2	1	N/A
<i>Post-exposure prophylaxis for occupational exposures to HIV</i>	4	3	2	1	N/A
<i>Psychosocial support for people living with HIV and their families</i>	4	3	2	1	N/A
<i>Sexually transmitted infection management</i>	4	3	2	1	N/A
<i>TB infection control in HIV treatment and care facilities</i>	4	3	2	1	N/A

<i>TB preventive therapy for people living with HIV</i>	4	3	2	1	N/A
<i>TB screening for people living with HIV</i>	4	3	2	1	N/A
<i>Treatment of common HIV-related infections</i>	4	3	2	1	N/A
<i>Other[write in]: Improving living standards (1) Reducing Poverty (1)</i>	4	3	2	1	N/A

**2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?**

	<b>No</b>
--	-----------

**Please clarify which social and economic support<sup>30</sup> is provided:**

Government does not provide social & economic support for PLHIV.

*Respondents comments:*

- Social & economic support is given by charity organizations & churches.
- NACS has small grants for FBOs and NGOs to assist HIV people or (HIV related work ) with Services.

**3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?**

	<b>No</b>
--	-----------

**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?**

	<b>No</b>
--	-----------

**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**

<sup>30</sup> These can include, for example, non-contributory state pensions/old age grants, Free primary health care and ART for the poor, Free and/or subsidized educational support (primary and secondary school) for the poor, Disability grants, Child grants, Micro-finance/credit, Start-up kits for income generation, and the care and support needs of carers.



## implementation of HIV treatment, care, and support programmes in 2011?

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

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

#### Respondents comments:

- Introduction of PICT (Provider, initiated, counselling and testing)
- TB nurse or nurse at STI clinic can offer their clients pre - counselling, then do HIV test.
- Upscale of PPTCT and treatment of children (less than 12 years old) with paediatric ARV.
- Maintaining and getting new ART supplies and trying to do this on a regular basis (maintain continuous supply). More ART prescribers
- Maintaining, stabilization procurement and supply of condoms
- Greater network and Participation, Development of the National HIV treatment, care and support strategy 2011 - 2015,
- Increased funding,
- More support from government institutions.
- Private sectors increased their capacity to provide VCT at workplace or make referrals using established organizations such as Business coalition Against HIV and AIDS (BAHA).

### What challenges remain in this area:

#### Respondents comments:

- Increased ARV resistance
- Limited access to TB prophylaxis for PLHIV
- PEP and allocating funds to improve VCT services & sustain ART.
- Expand & strengthen nutritional care for PLHIV.
- Expand integrated approach to treating HIV, TB & STI.
- Delay in Confirmatory tests from Health Department.
- The quality of testing, reporting & monitoring
- The logistics & distribution of commodities. Commodity supply issues – test kits to sites. ART stockouts – regular
- The geographical location (culture & language issues)
- Capacity of care givers (health officers)
- Discrimination poses threat to those seeking treatments.
- Procurement services very low, scale up is only concentrated in urban and semi urban areas. Majority of people live in rural areas and remote can't be reached. Roll out of ART to rural majority
- Data/surveillance not being prepared on time from the Health Department.

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

Yes		
-----	--	--

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

Yes	
-----	--

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

Yes	
-----	--

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

	No
--	----

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

DNK%
------

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

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

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

*Respondents comments:*

- Development of the Lakautim Pikinini Act. Communities now know needs of orphans & vulnerable young children.
- National Social Protection Task Force has been set up to deal with vulnerable children/orphans. NGOs handle the orphans. Just a testing, treatment has been improved

**What challenges remain in this area:**

*Respondents comments:*

- NACS needs to strengthen partnership with Dept of Communication Development in four areas: Gender, Women and Children, Orphans and Vulnerable Children, the law, HIV and special populations ( CSW, Trans - gender etc. ) .
- Vulnerable children populations increasing yearly so there is need for more awareness on HIV done to protect orphans and other young children. No real focus at this time, a lot of adhoc activities (activities for vulnerable children)
- Could be missing out on real data for number of vulnerable children. Government should improve existing Acts [e.g.: Lakautim Pikinini Act] to cater for orphaned children under current development strategies.
- Government to support organizations which are dealing with orphanage issues in the country.

---

---

## VI. MONITORING AND EVALUATION

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

Yes		
-----	--	--

**Briefly describe any challenges in development or implementation:**

*No challenges described in the development of the NHS 2011-2015 M & E Plan.*

*Respondents comments: Challenges in implementation:*

- Capacity to monitor and establishing good monitoring systems.
- Strengthen coordination at all levels.
- Capacity building.
- Training.
- Collection of data and processing of data needs improvement
- Data dissemination. National & Sub - National Databases
- Surveys and Surveillance
- HIV Evaluation and Research.

**1.1. IF YES, years covered [write in]:**

2011-2015

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

Yes, all partners		
-------------------	--	--

**Briefly describe what the issues are:**

*Not clear from responses if respondents were aware of the key partners having their own M & E requirements.*

*Answers are more on what is needed for PNG to scale up M & E*

*Respondents comments:*

- More training in order to align organizational plans to National HIV Strategy under each Priority Area for proper monitoring and evaluation,
- Building capacity to M&E officers at all levels in terms of knowledge and resources to coordinate and manage M&E processes

## **2. Does the national Monitoring and Evaluation plan include?**

<b><i>IF YES, what key messages are explicitly promoted?</i></b>		
<b><i>A data collection strategy</i></b>	<b>Yes</b>	
<b><i>IF YES, does it address:</i></b>		
<b><i>Behavioural surveys</i></b>	<b>Yes</b>	
<b><i>Evaluation / research studies</i></b>	<b>Yes</b>	
<b><i>HIV Drug resistance surveillance</i></b>	<b>Yes</b>	
<b><i>HIV surveillance</i></b>	<b>Yes</b>	
<b><i>Routine programme monitoring</i></b>	<b>Yes</b>	
<b><i>A data analysis strategy</i></b>	<b>Yes</b>	
<b><i>A data dissemination and use strategy</i></b>	<b>Yes</b>	
<b><i>A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)</i></b>	<b>Yes</b>	
<b><i>Guidelines on tools for data collection</i></b>	<b>Yes</b>	

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

<b>Yes</b>		
------------	--	--

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

<b>8 %</b>
------------

## **4. Is there a functional national M&E Unit?**

<b>Yes</b>		
------------	--	--

**Briefly describe any obstacles:**

<p><i>Respondents comments:</i></p> <ul style="list-style-type: none"> <li>• Lack of coordination therefore, it seems dysfunctional.</li> <li>• Lack of a shared understanding of the M&amp;E framework and a capacity to implement.</li> <li>• Lack of resources to backup and support in collating and collecting HIV and other related information.</li> <li>• No proper coordination</li> <li>• Needs major improvement</li> </ul>
--

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

<i>In the Ministry of Health?</i>		<b>No</b>
<i>In the National HIV Commission (or equivalent)?</i>	<b>Yes</b>	
<i>Elsewhere [write in]?</i>		

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

<b>POSITION [write in position titles in spaces below]</b>	<b>Fulltime</b>	<b>Part time</b>	<b>Since when?</b>
<i>Permanent Staff [Add as many as needed]</i>			
M & Manager	<i>Yes</i>		2004
M & E Officer	<i>Yes</i>		2004
Data Officer	<i>Yes</i>		2004
Surveillance Officer	<i>Yes</i>		2004
Surveillance Officer	<i>Yes</i>		2004
Surveillance Officer	<i>Yes</i>		2004
	<b>Fulltime</b>	<b>Part time</b>	<b>Since when?</b>
<i>Temporary Staff [Add as many as needed]</i>	<i>NA</i>		

**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?**

<b>Yes</b>	
------------	--

<b>Briefly describe the data-sharing mechanisms:</b>
National Oversight Committee at National AIDS Council (NAC) and National Department of Health (NDoH) oversee all M&E operations .
<i>Respondents comments:</i>
<ul style="list-style-type: none"> <li>• The NACS M&amp;E unit coordinate the programs data whilst NDoH surveillance unit is responsible for surveillance information.</li> </ul>

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

**What are the major challenges in this area:**

*Respondents comments:*

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

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

Yes	
-----	--

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

Yes	
-----	--

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

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

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

Yes, all of the above		
-----------------------	--	--

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

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

**6.2 Is there a functional Health Information System<sup>31</sup>?**

<i>At national level</i>	Yes	
<i>At subnational level</i>	Yes	
<i>IF YES, at what level(s)? [write in]</i> It is based at the national level, data comes from facility, data is mostly used at national and provincial level		

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

Yes	
-----	--

**8. How are M&E data used?**

<i>For programme improvement?</i>	Yes	
<i>In developing / revising the national HIV response?</i>	Yes	
<i>For resource allocation?</i>	Yes	
<i>Other [write in]: Advocacy</i>	Yes	

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

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

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

<i>At national level?</i>	Yes	
<i>IF YES, what was the number trained: 30</i>		
<i>At subnational level?</i>	Yes	
<i>IF YES, what was the number trained? 30</i>		
<i>At service delivery level including civil society?</i>	Yes	
<i>IF YES, how many? 50</i>		

<sup>31</sup> Such as regularly reporting data from health facilities which are aggregated at district level and sent to national level; data are analysed and used at different levels)?

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

Yes	
-----	--

<b>IF YES, describe what types of activities</b>
<p><i>Respondents comments:</i></p> <ul style="list-style-type: none"> <li>• Awareness &amp; issuing of condoms and demonstration on how to use condoms.</li> <li>• Setting up of HIV Monitoring and Evaluation position in the government structure at National and Provincial level.</li> <li>• NCPI interviewer training</li> </ul>

**10. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the HIV-related monitoring and evaluation (M&E) in 2011?**

Very Poor										Excellent
0	1	2	3	4	5	<b>6</b>	7	8	9	10

<b>Since 2009, what have been key achievements in this area:</b>
<p><i>Respondents comments:</i></p> <ul style="list-style-type: none"> <li>• The completion of M&amp;E framework and toolkit</li> <li>• Completion of NHS and M&amp;E framework recruitment and induction of 20 provincial M&amp;E officers and 5 National officers.</li> <li>• Greater network and Participation, National AIDS Council to play coordination role, Provincial AIDS Committee in place.</li> </ul>
<b>What challenges remain in this area:</b>
<p><i>Respondents comments:</i></p> <ul style="list-style-type: none"> <li>• Lack of leadership on M&amp;E and surveillance</li> <li>• Need for better communication between M&amp;E and programme</li> <li>• Skill development for new M&amp;E officers</li> <li>• Data management is still a challenge</li> <li>• No separate budget for M&amp;E</li> <li>• The surveillance unit at NDoH in under-staffed and suffered a loss in budgets and staff in 2011</li> <li>• Lack of coordination between M&amp;E staff and Provincial Health Officers at provinces</li> <li>• Difficulty in communication between provinces and national level</li> </ul>



# NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)

## PART B

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

### **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?**

LOW					HIGH
0	1	2	3	4	5

#### **Comments and examples:**

##### *Respondents comments:*

- Civil Societies have been instrumental in formulation and policies on: children’s rights, women and girls, most vulnerable population such as transgender, men who have sex with men and female sex workers.
- Though political commitments have not yet resulted in policies and laws for MSM and FSW, gender based violence policies (The Family Protection Bill and the National Family and Sexual Violence strategy) are all still in draft there has been increased debate in the public as a result.
- Private businesses are a strong factor in contributing to the response – (e.g. Steamships, RH, OK Tedi) a ) Through Sponsorship b ) Moving Condoms c ) Funding.
- Every time there is a review on National HIV Strategy (NHS), civil society is well presented & gives inputs into the review process.
- Civil Society has contributed a lot to the contribution to strengthening the political commitments of top leaders
- The civil society organizations have being very engaged in the response. They have umbrella organization responsible for coordination. e.g. PACSO which is the member of CCM in PNG. Apart from that, there are other organizations involved in influencing policies from different sectors including PLWH, the CBOs and Churches. They are involved in strategic planning process and hence influence the policies. They also do advocacy for

\* Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

services e.g. IGAT hope.

- An example of where civil society has been influential in national law reform is the NEC reference to review the Summary Offences Act and the Criminal Code Act as it relates to sex work and sodomy. FYI although this started as an attempt to decriminalise sex work and sex work it ended up being a request to review rather than decriminalise.

**2. To what extent (on a scale of 0 to 5 where 0 is “Low” and 5 is “High”) have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?**

LOW					HIGH
0	1	2	3	4	5

**Comments and examples:**

*Respondents comments:*

- Civil Societies have contributed to the formulation of the NSP. This organization worked on developing sections in the NSP on most at risk populations (MARPS) in the current NHS 2011-2015, which were absent in the previous NSP.
- CSOs involved in Activity Planning = 4/higher. CSOs involvement in Budgeting given a low 1. The influence of Civil Society's representatives individual in planning and budgeting for NHS very small.
- CSO has played a key role, They are the eyes & ears of marginalized groups played a vital role in planning & budgeting. Igat Hope successfully lobbied NACS to give recognition to the stigma & discriminations' component in NHS.
- They have participated in preparations for the National HIV Strategy and they have been involved in development of proposals for resource mobilization e.g. GFATM. They are also developing proposals to donors-AusAID to support implementation of programmes.
- It has been extremely challenging to develop a budget for the NHS 2011-2015. A costing exercise was started with civil society involved but never completed. CSO are concerned that the NHS 2011-2015 does not have a budgeted annual cost.

**3. 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?*

LOW					HIGH
-----	--	--	--	--	------

0	1	2	3	4	5
---	---	---	---	---	---

***b. The national HIV budget?***

<b>LOW</b>					<b>HIGH</b>
0	1	2	3	4	5

***c. The national HIV reports?***

<b>LOW</b>					<b>HIGH</b>
0	1	2	3	4	5

**Comments and examples:**

*Respondents comments:*

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

**4. 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?***

<b>LOW</b>					<b>HIGH</b>
0	1	2	3	4	5

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

<b>LOW</b>					<b>HIGH</b>
0	1	2	3	4	5

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

<b>LOW</b>					<b>HIGH</b>
0	1	2	3	4	5

**Comments and examples:**

*Respondents comments:*

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

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

LOW					HIGH
0	1	2	3	<b>4</b>	5

**Comments and examples:**

*Respondents comments:*

- The involvement of the marginalized groups is better than previously UNGASS period, less adhoc, and less tokenistic and more meaningful
- Civil Societies are at the forefront in HIV efforts in being inclusive of diverse organisations. Its organisations like FHI 360 and Save The Children initiating interventions for PLHIV, FSW and MSM in PNG and are continuing to do so.
- Some of the national committees such as RAC, NAC and CCM have diverse organisations as members.
- Many PLHIV organizations are established but not many are involved in

- planning. These organizations do not have skilled people to manage their orgs. They tend to continue to work in isolation to each other.
- CPP-Church partnership programs with each other recognizes the diversity in approaches. BUPNG is part of the CCP including the seven main line churches of PNG-Lutheran, catholic and SDA, salvation army, united and Anglican
    - Example: BUPNG Baptist union of PNG works in collaboration with two groups
  - True Friends (Positive women) and True Warriors (PLHIV): Both groups advocate as service providers

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

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

LOW					HIGH
0	1	2	3	4	5

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

LOW					HIGH
0	1	2	3	4	5

**Comments and examples:**

*Respondents comments:*

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

donors, unilateral/bilateral but should work closely with organizations to address issues in the organization.

- There has been an increase in technical assistance at national level but there is an emerging need for technical assistance at provincial level which is not so easy to get funding for.
- There is currently a lost opportunity to share available technical assistance between NGO partners.

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

	<25%	25-50%	51-75%	>75%
<b>Prevention for key-populations</b>				
<i>People living with HIV</i>	<25%	25-50%	51-75%	>75%
<i>Men who have sex with men</i>	<25%	25-50%	51-75%	>75%
<i>People who inject drugs</i>	<25%	25-50%	51-75%	>75%
<i>Sex workers</i>	<25%	25-50%	51-75%	>75%
<i>Transgendered people</i>	<25%	25-50%	51-75%	>75%
<b>Testing and Counselling</b>	<25%	25-50%	<b>51-75%</b>	>75%
<b>Reduction of Stigma and Discrimination</b>	<25%	25-50%	51-75%	>75%
<i>Clinical services (ART/OI)*</i>	<25%	25-50%	<b>51-75%</b>	>75%
<i>Home-based care</i>	<25%	25-50%	51-75%	>75%
<i>Programmes for OVC**</i>	<25%	25-50%	51-75%	>75%

\*ART = Antiretroviral Therapy; OI=Opportunistic infections

\*\*OVC = Orphans and other vulnerable children

**8. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts to increase civil society participation in 2011?**

Very Poor										Excellent
0	1	2	3	4	5	<b>6</b>	7	8	9	10

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

*Respondents comments:*

- Seeking wider consultation from Civil Societies prior to drawing up strategies by the government, e.g., NSP ( 2011 - 2015 )
- Over past 3 years, the number of NGOs, CBOs working on HIV and AIDS have increased. The environment has increased. A few more NGOs now support Sex workers. Legal support and home based care have emerged as well
- NGO forums which are bringing together CSOs info & sharing to exchange

activities, sharing the 'know how', working in partnership & not isolation, to avoid duplication. Also educating CSOs to focus on their strengths and weaknesses, and work with each other to carry out activities.

**What challenges remain in this area:**

*Respondents comments:*

- NGO's and CBO's seem to be more worried about doing organizational activities. They are not so much involved in mobilizing society/other NGOs to stand for the rights of the people.
- Most organisations fight for their own organisation's needs/requirements and not for focus of Whole Civil Society's participation.
- Need improved coordination of funded programs. The government and in this case NACS and NDOH need to improve their coordination of the NGO/CSOs responding to the epidemic HIV. 'Civil Society organizations can go off on a tangent and waste resources if they are not managed and coordinated properly'.
- That means it is not properly coordinated as a result of less contributions coming in from larger international NGO's, resulting in less information/awareness within Civil Society Organisations in local communities. There are also challenges of logistics.
- However, their full potential has not been realised by the Government. Many times the capacities in these organizations are lacking and this prevents their effective engagement
- (Staff turnover huge) - Improve salary + benefits to retain staff in organisation.
- Communication improved so CSOS participation is high.
- Increase financial support to encourage more participation for CSOS.
- Legal environment which is prohibitive for some risk populations, limited resources, unsupportive policy framework

---

---

## II. POLITICAL SUPPORT AND LEADERSHIP

- 1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?**

Yes	
-----	--

**IF YES, describe some examples of when and how this has happened:**

*Note: A mixture of examples showing some minority views that government hadn't been as involving of people as others reported.*

*Respondents comments:*

YES

- PLWHA were involved in design of the NHS, in the CCM for the GFATM, and in programme implementation in many programmes. However, these areas can also be greatly strengthened so that the involvement is more meaningful and highly appreciated.
- The GoPNG through CDC has arranged forums for key population groups to start dialogue on legal issues that hinder the involvement of CAP.
- However working with the KAPs such as CSW and MSM/TG are difficult still due to prohibitive laws in PNG.
- In legal reforms there has been an improved & increased partnering of marginal populations - with partners & stakeholders to provide legal assistance for PLHIV issues.

NO

- Absolutely No. Igat Hope has pushed the Parliamentary AIDS Committee to have a PLHIV as committee member or to partner with Igat Hope but did not get any response.
- The department of development through Lady Kidu has attempted to enact laws de - criminalizing prostitution and same sex behaviour but is yet to get the support of Parliament.

---

---

### III. HUMAN RIGHTS

***1a. 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:***

<b>KEY POPULATIONS and VULNERABLE SUBPOPULATIONS</b>		
<i>People living with HIV</i>	Yes	
<i>Men who have sex with men</i>		No
<i>Migrants/mobile populations</i>		No
<i>Orphans and other vulnerable children</i>	Yes	
<i>People with disabilities</i>	Yes	
<i>People who inject drugs</i>		No
<i>Prison inmates</i>	Yes	
<i>Sex workers</i>		No
<i>Transgendered people</i>		No



<i>Women and girls</i>	Yes	
<i>Young women/young men</i>	Yes	
<i>Other specific vulnerable subpopulations<sup>32</sup>[write in]: Refugees (1) Yes. Religion (1) Yes:</i>		

***1b. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?***

Yes	
-----	--

<b><i>IF YES to Question 1a or 1b, briefly describe the contents of these laws:</i></b>
<p><i>Note: Confusion represented by the majority referring to the non HIV specific law as the HAMP ACT.</i></p> <p><i>Respondents comments:</i></p> <ul style="list-style-type: none"> <li>• The Constitution has Human Rights embedded. Example: Protecting the rights of women. <ul style="list-style-type: none"> <li>1 ) The Constitution supports Human Rights, and especially on the principle democratic rights and freedom.</li> <li>2 ) The Country also supports most of UN and other organizations that strongly support Human Rights issues. The country's constitution provides for freedom &amp; equal treatment for all people in PNG.</li> </ul> </li> <li>• However some laws are prohibitive because it considers MSM &amp; CSW as criminal acts.</li> <li>• Constitution is the overall law that protects everyone's rights but actually/takes away rights of the key affected populations by not expressly including them.</li> <li>• HAMP ACT attempts to protect PLHIV in the workplace &amp; public places but inconsistent with minimal laws for sodomy &amp; prostitution.</li> <li>• The Discriminatory Practices Act 1963 makes it illegal to discriminate on the grounds of ethnicity, race, religion. It does not say anything about PLHIV.</li> </ul>
<b><i>Briefly explain what mechanisms are in place to ensure that these laws are implemented:</i></b>
<p><i>Respondents comments:</i></p> <ul style="list-style-type: none"> <li>• Laws are in place but the problem still remains in the policing of those laws. The role of the CSO in PNG today is struggling to put this in order as they create pressure within the government departments and the sectors especially Justice and police.</li> <li>• There are other laws that protect rights of women and children against abuse but implementation is a challenge since many implementers such as police are NOT properly trained to uphold such laws.</li> <li>• There is some training with police and other law &amp; justice sector personnel on the relevant laws and their roles and responsibilities in implementing these however within the police and court system there are currently few or no consequences for officers who do not implement the laws.</li> </ul>
<b><i>Briefly comment on the degree to which they are currently implemented:</i></b>

<sup>32</sup> Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners, and refugees)

*Respondents comments:*

- Laws to stop violence against women, to protect women. These laws are implemented differently at rural and urban areas.
- Discrimination is seen against women if suspected of sorcery and are beaten. More effort is needed to be put in awareness of children's rights to reduce abuse of children.
- The Police and Court System are putting in a lot of effort to ensure protection of its citizen's rights.
- Police now have 7 operational Family and Sexual Violence Units.
- Magisterial Services (District Courts) are now issuing Interim Protection orders.

**2. Does the country have laws, regulations or policies that present obstacles<sup>33</sup> 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		
<i>People living with HIV</i>		No
<i>Men who have sex with men</i>	Yes	
<i>Migrants/mobile populations</i>	Yes	
<i>Orphans and other vulnerable children</i>		No
<i>People with disabilities</i>		No
<i>People who inject drugs</i>	Yes	
<i>Prison inmates</i>		No
<i>Sex workers</i>	Yes	
<i>Transgendered people</i>	Yes	
<i>Women and girls</i>		No
<i>Young women/young men</i>		No
<i>Other specific vulnerable populations<sup>34</sup> [write in]:</i>		

**Briefly describe the content of these laws, regulations or policies:**

<sup>33</sup> These are not necessarily HIV-specific policies or laws. They include policies, laws, or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships", "laws that criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc.

<sup>34</sup>Sub-population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, lesbians, prisoners, and refugees) ditto above changes if you agree.

*Respondents comments:*

- Sex Work, MSM, Transgender IDUs are unable to access HIV services as the nature of their activities are forbidden under our Country's laws.
- Law Against drugs under the criminal code for people who inject drugs.
- Sodomy law in the Criminal Code Act 210 & 212 - Offense for sodomy & indecent acts between males.
- Summary Offense act 1977 living off earnings room prostitutions is illegal.
- Criminal code on trafficking, Summary Offenses Act & Crimes Act are all impediments to HIV treatment, care & support.
- There were major efforts in 2011 to decriminalize consensual sex between adults but the proposal did not progress, however significant advocacy around the issue was a good first step in the right direction as it identified major barriers where more advocacy will be required to pass the law when it is re-tabled.

**Briefly comment on how they pose barriers:**

*Respondents comments:*

- Main obstacle in implementing law is the culture of PNG. Customs are accepted in society & are applied by legal systems. Customary Law frequently takes precedence over Statutory Law.
- Because of the nature of their activities, they cannot come out openly and seek HIV services as they are afraid of prosecution and criminalisation etc.
- If peoples' sexual behaviour is criminalized, they will not go to get services & products for prevention, care & support. MSM and Sex workers may be reluctant to disclose risky behaviours and therefore would not be given the correct risk reduction information.
- Some health care workers may deny treatment if they felt the patient was breaking the law.

**3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?**

Yes	
-----	--

**Briefly describe the content of the policy, law or regulation and the populations included.**

*Respondents comments:*

- Laws that exist are not being enforced well.
- There are laws governing assault that prosecute people who hit other people. Summary Offenses Act covering assault. Laws against violence on women. Criminal Code also includes sexual assault, rape, grievous bodily harm, aggravated assault
- Laws that attempt to side with polygamy (where customary), bride price & dowry - women may face discrimination when at fault. Ownership rights (customary law) - men who treat women like objects (women have no rights).
- There is widespread advocacy to reduce gender based violence but there is a

long way to go for the realization of the crime as the act is so widespread. E.g. GoPNG have implemented a policy that exempts people experiencing family, sexual and gender based violence from paying the 'Fight fee'

- There are provisions in the Matrimonial Act relating to rape within marriage
- The Family Protection Bill is currently being drafted.
- There is a draft National Strategy for Family and Sexual Violence.

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

Yes	
-----	--

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

*Respondents comments:*

- Protection of human rights mentioned in NHS 2011-2015, Medium Term Development Plan & National Gender Equality Policy 2011-2015.
- International obligations, conventions: CEDAW, UNGASS, and Universal Access Declaration also mention human rights related to HIV.
- HAMP ACT 2003, Protects and promotes the rights of those living with HIV AIDS and the Laukitim Pikinini Act.

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

Yes	
-----	--

**IF YES, briefly describe this mechanism:**

*Respondents comments:*

- No Human Rights Commission in PNG to record, document & address cases of discrimination. There has been pressure on PNG to have a Human Rights Commission to assist people whose rights have been violated. The enabling legislation that would allow the establishment of PNG's Human Rights commission has been drafted.
- The court system is expensive & time consuming.
- PNG IDLO currently providing legal assistance for PLHIV & key affected populations. Takes first discrimination case on HIV to court in May 2012. The PNG IDLO does community awareness for human rights
- Other cases on abuse if women have been represented in court already
- The court system is expensive & time consuming.
- Each organisation has their monitoring facilities to capture discrimination cases. Clinics drop-in-centres (Anglicare-StopAids, World Vision, Catholic Services, Hope Worldwide) record cases of discrimination. Discrimination cases also recorded through home based care

- There are several mechanisms available, the main problem is people don't know about them or don't know how to access them. See Part A for details.

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

	Provided free-of-charge to all people in the country	Provided free-of-charge to some people in the country	Provided, but only at a cost
<i>Antiretroviral treatment</i>	Yes		
<i>HIV prevention services</i> <sup>35</sup>	Yes		
<i>HIV-related care and support interventions</i>	Yes		

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

*Respondents comments:*

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

<sup>35</sup>

Such as blood safety, condom promotion, harm reduction for people who inject drugs, HIV prevention for out-of-school young people, HIV prevention in the workplace, HIV testing and counselling, IEC<sup>35</sup> on risk reduction, IEC on stigma and discrimination reduction, prevention of mother-to-child transmission of HIV, prevention for people living with HIV, reproductive health services including sexually transmitted infections prevention and treatment, risk reduction for intimate partners of any of the above three key populations, risk reduction for men who have sex with men, risk reduction for sex workers, school-based HIV education for young people, universal precautions in health care settings.

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

Yes	
-----	--

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

Yes	
-----	--

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

Yes	
-----	--

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

HAMP Act is the law that not only covers people with the virus but also people who are affected by virus & promotes human rights and the National HIV Strategic Plan 2011 – 2015. Both documents supports those affected by HIV.

*Respondents comments:*

- The NHS has and emphasis on having in place user-friendly services accessible by all the KAPs including gender sensitive services. The NHS identifies strategies for risk populations including women and most vulnerable children.

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

Yes	
-----	--

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

*Respondents comments:*

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

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

Yes	No
-----	----

<b>IF YES briefly describe the content of the policy or law:</b>
<p><i>Respondents comments:</i></p> <ul style="list-style-type: none"> <li>• The HAMP Act and all other workplace policies developed by both private and government sectors do not allow for HIV testing prior to employment.</li> <li>• HAMP Act but employers are doing it and nobody is saying anything. Government is going against their own laws.</li> <li>• Immigration (HIV Screening ). There is certainly a perception that immigration requires an HIV test but actually they do not require on for the issuance of a work visa. It is required that there is an HIV test for people who intend to migrate to PNG.</li> <li>• It is the policy of the PNG Defence Force to test all recruits for HIV and in the past there have been cases where a positive test result meant the person would not be recruited. This policy is in contravention to the HAMP Act. If potential recruits wished they could take legal action against the military on the basis of mandatory testing and if they were not recruited on the basis of returning a positive result they could take action for discrimination.</li> </ul>

**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
--	----

<b>IF YES on any of the above questions, describe some examples:</b>
<p><i>Note: Respondents expressed low levels of knowledge on what exists</i></p> <p><i>Respondents comments:</i></p> <ul style="list-style-type: none"> <li>• Law And Justice Sector, Ombudsman Commission monitor and enforce human rights issues.</li> <li>• Ombudsman Commission and also is supposed to ensure that performance indicators for the protection of the Constitutional rights are in place.</li> </ul>

**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)*<sup>36</sup>? 

Yes	
-----	--

b. *Programmes for members of the judiciary and law enforcement*<sup>37</sup> on HIV and human rights issues that may come up in the context of their work? 

Yes	
-----	--

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

a. *Legal aid systems for HIV casework*

Yes	
-----	--

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

Yes	
-----	--

**13. Are there programmes in place to reduce HIV-related stigma and discrimination?**

Yes	
-----	--

<i>IF YES, what types of programmes?</i>		
<i>Programmes for health care workers</i>	Yes	
<i>Programmes for the media</i>	Yes	
<i>Programmes in the work place</i>	Yes	
<i>Other [write in]: Sports (1), Civil Society (1), Churches &amp; FBOs (1).</i>	Yes	

**14. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?**

<sup>36</sup> Including, for example, Know-your-rights campaigns – campaigns that empower those affected by HIV to know their rights and the laws in context of the epidemic (see UNAIDS Guidance Note: Addressing HIV-related law at National Level, Working Paper, 30 April 2008)

<sup>37</sup> Including, for example, judges, magistrates, prosecutors, police, human rights commissioners and employment tribunal/ labour court judges or commissioners



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

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

*Respondents comments:*

- Many organizations, both Private and Public sectors are coming up with policies and regulations on HIV discrimination within their working environment.
- A Major achievement is the breakdown of discrimination and stigma enabling more people to come out as PLHIV, clearly as a result of more awareness.
- Attempt to change laws particularly in the Criminal Code.
- Developed workplace policies for resource entities,
- National conversations/dialogue on legal reforms for KAPS.
- Developed workplace policies for resource entities, converse dialogue as legal reforms for KAPS.
- A growing number of the affected populations know their rights for protection. Populations like MSM, TG and Sex workers.
- Increasing numbers of people from affected populations accessing HIV services.
- Family support centers have been established to provide care of victims. These are generally based in hospitals and are supported mostly through Dept of Community Development.
- RPNGC has established 7 units specifically to respond to Family and Sexual Violence.
- Hospitals and other NGOs are providing the PEP for survivors of sexual assault.
- The major advocacy achieved in trying to pass the law to decriminalise consensual sex between same sex. It helped to make well known the stigma and discrimination faced by MSM, Sex Workers and transgendered in PNG.
- IDLO has now given legal assistance to PLHIV who for example have been fired from work.
- The Office of the Public Solicitor has provided legal aid to PLHIV
- The Village Courts are dealing with increasing numbers of cases related to HIV, but only those that fall into the proscribed offences under the Village Courts Act as they have no jurisdiction under the HAMP Act.

**What challenges remain in this area:**

*Respondents comments:*

- Actual implementation of the policies and laws that are in place and whether the end results are achieved ( Protection of Human Rights ).
- Change attitudes of people towards affected populations through sensitisation programs, awareness programmes and Human Rights programmes.
- Information on the HAMP Act .Simplify legal terms (policies/legislations ) so that key population understand what is for them so that they can easily access services.
- Increase manpower for Human Rights Service Providers to help affected

- populations.
- The weak law enforcement agencies need strengthening to assist key affected populations whose rights have been violated.
- More Political will and Leadership engagements

**15. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?**

<b>Very Poor</b>										<b>Excellent</b>
0	1	2	3	4	5	6	7	8	9	10

<b>Since 2009, what have been key achievements in this area:</b>
<i>Respondents comments:</i> <ul style="list-style-type: none"> <li>• More Human Rights abuse cases been reported to appropriate authorities.</li> <li>• More awareness on human rights by Law and Justice for general population.</li> <li>• More Stakeholders 2011 involved in improving legal rights – CSO in working group to organise the National Dialogue on HIV, Law and Human Rights organised in 2011</li> </ul>
<b>What challenges remain in this area:</b>
<i>Respondents comments:</i> <ul style="list-style-type: none"> <li>• To educate more Papua New Guineans on Human, civil and legal Rights so that they can change their behaviour towards protecting the rights of others</li> <li>• Cultural belief system that still exist with communities in the midst of churches</li> <li>• Political willpower in making firm decisions - this is lacking today. MPs not making 100% personal commitment.</li> <li>• More resources and efforts needs to be put into developing human rights policies.</li> </ul>

**III. PREVENTION**

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

Yes	
-----	--

<b>IF YES, how were these specific needs determined?</b>
<i>Respondents comments:</i> <ul style="list-style-type: none"> <li>• Yes but big caveats. PNG has developed NSP which was incorporated into NHS; however, there are specific needs for specific populations - not enough biological evidence to support key affected groups. Example: Past 3 year’s only one biological study among high risk population sex workers in PNG.</li> <li>• Data were collected and not analyzed properly to give information on specific needs for key affected populations</li> </ul>

<ul style="list-style-type: none"> <li>• What's identified is not what is implemented.</li> <li>• HIV prevention programmes are scaled - up by identifying needs of the communities. FBO's, CBO's, Private Sectors working with Communities.</li> </ul> <p><i>Some comments suggested respondents were not sure on how evidence based programmes are designed.</i></p> <ul style="list-style-type: none"> <li>• Through reports provided by stakeholders and natural forums for HIV trends in PNG. It is also determined at national data collectors workshops.</li> </ul>
<b>IF NO, how are HIV prevention programmes being scaled-up?</b>
<p><i>Respondents comments:</i></p> <ul style="list-style-type: none"> <li>• Lack of prevention programs that specifically target MARPS/KAP's</li> <li>• Recognise there has not been sufficient data in the past to inform prevention programs but it has improved over the last 2 years</li> <li>• There has been a shift away from NACS designed prevention programs to more programs designed at local level and by CSOs</li> </ul>

### 1.1 To what extent has HIV prevention been implemented?

HIV prevention component	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
<i>Blood safety</i>	1	2	4	5	N/A
<i>Condom promotion</i>	4	3	2	1	N/A
<i>Harm reduction for people who inject drugs</i>	4	3	2	1	N/A
<i>HIV prevention for out-of-school young people</i>	4	3	2	1	N/A
<i>HIV prevention in the workplace</i>	4	3	2	1	N/A
<i>HIV testing and counselling</i>	4	3	2	1	N/A
<i>IEC<sup>38</sup> on risk reduction</i>	4	3	2	1	N/A
<i>IEC on stigma and discrimination reduction</i>	4	3	2	1	N/A
<i>Prevention of mother-to-child transmission of HIV</i>	4	3	2	1	N/A
<i>Prevention for people living with HIV</i>	4	3	2	1	N/A
<i>Reproductive health services including sexually transmitted infections prevention and</i>	4	3	2	1	N/A

<i>treatment</i>					
<i>Risk reduction for intimate partners of any of the above three key populations</i>	4	3	2	1	N/A
<i>Risk reduction for men who have sex with men</i>	4	3	2	1	N/A
<i>Risk reduction for sex workers</i>	4	3	2	1	N/A
<i>School-based HIV education for young people</i>	4	3	2	1	N/A
<i>Universal precautions in health care settings</i>	4	3	2	1	N/A
<i>Other[write in]:</i>					N/A

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

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

<b>Since 2009, what have been key achievements in this area:</b>
<p><i>Respondents comments:</i></p> <ul style="list-style-type: none"> <li>• Scaled up accessibility of ART, testing and counselling ,</li> <li>• Condom promotion and blood safety,</li> <li>• Increase in HIV prevention in workplace and youths out school.</li> <li>• Increase in number of people using VCTs</li> <li>• Increase awareness leading to Health Seeking behaviour</li> <li>• Increased knowledge HIV.</li> <li>• Networking with other Stakeholders which helps strengthen the Referral Systems.</li> <li>• More sites for counselling and testing have been made available, rapid testing was introduced.</li> <li>• Curriculum for HIV prevention for out of school youth was implemented for the first time in 2011. Condom promotion and social marketing was apparent.</li> <li>• The PPTCT Operational Plan was launched and the training curriculums were developed</li> </ul>
<b>What challenges remain in this area:</b>

*Respondents comments:*

- Focus HIV programs to most affected population (high risk groups).
- Provide evidence for HIV programs. Evidence should come from biological and behavioral studies.
- More needs to be done for the MARPS populations, also targeting couples instead of individuals to go for VCT to assist further with safe disclosure.
- More emphasis is needed on reducing risks in the vulnerable youth populations.
- PPTCT roll out has been hampered by the many vacant posts within NDOH during the restructure exercise in 2011, 2012 should prove to be much more productive with more staff on the ground to support and the extra assistance being funded by GFATM Round 10 for PPTCT and Paed AIDS.

---

---

## IV. TREATMENT, CARE AND SUPPORT

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

Yes	
-----	--

***IF YES, Briefly identify the elements and what has been prioritized:***

Yes, the NHS has a section dedicated to the Testing, treatment care and support services. Within that point of care rapid testing with an emphasis on PICT, STI and TB services; and increased access for adult and paediatric ART and OI/TB management at the district and local level in high prevalence provinces.

*Respondents comments:*

- Treatment of STI effectively,
- ART with good adherence
- Treatment of opportunistic infections
- Engagement of PLHIV to treat/care for PLHIV
- Accessible services provision-user friendly and non stigmatizing treatment sites.

***Briefly identify how HIV treatment, care and support services are being scaled-up?***

*Respondents comments:*

- The number of ART proscribing sites has increased in past 2 years to 80.
- Number of people started on ART has increased
- Point of care testing, revised treatment guidelines, more sites referring for PCR testing.
- More facilities meeting the national standards
- Improved collaboration with other stakeholders or partners
- Many HBC and family support centers being established by stakeholders- some not funded but initiated by communities.

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

<b>HIV treatment, care and support service</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Disagree</b>	<b>Strongly Disagree</b>	<b>N/A</b>
<i>Antiretroviral therapy</i>	<b>1</b>	2	4	5	N/A
<i>ART for TB patients</i>	4	<b>3</b>	2	1	N/A
<i>Cotrimoxazole prophylaxis in people living with HIV</i>	<b>4</b>	3	2	1	N/A
<i>Early infant diagnosis</i>	4	<b>3</b>	2	<b>1</b>	N/A
<i>HIV care and support in the workplace (including alternative working arrangements)</i>	4	<b>3</b>	2	1	N/A
<i>HIV testing and counselling for people with TB</i>	4	<b>3</b>	2	1	N/A
<i>HIV treatment services in the workplace or treatment referral systems through the workplace</i>	4	<b>3</b>	2	1	N/A
<i>Nutritional care</i>	4	<b>3</b>	2	<b>1</b>	N/A
<i>Paediatric AIDS treatment</i>	4	<b>3</b>	2	1	N/A
<i>Post-delivery ART provision to women</i>	4	<b>3</b>	2	1	N/A
<i>Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)</i>	4	<b>3</b>	2	<b>1</b>	N/A
<i>Post-exposure prophylaxis for occupational exposures to HIV</i>	<b>4</b>	3	2	1	N/A
<i>Psychosocial support for people living with HIV and their families</i>	4	<b>3</b>	<b>2</b>	1	N/A
<i>Sexually transmitted infection management</i>	4	<b>3</b>	2	1	N/A
<i>TB infection control in HIV treatment and care facilities</i>	4	<b>3</b>	2	1	N/A
<i>TB preventive therapy for people living with HIV</i>	4	<b>3</b>	2	1	N/A
<i>TB screening for people living with HIV</i>	<b>4</b>	3	2	1	N/A

<i>Treatment of common HIV-related infections</i>	4	3	2	1	N/A
<i>Other[write in]: Palliative care (1), Hospice care for terminally ill, (1)</i>	4	3	2	1	N/A

**1.2. Overall, on a scale of 0 to 10 (where 0 is “Very Poor” and 10 is “Excellent”), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2011??**

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

<b>Since 2009, what have been key achievements in this area:</b>
<p><i>Respondents comments:</i></p> <ul style="list-style-type: none"> <li>• More cases registered for ART.</li> <li>• Health seeking behaviour has increased.</li> <li>• People have adequate information on HIV so can look after themselves.</li> <li>• Partners of sex workers coming to get HIV Service ( Partner referral).</li> <li>• ART access has improved (with all provinces with sites),</li> <li>• PICT has also strengthened,</li> <li>• VCT access is also improved.</li> <li>• The care and treatment guidelines updated.</li> <li>• Scaling up Provider initiated testing and counselling.</li> </ul>
<b>What challenges remain in this area:</b>
<p><i>Respondents comments:</i></p> <ul style="list-style-type: none"> <li>• Quality of ART service especially linking ART &amp; TB services.</li> <li>• Treatment and care for terminally ill people.</li> <li>• PPTCT has had minimal progress since 2009.</li> <li>• HIV M&amp; E and surveillance capacity has weakened.</li> <li>• Issues with improving/supporting - Treatment adherence, treatment retention, treatment access. i.e. adequate Drug supply.</li> <li>• Limited technical capacity of service providers to fully utilise, mix and match available ARV’s for effective treatment</li> <li>• Need to scale up treatment support to community level. More community based care management services (FHI 360 examples)</li> <li>• HR capacity in NDOH is not sufficient to ensure stock outs do not continue- hopefully this will be addressed in 2012.</li> <li>• More training on PEP is required to ensure implementation.</li> <li>• Drug stock outs reported. Issues of drug movement, supply chain, procurement systems.</li> </ul>

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

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

Yes	
Yes	

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

Yes	
-----	--

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

	No
--	----

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

NK
----

**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 2011?**

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

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

*Note: Answers referred back to Question 2. Not 3.*

*Respondents comments:*

- The training on the Lukautim Pikinini Act is underway and some training roll out for churches working at community level has progressed to try and guide communities on their role in care protection and support of any vulnerable child.
- NHS includes a section on programming to reduce the vulnerabilities of children affected/infected by HIV.
- See answers to 1.2

**What challenges remain in this area:**

*Respondents comments:*

- System strengthening around second-generation surveillance systems will also help guide HIV treatment. However, overall program has being stagnant for past year due to reforms within health sector, the reduced funding from



donors- Global Fund

*Orphans/Vulnerable children*

- Policy is unclear and identification of orphans remains challenges. Less partners working in this area
- Requires more work to ensure HIV partners are aware of the national strategy and policy so that proper referrals can be made. Not enough partners working specifically to protect children and information management is weak.
- Paediatric wards, ANC's , Schools, and churches (places where children may be assessed) are important partners to ensure their roles and responsibilities to the child are well known.