Independent Review Group on HIV/AIDS

Report from an assessment visit
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Prepared by Peter Aggleton, Shalini Bharat, Alex Coutinho, Felecia Dobunaba, Roger Drew and Tobi Saidel

Introduction

To provide a framework within which to tackle the HIV epidemic, the Government of Papua New Guinea (GoPNG) has recently endorsed the National HIV and AIDS Strategy 2011-2015 (NHS). Although this supersedes the National Strategic Plan on HIV/AIDS 2006-2010 (NSP), it builds upon it to intensify efforts to reduce the transmission of HIV and other sexually transmitted infections (STIs), and to minimise their impact on individuals, families and communities. An NHS Implementation Framework and a National Monitoring and Evaluation Framework provide guidance to partners in developing their annual HIV activity plans and budgets, and in measuring progress in implementing the NHS.

An independent and transparent mechanism for the review of the national response to HIV and AIDS – the *Independent Review Group* (IRG) – was established in 2007 for an initial three year period to assess performance and to fulfill the Global Task Team's recommendations for accountability and oversight. The work of the group was extended by the National AIDS Council (NAC) in 2010, for a second three-year period. The IRG conducts a periodic higher-level assessment, reviewing the performance of planned activities against NHS objectives. The IRG reports to the NAC through the NHS Steering Group, after which its reports are made public. The core functions of the IRG are outlined in Appendix 1.

Five reviews have taken place so far.

- In August-September 2007, the IRG conducted an **initial orientation visit** to review the year 2008 Development Budget submission. A report from this visit identified a number of specific priorities to be pursued in each NSP Focus Area (Appendix 2).
- In April 2008, an **interim review of progress** in each NSP Focus Area was carried out together with a baseline assessment of provincial and district response capability and the response of private sector and faith-based groups. The report on this review together with priorities (Appendix 3) was presented to the NSP Steering Group in May 2008.
- A **third IRG review** took place in August-September 2008 and involved a one year-on stock-take of accomplishments since 2007 and a review of the year 2009 Development Budget submission. The review highlighted important areas of progress as well as key priorities to be pursued in 2008-9 (Appendix 4).
- A **fourth IRG review** took place in April-May 2009 to assess further progress in implementation and with a special focus on the education sector; care and support including a focus on orphans and vulnerable children; and options for scaling up the response at sub-national level. IRG priorities from this review can be found in Appendix 5.
- A **fifth IRG review** was undertaken in April-May 2010 to provide a further assessment of progress alongside a review of the development of the National HIV and AIDS Strategy (NHS) 2011-15. In addition, the IRG was asked to comment on processes to strengthen NACS, and on interventions that have the potential to arrest and control the epidemic. Appendix 6 contains the major priorities identified during this visit.

The present review builds upon this earlier work, albeit within the changed architecture of the NHS 2011-2015. The goals of the review were fourfold and involved assessing:

i. progress on implementation of the NHS both with respect to the strategy as a whole and with respect to the top 10 priority areas;
ii. progress in addressing the specific drivers of the HIV epidemic, especially gender based violence and inequality, multiple sexual partnering and economic corridors and enclave development;
iii. provision within the response for work with people who are vulnerable to HIV, in contexts where interventions have the potential to arrest and turn back the epidemic (with a specific focus on youth); and
iv. progress on the restructure and functions of the National AIDS Council Secretariat.

Appendix 7 contains the objectives and scope for the year 2011 review, and Appendix 8 lists the major priorities that have been set.

Six team members participated in the assessment visit. The team leader with overall responsibility for the IRG's work was Professor Peter Aggleton of the University of Sussex, UK. Professor Shalini Bharat (Tata Institute of Social Sciences, Mumbai, India), led the review of activities in NHS Priority Area 1, Prevention. Dr Alex Coutinho (Executive Director of the Infectious Diseases Institute, Makerere University, Kampala, Uganda) led the review of progress in NHS Priority Area 2, Counselling, Testing, Treatment, Care and Support. Felecia Dobunaba (Independent Consultant, Port Moresby, PNG), Dr Roger Drew (Independent Health and Development Consultant, UK) and Dr Tobi Saidel (Independent Consultant, New Delhi, India) took joint responsibility for the review of work within NHS Priority Area 3, Systems Strengthening.

In advance of the visit, an outline programme of activities was developed by the National AIDS Council Secretariat (NACS) on behalf of the NHS Steering Group. This included visits to four provinces (Western Highlands, Simbu, Eastern Highlands and Morobe), as well as meetings with national government departments, development partners, NGO stakeholders and other key players. Over the course of three weeks, it proved possible to talk and conduct interviews with over 170 agencies and individuals (Appendix 9). Additionally, a substantial number of background documents were reviewed (Appendix 10).

This report is structured to address in turn each of the three Priority Areas (PAs) identified by the NHS. After reviewing the current context and progress against NHS objectives in each of these areas, a series of key issues requiring attention are identified, together with IRG priorities for action over the next 12 months.

Progress and Planning by NHS Priority Area

Priority Area 1 – Prevention

A large number of stakeholders in NCD and four provinces were interviewed in relation to Priority Area 1. They included managers in NACS, provincial administrators and PAC staff; officials in UNAIDS, UNDP, UN women and the PNG-Australia HIV and AIDS Program; representatives of faith-based organisations; the BAHA Coordinator; staff in VCT centres;

coordinators and staff of Poro Sapot, PASHIP and Tingim Laip; community volunteers and local theatre group members; PLHIV network members; university faculty and social researchers, and members of the National Council of Women. A meeting also took pace with the Minister of Community Development in connection with the upcoming national dialogue on HIV, Human Rights and the Law.

Current Context

The IRG was pleased to note the enhanced focus on addressing structural drivers of the epidemic in the newly launched NHS. This is in line with the IRG's previous recommendations. The goal of reducing vulnerability and risk to HIV compared to a previous focus only on HIV awareness and behaviour change is particularly welcome. An implementation framework and a user-friendly guide are ready for implementing the prevention strategy. However, orientation workshops for PACs and other stakeholders in the use of the implementation framework are only just beginning to be organised, five months after the NHS launch in December 2010. HIV prevention activity, therefore, is at much the same level as observed on previous visits.

It is of particular concern that HIV prevention among key populations such as sex workers, men who have sex with men and transgender people has not shown any appreciable scale up since the last review. For example, Poro Sapot's prevention work remains small-scale both in terms of numbers of people reached and geographical coverage. Community-based HIV prevention by Tingim Laip is also static, with some sites being non-functional awaiting the roll out of Tingim Laip-2, which is still under development. HIV prevention in some of the economic enclaves is progressing with some encouraging work involving men in improving couple relationships and addressing multiple sexual partnering among the male workforce and in surrounding communities. Condom distribution has strengthened since the last mission with the provinces visited reporting more adequate supply, and a re-branded male condom available from FHI labeled *1taim U*. Many more male than female condoms are being distributed, however, an issue returned to below.

Travel in the provinces revealed a number of missed opportunities for HIV prevention at sites where there is a high convergence of risk. For example, Yang Creek which serves as a halt and recreation point for public service vehicle and truck convoys travelling to and from the Highlands – bringing together mobile men with money, alcohol in all-night food bars, and mobile sex workers – was found not to be covered by HIV prevention programmes at intensity and scale. Similarly, there was little evidence of HIV prevention at Umi market and other market stops along the highway from Goroka to Lae. In general, there seems to be no systematic HIV prevention activity in the informal markets that are the hub of activities in all towns, big and small, and sites where multiple risk factors converge. HIV prevention work, on the other hand, is better organised in hot-spots such as, night clubs, hotels and lodges – but even in these settings it does not have the intensity and coverage required.

Of particular concern is the lack of an enabling environment for HIV prevention. The IRG heard stories of stigma against HIV positive people, attacks on programme staff and police brutality against sex workers and men who have sex with men causing the suspension or slowing down of prevention work in many sites. The IRG also noted the absence of community mobilisation and collective action as strategies for reforming punitive laws and strengthening the agency of marginalised groups.

Another observation was the lack of involvement in HIV prevention by those ciivil society organisations (CSOs) that have been at the forefront of addressing structural drivers of the

epidemic – such as family violence, sexual abuse, rape (including marital rape), and child abuse. The lead taken by the Department for Community Development and a few community groups in organising a national dialogue on HIV, Human Rights and the Law is a very positive development. It is to be welcomed not only for signalling a step towards creating a more enabling environment, but also for the possibility of building greater synergy between CSOs, including the National Council of Women and their networks, for community-based HIV prevention.

Progress against NHS objectives

Despite the implementation of the NHS, annual targets for HIV prevention priority areas have not been set. Assessment of progress on different aspects of prevention remains based on pre-NHS activities. Thus, for example, in line with the objectives under Strategic Priority 1 ('Reduce the risks of HIV transmission'), progress is minimal and limited to only a few objectives. For example, a start is being made in different provinces to employ community-based approaches to increase understanding of local contributing factors, driving forces and behaviours influencing risk of HIV and other STIs. These include Community Conversations in some rural areas, the use of theatre groups including interactive theatre, and the development of media and film production involving local people. Each of these efforts highlights the increased emphasis now being placed in programmes on using community wisdom to identify the local drivers of the epidemic. The downside though is that all of these initiatives are still in a pilot phase and need urgent finalisation and speedy roll out.

No new IEC materials have been produced for use in the multi-media campaigns mentioned as part of major activity under this objective, although Kina 500,000 has been earmarked for the reproduction and printing of new IEC materials in the 2011 development budget submitted by NACS to NAC. Promoting the correct and consistent use of condoms and lubricants among key populations is a key aspect of HIV prevention but no programme indicators are available to assess progress against set targets. Condom distribution has improved since the year 2010 IRG mission but the low number of female condoms distributed (for example, the March-April 2011 BAHA report mentions 2,861,568 male compared to 186,000 female condoms), either suggests an unmet need for female condoms or poor demand, which may be due to indifference in promoting these.

Addressing concurrency of sexual partners is one of the objectives of PSI's behaviour change and condom social marketing project in rural development enclaves, but work is needed to demonstrate the project's impact on partnering behaviour. A recent internal evaluation suggests that the strategy of improving sexual satisfaction in primary relationships and thereby reducing multiple partnering has evoked interest among male participants and a greater appreciation of the associated risks of HIV infection. Importantly, while men in this same study continued to express negative attitudes towards the male condom, some showed an interest in female condoms for partners, which may be exploited in future efforts to promote the female condom.

There remain no specific programmes in relation to reducing risk among the clients of sex workers or other groups who transact sex. In addition to sex workers and men who have sex with men, several other groups at high risk of HIV are inadequately covered by existing HIV prevention. They include children engaged in transactional sex, the clients of male and transgender sex workers, the regular non-paying partners of sex workers, the partners of HIV positive people, mobile men and 'village big men' with money, women vendors, and prisoners.

Progress on meeting the objectives related to vulnerability can be said to be incremental, with gender-related vulnerability increasingly recognised in some programmes. Community-based approaches are increasingly being employed (for example in FHI's CoPCT and Poro Sapot's work in Lae) to engage with gender-based inequality and violence and cultural practices as drivers of the epidemic. COMPASS, a project in Lae for men and boys, addresses gender relations issues through a clinical outreach, advocacy and sexual health services programme. The Safe City Project developed by UN Women is designed to develop interventions for informal markets with a view to addressing the vulnerability of women vendors resulting from threats of rape, violence, abuse and coercion by security staff, thugs and customers. In Lae, the Salvation Army provides shelter to women victims of violence and also skills development to enable women to become economically independent. The establishment of a family desk at the police headquarters in Lae offers an example of how access to the law can be improved for victims of violence, particularly women and children.

The problem, however, is that nearly all of the above programmes are at an early phase of development and therefore need rapid finalisation and implementation across multiple sites. Specific interventions for tackling deep-seated cultural practices that increase HIV risk and vulnerability – including bride price, polygamy and compensation practices – are noticeably lacking. Another critical gap is the absence of initiatives to address economic and political factors contributing to people's vulnerability, especially in new development projects such as LNG and the proposed economic corridors.

Progress in addressing the vulnerability of young people is shockingly slow considering that those aged 15-24 are particularly vulnerable to HIV. Only a handful of programmes target youth in communities, such as the Youth Outreach Project of Save the Children and the COMPASS project in Lae. Youth-friendly information material on sexuality and sexual and reproductive health is increasingly available through work supported by UNICEF and NACS, but there are no indicators to show how many out-of-school youth are being reached with the newly developed materials.

Progress in addressing the special vulnerability of children remains slow although strongly supported by the Lukautim Pikinini Act, 2009 and measures such as the Child Protection manual developed by the Eastern Highlands Provincial Division of Community Development. A focus on most-vulnerable children is evident in Goroka where Family Voice is working with Save the Children to target children in settlements. However, this work currently lacks scale. Of particular concern is lack of services for sexually-abused children for which there is no NHS objective listed. Case reporting from two clinics in Eastern Highlands Province indicates that 44 girls below age 12 were detected with signs of sexual abuse and/or rape, and some of them with STIs, during 2010. Throughout the IRG's mission it was not possible to identify any programmes supporting the parents and communities of especially vulnerable children.

Assessment of progress in relation to HIV prevention with sex workers, men who have sex with men, transgender people, mobile men in economic enclaves and other groups at higher risk of HIV, is difficult given that size estimates are not available. Since the IRG's 2010 visit, there appears to have been little increase in numbers of key populations reached in sites where they are most at risk, such as recreation centres and market places. Although social research is able to guide risk and vulnerability identification, evidence-based programming is slow to develop, with no new programmes reported for key populations beyond those mentioned above.

Stigma continues to be a real barrier to HIV prevention. The UNAIDS Stigma Index has been piloted in four provinces but needs to be finalised and implemented with speed. Programmes with potential to address multiple sexual partnering and male involvement are reported for economic enclave workers but need to demonstrate impact on key outcome variables. Prevention work to address alcohol and drug-related vulnerability is low key and lacks a national policy on harm reduction. Other elements under this cluster are similarly not addressed thus far.

In relation to the creation of supportive and safe environments, progress is limited. The establishment of the PNG Committee on HIV Prevention through Sports indicates some progress towards creating a supportive environment, within this context at least. However, there is little evidence of programmes to address vulnerability in high-risk settings in the run up to the forthcoming 2012 general elections, which is causing major worry among NGOs. Equally lacking is progress on developing HIV prevention interventions in high cash flow areas surrounding LNG sites.

Progress in addressing HIV prevention at the work place is developing, with BAHA and provincial level committees working actively to take the lead. In Lae, for example, the Lae Chamber of Commerce covers port workers and has plans to expand services in view of the LNG project. Work is also underway at NACS to develop interventions for teacher unions in the public sector, although there is concern that this may duplicate work already undertaken by NDoE.

Key issues requiring attention

A number of areas of high risk and vulnerability convergence – characterised by mobility and cash flow, late-night drinking and the availability of sex workers – are being missed in HIV prevention. Prevention work must be intensified in such sites using a comprehensive prevention approach. In the context of upcoming development projects, many more sites of 'high risk convergence' are likely to emerge. Because of this, efforts must be made to ensure that HIV prevention is included in the plans of relevant government departments, for example the Departments of National Planning and Rural Development and the Department of Labour and Industrial Relations.

HIV prevention activities with groups at increased risk, such as sex workers and men who have sex with men, lack scale and intensity in terms of both the numbers and areas reached. There must be significant scale up to reach greater numbers in more sites with more comprehensive prevention activities. Additionally, several groups at risk of HIV are being entirely missed by current prevention programming. HIV prevention needs to expand the definition of vulnerable groups and develop appropriate prevention activities for these hitherto unreached groups.

PNG has a long history of engaging with difficult issues surrounding sexual violence and rape – including marital rape, family violence, child sexual abuse and sorcery – factors that enhance vulnerability to HIV. Yet there is quite inadequate involvement of the National Council of Women, associated CSOs and their networks. Initiatives by these groups have resulted in actions with far reaching consequences such as the inclusion of marital rape in the Criminal Code of PNG in 2003, and the establishment of the Family and Sexual Violence Action Committee in 2000. There should be stronger engagement with community service organisations and the National Council of Women to reach out into communities.

Beyond this, there needs to be an enhanced focus on addressing alcohol and drug use as co-drivers of HIV epidemic. Low condom use is strongly linked to alcohol and drug abuse among men reporting paid sex and/or multiple partners. The use of marijuana was reported to the IRG as being increasingly widespread. Despite this, there is insufficient focus on addressing alcohol and drug use in HIV prevention.

Finally, there should be greater support for the law reform with a view to establishing an enabling and non-threatening environment for HIV prevention work. The process of legal reform, given impetus by the forthcoming national dialogue on HIV, Human Rights and the Law, must be supported with the required financial and other resources, including up to date research evidence where appropriate.

Priority Area 1 – priorities for the next twelve months

Over the next 12 months, HIV prevention work needs to be prioritised as follows:

- Develop actions to address the deeper structural drivers of the epidemic – including harmful cultural practices such as bride price, gender inequality, and domestic and sexual violence – and not merely focus on individual risk.
- Move beyond the piloting of promising prevention approaches to developing and implementing concrete programmes with clear objectives and measurable HIV prevention outcomes.
- Scale up prevention activities with sex workers and men who have sex with men for intensity and coverage, and simultaneously expand to cover other unreached vulnerable groups.
- Create an enabling environment for HIV prevention by intensifying support for legal reform and stigma reduction.
- Increase the 'ownership' of HIV prevention by the groups and communities (sex workers, men who have sex with men and victims of violence) most affected, through support for community mobilisation and collective action through a coalition of partners including government, CSOs and key populations themselves

Priority Area 2 – Counselling, Testing, Treatment, Care and Support (CTTCS)

A large number of stakeholders in NCD and across four provinces were interviewed in relation to Priority Area 2 as well as PPTCT (also addressed in Priority Area 1). They included senior managers in NDoH, WHO, BAHA, faith-based organisations and NGOs. In provincial visits, the IRG visited Mount Hagen Hospital, Minginde Rural Hospital, Goroka Provincial Hospital, Kainantu District Hospital and Angua Memorial Regional Hospital, a number of smaller health facilities, VCT sites and care centres, as well as Tru Warriors in Mount Hagen.

Current context

2006-2010 was a period in which PNG made significant progress in HIV testing, counselling, treatment, care and support. The numbers tested for HIV increased from 4,018 in 2005 to 138,581 in 2010, of which close to 50,000 were among mothers attending antenatal care. Similarly, there was a scale up in numbers of people with HIV started on antiretroviral treatment, from only 320 in 2005 to an estimated 9060 on treatment by the end of 2010. These

tremendous gains were achieved through a combination of factors including an increased willingness to seek HIV testing and treatment; the scale up of counselling, testing and treatment programmes by NDoH, the private sector, faith-based organisations and civil society; capacity development in both numbers and skill-sets of lay and health workers; systems improvement in pharmacy, laboratory and data management; and leadership, passion and commitment from a range of individuals in PNG.

In addition, the scale up of services in Priority Area 2 contributes significantly to HIV prevention (Priority Area 1), since the early detection of HIV enables positive prevention and the prevention of opportunistic infections. Together with ART, this reduces the chances of transmitting HIV to other sexual partners or to unborn children.

The IRG noted much slower progress in making the routine offer of counselling and testing available to patients with STIs, patients with TB, in-patients, and members of groups such as sex workers and men who have sex with men. This has resulted in missed opportunities to offer treatment and care to people living with HIV, as well as to gain their support in positive prevention. As expansion has progressed, there have been challenges within laboratory systems and protocols. These have hindered the rollout of point of care HIV testing using a provider administered 2-test algorithm, and have resulted in extremely irregular and possibly unreliable CD4 counts. Limited ability to detect, prevent and treat TB in HIV positive individuals has also led to poor performance in indicators for TB/HIV co-management.

Until 2010, PNG also had poor performance on the four pillars of PPTCT, but the 2010 STI, HIV and AIDS annual surveillance report indicates some gains in this area particularly in screening women attending ANC and presenting in labour. PNG has also adopted several aspects of international best practice including rapid HIV testing algorithms, the initiation of ART at CD4 < 350 and will soon adopt the new WHO guidelines for PPTCT that will provide HAART to all HIV positive mothers until at least the end of breast feeding. These new approaches ensure better outcomes but do require additional skills as well as accurate and timely laboratory investigations.

In summary, PNG has both scaled up HIV counselling, testing, treatment, care and support services, and built capacity among lay and health workers to sustain the scale up. However there remain several areas in which progress continues to be slow and where there are serious quality concerns both in HIV testing as well as in monitoring those receiving care and treatment.

Progress against NHS objectives

The IRG is pleased to note that the GoPNG has assumed greater responsibility for funding Priority Area 2, especially since the end of GF Round 4 and the unsuccessful GF Round 9 application. In 2010, the IRG urged partners to identify ways to access alternate resources, and the commitment of GoPNG of Kina 6 million for ARVs and an additional Kina 15 million to continue programmes in Priority Area 2 is welcome. This should be increased incrementally over the next five year period. Additional government funds have also been made available to NACS which should ensure that the national response and its co-ordination improve if monies are used prudently. The IRG is also pleased to note a commitment by GoPNG to fund the National Health Plan 2011-2020 for 10 years to the level of Kina 5 Billion. This will greatly contribute to health systems strengthening which is the central to success.

The NDoH has produced a draft operational HIV and AIDS plan 2011-2013 to align with the NHS, ensure performance and meet the national targets to which NDoH contributes. The NHS stresses the importance of Priority Area 2 and PPTCT, and provides clear guidance on targets to be achieved in line with previous IRG recommendations. PNG now has a good five year track record of introducing and scaling up programmes in this area and, so long as leadership and resources are available, partners should be able to provide the planning, execution and management needed to scale up good quality work.

The IRG also welcomes the success of the GoPNG application for GF Round 10. This proposal seeks to consolidate and expand the gains from GF Round 4 as well as scale up PPTCT and programmes to address gender based violence, and build systems capacity. Despite its challenges, GF Round 4 was the key driver and resource provider for scaling up HIV counselling and testing, as well as for ensuring that individuals were able to access care, treatment and support. GF Round 10 will bring its own challenges, but the opportunities and benefits to PNG clearly outweigh these difficulties. Stakeholders should come together now to ensure that the ambitious targets outlined in the application are met and exceeded in the next five years.

There continue to be success stories in PNG that should serve to inspire others. In particular, the country has developed excellent guidelines and operational plans for scaling up PPTCT nationwide and has also documented a successful community-linked PPTCT approach in Minginde Catholic Hospital, show-cased as best practice in the region. Poro Sapot continues to demonstrate how to take services such as VCT and STI treatment to marginalised groups. Given capacity, will and funding, this is a model that is applicable to all urban and highway hotspots in PNG. The work of Susu Mamas in Mount Hagen provides a clear indicator of how high–quality, integrated MCH services will attract large numbers of women and children to services that include STI and HIV management. In Eastern Highlands, work supported by the Clinton Community Health Access Initiative (CHAI) has decentralised quality HIV services to districts, and is a practice worth duplicating elsewhere. The majority of services in this Priority Area are provided by nurses, midwifes and health extension officers, and PNG has demonstrated the tremendous potential of groups such as these to scale up HIV services.

Private sector involvement in Priority Area 2 – though the work of BAHA, the Asian Development Bank HIV/AIDS Prevention and Control in Rural Development Enclaves Project and Oil Search – is best practice of the kind that many countries would love to emulate. PNG needs to take pride in its own grassroots approach to the epidemic but progressively shift the focus to address scale up and quality in Priority Area 2.

Of concern, however, to the IRG is that while the various partners and actors in Priority Area 2 – in particular the NDoH and faith-based organizations – have maintained the gains achieved between 2007-2010, there continues to be unacceptably low performance in HIV testing for persons with STIs and TB, with little progress in TB/HIV co-management, as well as little change in the numbers receiving paediatric HIV treatment. In addition, there remain serious concerns about quality in relation to HIV testing and other laboratory tests as well as in ensuring treatment adherence for those on ART. Evaluations conducted over the last 12 months indicate there is sufficient information and analysis to diagnose bottlenecks. Key individuals affirmed that this is a time for solutions, decisions and implementation, but this will require all stakeholders to analyse the available data and take action.

The IRG visited the Western and Eastern Highland Provinces, as well as Simbu and Morobe. While staff had maintained service levels in 2010 relative to 2008 and 2009, there were common concerns across these provinces. These included increasing STI and HIV patient loads with static or diminished staffing levels; insufficient space with occupational health risks for staff and patients alike; and 'stock-outs' for some drugs and repeated stock-outs of HIV test kits. In addition, there are serious delays in getting HIV reactive results confirmed in provincial labs and most HIV treatment is not monitored with CD4 counts. There appears to be no quality assurance on the ground making many of the laboratory results questionable. In some sites, more than half of initially reactive HIV tests are not confirmed. Beyond this, there are challenges in ensuring drug adherence as well as large numbers lost to follow up or dying in the communities. The absence of viable community support structures (with the exception of Eastern Highlands) results in difficulties taking care and treatment closer to communities and, as noted in earlier IRG reports, there continues to be only sporadic involvement of HIV positive people in service delivery as expert clients or counsellors (with the exception of some modest progress in Goroka and Lae)

The draft 2010 report on STI/HIV/TB in the Highlands Region shows an evolving situation in which the capacity of the Tininga Clinic and the Mount Hagen Hospital laboratory to serve as a regional referral centre is being stretched with insufficient space, insufficient staff, unreliable laboratory testing equipment, large numbers of loss to follow up in adults and children (with more than 50% of pediatric patients lost within a year), and a PPTCT programme that has more challenges than successes. It is also clear there was insufficient frontline supervision at several levels (national to regional, regional to province and provincial to district). A particular area of concern is slow progress in rolling out the 2-test algorithm and the lack of regular quality assurance and quality control at testing sites. The IRG received feedback that the discordance between the initial screening test and the confirmatory test used in the provincial labs (Serodia) is as high as 50%. This requires urgent assessment as it has an impact at patient level as well as on the national surveillance data. The IRG is pleased that the Standard Operating Procedures for the 2-test algorithm was finally released in March 2011 and urges that roll out, including training, supervision and External Quality Assurance, is expedited. Data from Tininga reveal a retention rate of individuals started on treatment of just under 70% and a follow up confirmed that many of those lost were due to failure to return due to travel costs. This was confirmed by community groups who identified transport challenges and nutrition as key problems preventing HIV positive people from accessing treatment and care. Existing resources such as community support groups, aid posts and outreach clinics should be used to bring services closer to the people.

In the Eastern Highlands, the situation is somewhat better as NDoH, the province, the provincial hospital and the Clinton Foundation are working together to take good quality services closer to where people live and there are several innovations in place to improve and maintain case management. In Lae, the service was very well run but frustrated by long delays to confirm HIV reactive results by the provincial lab that was only 100 metres away – sometimes taking up to one month to get a confirmatory Serodia test done. In both Goroka and Lae, CD4 machines had not been operational for the past five months, that in Mount Hagen was performing sporadically, and that in Mendi was also reported not to be working. The CD4 machine in Mingende had not worked for two years. The combination of delayed confirmatory HIV tests and lack of CD4 counts severely affects the quality of patient care and, as mentioned in the previous two IRG reports, is a serious cause for concern.

At the national level, the end of the GF Round 4 and the ongoing restructuring of the NDoH has affected the STI/HIV/AIDS unit with several key staff lost and insufficient funds to support supervisory activities as well as other key functions, like the supply of test kits, the maintenance of CD4 machines and the procurement of some laboratory supplies.

A key focus of the current IRG review is to look at the drivers of the HIV epidemic in PNG. An often unrecognised driver lies in HIV positive people who are unaware of their HIV status and are therefore unable to seek counselling, care and treatment, and receive advice on positive prevention. Other drivers of the epidemic include HIV positive patients who are inadequately managed and either do not start treatment on time or are not adherent or are not properly monitored to detect a treatment failure. Thus failure to scale up and provide quality in Priority Area 2 contributes significantly to the drivers of the epidemic. Globally, there is discussion of whether universal testing and treatment can be a key contributor to HIV prevention. While a universal 'test and treat' approach is not currently appropriate to PNG, it is important to use every opportunity to identify people who are HIV positive and to promote positive prevention (through consistent and proper condoms use, etc) and provide treatment and care which, by improving health and reducing viral load, will add to HIV prevention.

Overall, the situation above does not bode well for the progress of Priority Area 2 in 2011. All stakeholders therefore need to put in place an emergency plan to rapidly correct these bottlenecks if the NHS is to progress as planned. In particular, the quality of programmes in this area, including PPTCT, need to have regular and focused supervision and mentoring with the regular administration of several quality assurance tools in particular for HIV testing, case outcomes, laboratory performance, availability of drugs and test kits, and the quality of data captured.

Key issues requiring attention

There are a number of concerns which if promptly addressed should enable PNG to build upon the gains achieved in Priority Area 2 as well as prepare for the next phase of programme expansion. First, and most importantly, there has been a failure to adequately follow up or act on previous recommendations, reports and evaluations. We were informed by many that the IRG report of May 2010 has not been discussed in a national forum or even disseminated, and yet it contains clear recommendations and guidelines. The IRG also reviewed several documents prepared in the last 12 months that provide good evaluations and advice relevant to Priority Area 2. The IRG is also aware that several of its own recommendations made since 2008 are still pending full action – a case in point being the much delayed national rollout of a 2-test HIV Counselling and Testing (HCT) algorithm. The 2009 report and draft 2010 report from the Tininga Clinic in Mount Hagen hospital contain excellent recommendations made by health workers on the frontline that are relevant to many VCT and ART sites in the public sector and yet the IRG did not see evidence of these recommendations being taken seriously. It is clear that PNG and its frontline providers have a good understanding of its epidemic and also – as articulated in the GF Round 10 application – a good idea of what needs to get done in this Priority Area. What is needed are the skill sets to plan, implement and monitor large-scale programmes with periodic adjustments and the national will to provide resources to the various frontline actors in a timely and responsive fashion.

There are several transition challenges for PNG between the end of GF Round 4 in August 2010 and the start of GF Round 10 in January 2012. While the GoPNG has provided the first tranche of funds to ensure stabilisation of the supply of ART; funding for test kits, human resources and other activities has only just been made available and this delay has led to key

positions in the HIV/AIDS/STI unit becoming unfunded with ensuing discontinuation of staff. There are reported stock-outs of some drugs and test kits in a significant percentage of facilities. Few frontline players are aware of the activities and targets in the GF Round 10 proposal and yet the next six months need to be used to engage, educate and involve providers who will be responsible for delivering these ambitious targets (1,582,930 HIV tests in five years, 15, 658 adults and 2,185 children on treatment, and 80% of all ANC, TB and STI cases receiving HIV tests by the end of 2015). PNG has made significant progress over the last five years and should ensure that this transition period should not jeopardise those gains or kill momentum.

Both NDoH and NACS are undergoing restructuring that has had an impact on human resources and the morale of staff. This in turn can affect programmes and ultimately beneficiaries. At NDoH, there is concern that provincial supervision will be difficult as the result of the exodus of staff from the HIV/AIDS/STI Unit. Departmental leadership should take special efforts to ensure minimal impact on programme performance.

The IRG also received several negative comments on the Global Fund process. NDoH in particular, which stepping down from being Principal Recipient, feels that GF Round 4 required too much 'project mode management' that goes against a system-wide approach. There is also the feeling that the GoPNG can provide funds that are more flexible to achieve the same aims. Nonetheless, credit needs to be given to the gains achieved with GF Round 4. There will be tremendous advantage if PNG achieves the targets set in the GF Round 10 proposal particularly for PPTCT, HCT and care, support and treatment targets including TB. All partners, including the GF secretariat, need to work together to ensure the resources reach those who need them. While the National Health Plan 2011-2020 is welcomed, there needs to be an emergency plan to address key issues over the next 12 months.

Over 50% of the HIV/AIDS response in PNG is driven by the private, civil society and faith-based sectors. Success in Priority Area 2 in particular depends on delivery by faith-based organisations – particularly Catholic Health Services, Anglicare and various NGOs. It was clear on this visit that many of these bodies are challenged by capacity issues and have difficulty generating and interpreting data. The next phase of the response is even more ambitious particularly in terms of coverage and quality, and it is imperative the next 12 months are used to address these capacity challenges in partners and sub-recipients.

Priority Area 2 – priorities for the next twelve months

Overall, the following priorities should be pursued over the next 12 months.

- Ensure the dissemination process for the NHS is expedited and all players contributing to Priority Area 2 and PPTCT are aware of the priorities, targets and approaches, and focus on execution and delivery of services
- Begin the process of engaging all partners responsible for roll out of the GF Round 10 to ensure buy in, commitment and adequate planning to rapidly scale up
- Invest in leadership development and succession planning to ensure the response in PNG continues to be led by visionary leaders with the skill-sets to inspire, manage and innovate
- Invest in and strengthen sub-national service delivery ensuring that resources are made available to the health systems and the provincial structures and that technical

assistance is focused on capacity building, supervision and mentoring that benefit service delivery

- Provide additional focus for those populations and services where there is current underperformance. This should include a nationwide expansion for HIV services for sex workers, men who have sex with men, prisoners, migrant populations (mobile men with money). Poorly performing services like STI treatment, TB/HIV co-management and sexual and reproductive health services should be prioritised and scaled up by all partners
- Develop a risk analysis and management plan for Priority Area 2 and PPTCT to understand key risks and potential bottlenecks in relation to demand for services and gaps in the service provider chain

NHS Priority Area 3 – Systems Strengthening

Within this area there are three inter-related strategic priorities: improving strategic information systems, strengthening the enabling environment for the national HIV response, and strengthening organisational and human capacity for coordinating and implementing the NHS. This section focuses on each of these priorities in turn.

Improving strategic information systems

A large number of stakeholders were interviewed in relation to this strategic priority. They included managers in NACS and NDoH, provincial administrators and PAC staff; officials in WHO, UNAIDS and the PNG-Australia HIV and AIDS Program; representatives of faith-based organisations; staff in VCT centres; coordinators and staff from the Asian Development Bank HIV/AIDS Prevention and Control in Rural Development Enclaves Project, Family Health International, Population Services International, Poro Sapot, Save the Children, the Clinton Foundation and Tingim Laip; as well as university faculty and social researchers from NRI and PNG IMR.

Current context

The new NHS calls for planners and managers at all levels to use strategic information to inform the development and implementation of a strong national response to the HIV epidemic. A weakness in PNG has been the lack of a solid basis for prioritising key populations and locations for prevention and care responses. In the past, there has been a heavy reliance on reported HIV infections to identify priority provinces. However in concentrated epidemics such as those in PNG these data paint an incomplete picture of epidemic potential. It is critical to locate areas of convergence of risk factors (mobility, regular cash flow, sex work, heavily trafficked transport routes, presence of seasonal workers, nightlife, alcohol, etc), and to prioritise these locations for programme interventions on the basis of the volume of risky behaviour, and where possible, biological evidence of high HIV prevalence that suggests the epidemic has already been established in that geographic zone. In some cases, implementing partners have taken the step of conducting rapid risk assessments in selected areas upon which to base programme priorities (e.g. FHI, Poro Sapot). However it is increasingly acknowledged that these discrete exercises do not provide a comprehensive evidence base for planning. A specific example is the Poro Sapot project in Lae, which had capacity to map and do programming in only three of nine districts in Morobe, despite requests from other districts (e.g. Markham) that are clearly in need of prevention services. This type of situation exists in other provinces as well. Strategic information to ensure that the right packages of services are

delivered to the right groups of people with the right levels of coverage is essential for well-designed and well-executed programmes. Without information to set targets and measure coverage, it is not possible for the country to gauge progress, or even to know how much is required to be on-track.

Progress against NHS Objectives

Making better information available for decision making requires that the surveillance unit at NDoH, and the research coordination and M&E units at NACS work together with all their partners, to ensure that a broad spectrum of data is collected, analysed, synthesised, and disseminated. This is at an early stage in PNG, but there are many hopeful signs. The new Tingim Laip project is one example of a large-scale project that plans to strategically expand its intervention coverage on the basis of a widespread mapping exercise across several provinces, designed specifically to locate areas of risk convergence. This is a positive step which will make a significant contribution not only for Tingim Laip, but also for other partners involved in the prevention response. NRI, under their memorandum of understanding with NDoH for behavioural surveillance also plans to map hotspots on the highway between Mount Hagen and Lae. Such efforts should be supported and encouraged by the NACS Research Coordination Unit. AusAID, Poro Sapot, Tingam Laip, PSI, FHI and others all mentioned that they are engaging with NACS on developing and reaching consensus on national indicators. They plan to bring their M&E systems in-line with those indicators to the extent possible. NACS has hired M&E officers in four priority provinces to help build strength for compiling and using data at the provincial level. At the moment, there is a lack of information to help set provincial level targets, but over time, as relationships are built within provinces, this will hopefully change.

During visits to four provinces, the IRG found that in Eastern Highlands Province the ProMest has taken steps to act as a checkpoint for quality control of data from the province before it is sent to the central level. And in Morobe, despite the absence of a well-functioning PAC, the newly hired PAC M&E officer indicated that although there were no stakeholders reporting to the PAC when he arrived 6 months ago, there are now 37 doing so. Although most PACs are focused first and foremost on their 'requirement' to send data to NACS, the Morobe ProMest has taken the initiative to make its own database and compile information that can be used in the province. It is attempting to develop province-specific indicators and with some additional effort and guidance, it aims to develop graphs and charts to provide feedback to stakeholders throughout the province. This will raise awareness about the importance of working cohesively to ensure good coverage. Also in Morobe, one of the key stakeholders (Poro Sapot) is being strengthened under the M&E Learning and Sharing (MELS) initiative of Save the Children. In addition to using monitoring data to look at their numbers and trends, Poro Sapot is grappling with the need to work with targets, and to measure not only the number of people they are reaching, but also the number of individuals they need to reach to make a difference. At the national level, VSO volunteers working under the auspices of NACS, AusAID and UNDP are working with NACS to develop an M&E toolset and revised indicators for the new NHS to be pilot-tested and rolled out this year.

Key issues requiring attention

The response lacks sufficient information for target setting. Although many stakeholders are collecting and reporting quarterly figures on indicators like number of condom dispensers installed and operating, and number of male and female condoms distributed, information about who the condoms were distributed to, and whether that number is sufficient, is universally lacking. It is also difficult to know whether condoms are getting into the hands of

those who most need them, as opposed to those who are convenient to reach. For example, it may be easy to distribute a large quantify of condoms through dispensers at STI clinics. However, this does not ensure that enough condoms will be available to those who need them at the locations where risk behaviour is taking place.

An issue which affects prioritisation of populations and geographic locations for interventions is the use of reported HIV case data for surveillance, as opposed to HIV prevalence data from sentinel sites. In some ways, the reliance on case reporting data is a strong point for PNG, at a time when many countries are looking for alternative approaches that will allow them to collect data at lower cost and make use of other existing systems. However, a key limitation of these data is that the trends reflect the profile of those who are most likely to be tested, which does not reflect the population in a representative way. An additional complication is that many people are not tested in the districts or provinces they live in, which further limits the utility of the data for targeting locations and populations with the highest risk potential. Doing a better job of tracking who is being tested (i.e. district of origin and residence as well as risk profile), will help provide a clearer picture of where and among whom new infections are occurring. These data are currently being captured only for individuals who test positive, except at surveillance sites, where it is captured for everyone who is tested. The latter source could be very useful if it were analysed to understand more about the profile of those being tested. A related issue is that the information collected on risk profile in the past has not been very successful at distinguishing between infections spread through sex work, multiple concurrent partner sex, and same-sex practices, which makes it difficult to use the data to identify the relative contribution of these risk behaviours to the spread of HIV in PNG, (important for prioritising prevention efforts). Improving the surveillance standard operating procedures (SOPs) for this purpose is an area where the expertise in sexual behaviour research developed at NRI could be put to good use.

Many opportunities to use strategic information at the provincial level and by implementers are being lost because staff are not sufficiently empowered to use their own data. When asked what they do with data, most staff in the provinces said that they 'send' it to NACS and NDoH. It is ironic that provinces and programme implementers are so 'disconnected' from the data that they do not perceive that it is primarily intended for their own use. It is also ironic that much of the focus seems to be on problems with data quality rather than on the challenges of using the data. When asked what they would like to do with data, most people felt that it should be used to measure the impact of their programmes. Few had the idea that they could use it to help plan and improve programmes within the province. A provincial data analysis and use training workshop was conducted by NDoH, NACs and several international partners in October 2010 in Goroka, for Eastern Highlands and Simbu Provinces. But participants from that workshop still lack confidence and report being unsure what to do with data. Very basic things are not being done, such as tracking the number of cases relative to the number of tests over time, analysing cases by district of detection and district of origin, analysing the information in the case notification forms on risk profiles, and looking at programme level indicators over time from different districts.

Apart from the capacity issues around strategic information, there are systemic problems that serve as obstacles to effective use of data. Some of these include 1) the lack of data sharing, 2) the lack of a central repository at the provincial level managed by a single entity that has the authority to gather all the data, 3) the failure of collaboration between partners in the provinces, including provincial health, provincial administration, and the ProMEST (who report to NACS), and 4) multiple reporting channels. At the moment, the provincial health office has the authority

to obtain the data from all health facilities, but not the mandate to use the data, other than to pull out information required for the National Health Information System. The ProMEST has the mandate to use the data for the province, but it does not have access to the health data unless there are good relations with key partners, including the Provincial Disease Control Officer, the Provincial HIS officer, and the Laboratory Manager. Efforts to use data for the benefit of the provinces require leadership and collaboration among partners who must meet regularly to discuss, analyse and interpret data.

There continues to be a very serious problem for the HIV case reporting system. An indicator of this is the high number of tests that are HIV-antibody reactive at HIV testing sites, but not confirmed at the provincial laboratory, either because the confirmatory test is never done or because the confirmatory test is negative. This has serious implications for a range of issues, especially the effect of the process on the individuals being tested. It is noteworthy that the problem of false-positive tests is much less pronounced at ANC sentinel sites, suggesting that the increased levels of training and supervision at those sites improves quality. However, even the ANC sites have higher than acceptable rates of false positivity, and in general, quality improvement is still a clear priority.

With the end of GF Round 4 and the Asian Development Bank HIV/AIDS Prevention and Control in Rural Development Enclaves Project, support for many staff at NDoH and NRI will soon be ending. ProMESTs are in a critical stage of development and need a great deal more support to realise their potential. One of the main challenges is that even as the country struggles to strengthen developing systems, the benefits will not be reaped if support from the central level is not maintained. The desire to strengthen the provincial level is laudable, but if done in such a way that central systems collapse, it will defeat its purpose. Other partners (e.g. BAHA, Catholic Health Services or CDC) may be in a position to pick up some of the shortfall.

Strengthening the enabling environment

The views of a range of stakeholders were sought with respect to this strategic priority. They included the Minister for Community Development, members of NAC and the NHS Steering Committee, staff in NACs, provincial administrators and PAC staff, officials in UNAIDS and the PNG-Australia HIV and AIDS Program, representatives of faith-based organisations, staff in VCT centres, coordinators and staff in Save the Children, Tingim Laip, YWCA, PACSO, the Lae Chamber of Commerce, and Igat Hope and its affiliated network.

Current context

As indicated in previous IRG reports, far too little emphasis is being given to the gender dimensions of the HIV epidemic at national and provincial levels as well in relation to local implementation. Without steps to address the special vulnerabilities women and girls face, and without action to ensure women's leadership in the national response to HIV, outcomes will remain limited. Action needs to be taken along the line suggested by the NHS to upscale HIV prevention with women and to enable them to access the counselling, testing, treatment and care that they need.

Igat Hope has reached a milestone in establishing itself legally with national and local representation. Despite support from AusAID, it lacks the funds it needs for capacity building for its affiliated network and for specific programmes and projects. Stronger support needs to be provided to groups such as this, particularly in understanding funding priorities, preparing project proposals and accessing support. Opportunities need to be created for income

generation as a means of supporting and caring for one another. Anecdotal reports suggest that people are having to travel long distances in order to access ART, medication and supplies, which puts enormous strain on individuals and their families. Western Highlands and Eastern Highlands are moving towards providing ART at district level which will greatly ease the burden of access.

Leadership and ownership are central to an effective HIV response. However, the IRG noted that a number of key leaders from various sectors – development agencies, NDoH, UN system agencies, faith-based organisations and civil society – are due to retire, leave the country or take on other responsibilities. Planning is imperative to ensure that successors are identified, and key leadership positions filled to minimise discontinuity. The final draft of the Leadership Engagement Framework is to be welcomed. While leadership at political and organisational levels needs to be built and sustained, equally important is leadership within the family and the community. Churches have a unique role to play by embracing and providing a safe and caring environment for people living with HIV, particularly those who have been violated or brutalised.

BAHA, donors and local organisations continue to mobilise private sector companies to respond to HIV issues. 'Guidelines for Workplace Action to Reduce HIV/AIDS' is an excellent resource to help companies formulate good workplace policies and practice in Lae. The Lae Chamber of Commerce is also partnering with ADRA to provide HIV training to private sector employees, and ADRA also provides Small Enterprise Development funds to people living with HIV, an initiative which needs to be scaled up for others to follow.

Progress against NHS objectives

There exist significant opportunities to strengthen the national response in line with NHS objectives. Opportunities exist to partner with bodies such as the National Council of Women, the National Youth Commission and PACSO to deliver on NHS priorities. Linkage with Trades Unions in relation to HIV is weak, yet unions have the potential to reach substantial numbers of men and women with HIV prevention, treatment, care and support. Links also need to be strengthened between NAC and PAC members and the interests they represent particularly for positive people and women. Strong representations were made to the IRG that the concerns of HIV positive people are not reaching the higher levels. NACS could assist by providing a forum for regular meetings between relevant parties.

The Reference Group on Human Rights initiated and chaired by the Minister for Community Development, has been working on issues of discrimination particularly in relation to halting violence and brutality based on sexual orientation and gender, or against sex workers. An HIV and Law National Dialogue is planned in June 2011, to highlight these concerns. The Reference Group has been successful in seeking the National Executive Council's approval for a judicial reference to the Constitutional Law Reform Commission and, based on these findings, consideration will be given to laws that need to be drafted or reviewed. This however has not yet progressed.

Some further steps have been taken by the Department of National Planning to bring government agencies together with the aim of establishing a National Joint Co-ordination Committee (NJCC), a key national co-ordination mechanism for government. What is promising is participation by the Department of Provincial and Local Level Government and Department of Personnel Management into the Joint Provincial Planning Workshops organized by NACS. Consolidation of these efforts is, however, required to ensure the NJCC is established and operational.

Progress has been made to align with the National Government's broad policy framework and to meet government's objectives for service delivery following a clearer articulation of roles and responsibilities for HIV and AIDS through the Determination Assigning Service Delivery Functions and Responsibilities to Provincial and Local Level Governments. The Director of NACS recently addressed members of the Provincial and Local Level Services Monitoring Authority on new initiatives at provincial level. The initiative gained wide support from PLLSMA members and provincial administrators and led to a directive to work closely with the Department of Provincial and Local Level Government Affairs. Reporting and consulting with the NHS Steering Committee and National AIDS Council is also needed.

At provincial level, the IRG was pleased to see increasing provincial government support for HIV and AIDS, showing clear sign of leadership of the HIV response by both politicians and administration. Several provinces have increased financial, human and other resources to support implementation. In Western Highlands and Eastern Highlands there is a strong push to district level implementation. In Simbu, the provincial administration has taken set up District AIDS Council Secretariats first before establishing DACs. As the NHS states, 'delivering a truly multi-sectoral and decentralised response will hinge on greater integration of HIV in government development frameworks'.

Having said this, some PACs and National Co-ordinating Mechanisms are not operating or are dysfunctional. A process is needed to unblock impediments where they arise. This should include direct intervention by the Director NACS, should other actions fail.

Key issues requiring attention

Against this background, a high priority should be the finalisation and implementation of the draft volunteer policy so volunteers are recognised for their contribution and provided with financial support as well as other incentives. Present arrangements are not sustainable in the medium- to longer-term and there are a variety of models to draw upon in thinking creatively about these issues

Leadership training at community and family levels should be scaled up to provide better support for people living with HIV in their communities. PNG's long tradition of caring for family members should be drawn upon, as part of this work, strengthened and sustained. Through such action it should prove possible not only to enhance support for affected individuals and communities, but stigma and discrimination may also lessen, creating to a more supportive environment for HIV prevention, counseling, treatment and care more generally.

Stronger links are required between NACS and bodies such as the National Council of Women and the National Youth Commission. Such organizations have the potential to reach out to many partners otherwise not involved in the national response to HIV. In establishing these links, the role of the Secretariat should be to co-ordinate and set the agenda in partnership with these organisations, based on the understanding that a strengthened relationship will be beneficial to all parties.

Strengthening organisational and human capacity

Findings under this heading are drawn from an analysis of documents and from discussion with key players including NACS staff, members of NAC, other government agencies, development partners, and other stakeholders. The focus under this aspect of systems strengthening is on

resource allocation and financial management together with progress on the restructure and functions of the National AIDS Council Secretariat

Current Context

The new NHS is an impressive document that reflects a huge amount of work and a high degree of consultation. The identification of ten key priorities is excellent. However, there has, as yet, been no analysis of how budget allocations for 2011 are aligned to NHS priorities. There does not appear to be any plans or mechanism for analysing spending against actual NHS priorities. The continued failure of PNG to produce a National AIDS Spending Assessment remains a major concern for the IRG.

The 2011 budget documents produced by NACS are very weak compared to 2010. They contain a number of significant typographical, calculation and factual errors. Despite the issue being raised previously by the IRG, some key figures continue to be omitted from the budget including funds from Government of PNG (GoPNG) outside of NACS, e.g. through National Department of Health. Overall, the budget available for implementation of the National HIV Strategy in 2011 (K102.6m) is lower than for implementation of the National Strategic Plan in 2010 (K129.6m). Funds available from GoPNG through NACS rose from K16m in 2010 to K26.9m in 2011. Of this, K6.9m is in the recurrent budget and K20m in the development budget. Of the development budget, K10m has not yet been approved by NAC although NACS considers that this budget has been approved by CACC and is already implementing activities in that budget.

There are significant bottlenecks in utilising funds. So, although national-level stakeholders may consider that PNG has adequate financial resources available for its response to HIV, stakeholders at provincial level and within NGOs report that they are starved of funds and the little money they do receive often arrives inconsistently and/or after long delays. Although the introduction of FMIU within NACS has meant that finances are being properly managed and accounted for, NACS has still not developed an effective mechanism for onward granting funds to others, including PACS and NGOs. As stated in our previous report, the IRG concurs with the view expressed in the Tuckwell review that NACS is not able to carry out this onward granting function. The IRG believe that NACS should work with others, e.g. SPSN, to achieve this. It is disappointing to note that no progress has been made on this despite suggesting this in our last report.

Progress against NHS Objectives

One of the top ten priorities within the NHS is to build the capacity of NACS and PACS. In the IRG's last report, we were optimistic because a new NACS Director had been appointed and he had begun to tackle longstanding issues of poor financial management and accountability within the secretariat. As a result, credibility was beginning to be re-established within government and with development partners. Unfortunately, things have not progressed well since then. The restructuring of NACS has been a long and protracted process and has not resulted in the changes that many stakeholders hoped for. Although minuted management team meetings are now being held, the senior management team within NACS remains weak.

There appear to be some discrepancies in the NACS structure as currently operating and as formally approved, there are reported anomalies in procedures for some appointments, and the relationship between NAC and the NACS Director has become severely strained. There are very high levels of frustration about the NACS restructure in provinces, and among NAC members and development partners. NAC has instituted a review of NACS. This represents a

critical, and perhaps final, opportunity to address the issues NACS is facing so that it can be energised to play a constructive role in coordinating the national response to HIV.

The IRG is also concerned that there is no shared understanding of what it means for NACS to have such a coordinating role. Adjustments to the NACS structure, to re-profile the Deputy Director posts as 'prevention' and 'care and support' seem to indicate that the secretariat may be heading back into an implementing role and risks straying into areas that are the responsibility of other actors. Similar concerns arise from analysis of some of NACS plans for its 2011 development budget.

The IRG is very concerned about NACS' capacity to manage effectively and safely the increased financial resources being made available to it from GoPNG. The IRG is particularly concerned that the NACS budget implies a very substantial expansion of the secretariat's role in providing and managing grants, a role for which it is particularly ill-equipped. Although NACS' basic financial functioning has been secured through AusAID funding of an external contractor to manage NACS funds, this support is scheduled to cease at the end of May 2011. Given that NACS has only recently recruited senior finance staff, the major increase in GoPNG funds available to NACS and the announced resignation of the Chair of the NAC Finance Committee, this move seems premature and laden with risk. The IRG would like to see NAC take measures to ensure that its finances are managed well and that there is a proper and planned transition of responsibilities from the current contractor to NACS' own staff.

Key Issues Requiring Attention

The planned review of NACS needs to advise NAC on how the secretariat can be energised to play a constructive role in coordinating the national response to HIV.

NAC needs to ensure that its finances are managed well. Some interim arrangement needs to be established urgently to ensure this after the proposed closure of FMIU at the end of May.

NAC needs to establish an alternative mechanism for grants to be provided to provinces, NGOs and other government departments. The suggestion made by the IRG last year to do this through the SPSN programme needs to be pursued.

Priority Area 3 – priorities for the next twelve months

Overall, the following priorities should be pursued over the next twelve months

Improving strategic information systems

- Establish a national working group on mapping and size estimation to assist the national and provincial levels in quantifying risk and prioritising and setting targets for the HIV prevention response.
- Bring at least four ProMEST teams in priority provinces up to speed in analysing and using data.
- Design and roll out to major HIV prevention partners, a set of national level indicators that are matched to defined packages of services and designed to measure coverage targets among key populations.
- Conduct a full and comprehensive independent review of the reasons for high numbers of reactive but unconfirmed HIV tests.

Strengthening the enabling environment

- Finalise and implement the draft volunteer policy so volunteers are recognised for their contribution and provided with financial support as well as other incentives.
- Develop and scale up leadership training at community and family levels to provide greater support for people living with HIV in their communities.
- Establish stronger links between NACS and the National Council of Women and the National Youth Commission.

Strengthening organisational and human capacity

- In the short-term, the priority for NAC should be ensuring that its finances are managed well by ensuring appropriate arrangements are made following the proposed closure of FMIU.
- In the medium term, the planned review of NACS is critical if the secretariat is to be energised to play a constructive role in coordinating the national response to HIV.
- In the longer term, NAC needs to ensure a safe and reliable way of providing grants to provinces, NGOs and other government departments, e.g. through the SPSN programme.

In conclusion

The present review highlights a number of areas in which there has been significant progress since the last IRG mission. It also provides an opportunity to reflect on progress made in the initial stages of implementing the NHS. In this final section, therefore, key elements of progress will be highlighted together with challenges that present themselves

With respect to Priority Area 1, over the last year the major change has been the publication of the NHS which, building upon the earlier HIV Prevention Strategy, stresses the importance of tackling both social vulnerability and individual risk as drivers of the HIV epidemic in PNG. The major challenge facing all stakeholders lies in changing the nature of their work so as to address vulnerability more systematically (while not neglecting risk) – particularly in relation to gender and age concerns. Numerous opportunities present themselves for doing so, perhaps the most important in terms of closer alliance between NACS and national bodies such as the National Council of Women, the National Youth Commission and their local partners.

But work must also take place with key populations severely affected by the epidemic. These include – in their diversity – sex workers and men who have sex with men, but also embrace populations not hitherto the focus of major HIV prevention efforts, including children engaged in transactional sex, the clients of and regular non-paying partners of sex workers, the partners of HIV positive people, mobile men and 'village big men' with money, women vendors, and prisoners. Some of the work needed includes law reform to establish a safe and enabling environment in which different groups can feel free to seek counseling, testing and treatment. Other actions include ensuring the full range of HIV prevention options, including male and female condoms, are widely available to those who need them, especially in contexts where risk and vulnerability converge as in halts, recreation points, guest houses, and so on.

In relation to Priority Area 2, it is the IRG's impression that some of the substantial gains made over the last few years risk being threatened by current events. In previous reports, the IRG has noted significant scale up in HIV counselling, testing, treatment, care and support. However there remain areas (including counselling and testing for patients with STIs, patients with TB, in-patients, and members of groups such as sex workers and men who have sex with men) in which progress continues to be slow, and there continue to be concerns about quality both in HIV testing (particularly in relation to confirmatory tests) as well as in monitoring those receiving care and treatment.

During the current visit, the IRG noted concern about capacity in both government and non-government provided services. Many services are over-stretched and there are issues of leadership succession to attend to in several key environments. Restructuring within the NDoH threatens to leave a number of central roles unfilled, and some antipathy was encountered towards the GF Round 10 proposal which, even in the presence of major GoPNG funding, will underpin a substantial part of the future counselling, testing, treatment, care and support response. The next six months need to be used to engage, educate and involve providers who will be responsible for delivering the ambitious but appropriate targets set in this proposal. There should be strong focus on those populations and services where there is current underperformance, and investment in sub-national service delivery to ensure that resources are made available to health systems and provincial structures.

Priority Area 3 provides the underpinning for success in Priority Areas 1 and 2. Without good strategic information, an enabling environment and strengthened organizational and human capacity, little can be achieved. Within this area too there is light and shade.

Positively, there is evidence of some strengthening of surveillance and M&E systems, although at both provincial and national levels there is much to be done to help stakeholders (including programme implementers) understand how to analyse and use data to improve the local and national response. Target setting, the prioritisation of populations and geographic locations for intervention, strengthened HIV case reporting, and training in the collection and use of data, are some of the areas in which attention is needed. There also needs to be continuity in staffing, or at least succession management, centrally in agencies such as NDoH if progress over the last few years is to be sustained.

With respect to an enabling environment, and as indicated earlier, the involvement of women and young people in the national and provincial response continues to be weak and urgent steps are needed to strengthen this. Organisations and groups of people living with HIV face financial and organisational challenges, and require support in dealing with these. There is encouraging joint work between NACS and the Department of Provincial and Local Level Government Affairs, and evidence that some provincial authorities are beginning to assume their responsibility for HIV and AIDS. Yet there are many lost opportunities – in relation to work with women's and young people's organizations and trade unions, for example – that must be remedied over the next 12 months.

Finally, there is continued evidence of very poor financial planning and management. The continued failure to produce a National AIDS Spending Assessment is of major concern to the IRG, the year 2011 budget documents produced by NACS are very weak compared to 2010, and there are significant bottlenecks in utilising funds. The restructuring of NACS has been slow and has not yet produced the kinds of changes many stakeholders hoped for. Within this context, the IRG cannot concur with the view that bodies such as NACS should assume a grant

making responsibility, but rather should be part of the process of ensuring that another more specialised body assumes this role. As indicated earlier, the planned review of NACS needs to advise NAC on how the Secretariat can be energised to play a constructive role in coordinating the national response to HIV.

Overall, therefore, there is evidence of continued progress but major challenges remain. The year 2011 provides significant new opportunities for further intensification of the national, provincial, district and local response. Many of the needed policy frameworks, structures and guidance are in place. There are major opportunities to be seized and a willingness to do so on the part of many stakeholders. But there are transitions and reorganisations that may impede progress. By drawing attention to some of these development, the IRG hopes that action can be taken to maintain momentum and increase involvement. The stakes are high and the future of many Papua New Guineans depends upon this.

Appendix 1 Core Functions of the Independent Review Group (IRG)

The core functions of the IRG are to

- Conduct an independent annual review of the performance of the response to HIV from sectors against key indicators of the Monitoring and Evaluation Framework, and to contribute to the periodic higher level of monitoring at an outcome and impact level as detailed in the NHS 2011-2015, UNGASS and Millennium Development Goals. To do this the IRG will:
    - Assess the progress of HIV prevention, care, treatment and support activities
    - Identify constraints and facilitators to implementation
- Assess mechanisms for planning, coordination, stakeholder engagement, resourcing/financing and reporting in relation to implementation of the NHS
- Conduct/collaborate with Development Partners in specific reviews/evaluations of aspects of multi-sectoral performance as requested by the NAC, or through joint NACS/HIV Donor Forum meetings
- Review the consistency of allocations and expenditure against priorities of NHS and their translation into the annual implementation plans
- Assess the effectiveness of donor harmonization/coordination, including the alignment of support among themselves and with Government for national policies, strategies, systems, cycles and plans
- Periodically, assess the quality and adequacy of monitoring and evaluation systems in NACS, identify strategies to strengthen the analysis and collection of data and use of this information.

Appendix 2 IRG identified priorities (September 2007)

Priority for Focus Area 1

- With respect to treatment, counselling, care and support, many programmatic elements are already in place. Still lacking, however, is scale up to all parts of PNG in order to meet the demand for services and to make an impact on the disease. To advance progress, stakeholders should **discuss and agree aspirational targets for Focus Area 1 for one year, and for the entire NSP period**. These should be set (specifying gender and age group) for numbers of people to be tested, numbers of people to start ART, numbers of people to access post-test services, and numbers of support groups for people living with HIV to be established. Target setting should be accompanied by an analysis of the key inputs and systems required to meet targets.

Priority for Focus Area 2

- HIV prevention is key the effectiveness of the national response. However, existing programmes do not address the cultural realities sufficiently well. Additionally, they are not informed by prevention approaches that have worked in other contexts and have been documented as best practices in HIV prevention. To advance progress in this focal area the next step should be to **begin a process to rapidly develop a strategic framework to intensify a comprehensive approach to HIV prevention using the UNAIDS prevention guidelines**

Priority for Focus Area 3

- Priorities for the establishment of effective and efficient surveillance systems should include **rapid endorsement of the National Surveillance Plan, a detailed work plan and clear lines of responsibility and accountability.** While surveillance systems are strengthened, planning for a population-based bio-behavioural survey to complement and complete the present understanding of the epidemic should be a priority.

Priority for Focus area 4

- The process of expanding social and behavioural research to underpin an evidence-informed programmatic response has begun. However, this will not ensure good quality, robust research unless efforts are also made to strengthen the capacity of local researchers and most importantly to increase their numbers significantly. The priority therefore should be to **create a capacity development plan for social and behavioural change research** that should include training and mentoring of postgraduate students and faculty in colleges and universities; strengthening research capacities within selected institutions and NGOs; and creating a national network to promote visibility of local leadership in research.

Priority for Focus Area 5

- Given the key role which NACS must play in supporting the implementation of the NSP and coordinating the national response to HIV and AIDS, it is of fundamental importance to quickly strengthen systems and structures within this organisation. To advance progress in this respect, action needs to be taken to **ensure clear lines of responsibility and accountability within NACS, an organisation that can deliver on the NSP, and a transparency of operation** which wins respect from partners and stakeholders. We believe that significant progress can be made on each of these fronts prior to April 2008.

Priority for Focus Area 6

- A legal framework exists to protect HIV positive people who are open about their status and active in communities. What is now required is an environment to support PLWHA and community volunteers to mobilize and provide awareness and services in rural areas. A key target therefore should be to **identify, support and strengthen groups of people living with HIV in each province to run an empowered network.** Concrete efforts should be made to link these networks of people living with HIV to community support groups, NGOs and faith-based organisations to ensure sustainability of approaches and respect of the rights of network members themselves.

Priority for Focus Area 7

- A functioning M&E system is essential to delivery on the NSP. The National HIV and AIDS Monitoring and Evaluation Plan and the recent UNAIDS sponsored assessment with its accompanying recommendations provide a framework for action but also demand strong leadership, experience, management skills and staffing. That management skill and M&E expertise is currently lacking. **Strengthening management capacity through the addition of trained and experienced staff and close monitoring by NAC, the NSP Steering Committee and NACS** should be priorities over the next six months.

Priority for Resource Allocation and Financial Management

- For there to be an effective national response to HIV and AIDS in Papua New Guinea, resources need to be prioritised appropriately and used effectively. Given NAC's recognised position as PNG's National AIDS Authority, the Council and its Secretariat have pivotal roles to play in this regard. Yet, their capacity in these areas has not expanded to keep pace with the rapid growth in availability of financial resources. A critical step to address this would be **for NAC to establish a Finance Sub-Committee, with clear terms of reference and members with appropriate skills,** to ensure initially that NACS reports appropriately for all funds that it receives and, over time, to ensure that financial resources are being prioritised appropriately for an effective national response to HIV and AIDS in PNG.

Appendix 3 IRG identified priorities (April 2008)

Priority for Focus Area 1

- With respect to treatment, counselling, care and support, and to bring about a significant enhancement in the quality and consistency of services provided, a **national quality assurance system for HIV testing, counselling, treatment and care should be established**. This should include regular site level supervision and follow up.

Priority for Focus Area 2

- In its previous report, the IRG commented on the absence of a comprehensive HIV prevention response in line with internationally recognized principles of good practice. The preparation of a draft *National HIV Prevention Strategy* is a major step forwards. To advance progress in this focal area **this strategy needs to be discussed, finalised and endorsed by NAC**. An implementation plan in line with NSP objectives should be prepared.

Priority for Focus Area 3

- The IRG's September 2007 report pointed to the need for rapid endorsement of the National Surveillance Plan. By way of follow up to this, an **actionable joint NDoH-NACS-NHIS implementation plan should be prepared** for provincial surveillance, health and M&E data collection. Beyond this, it is important to review the timeline and feasibility of starting the population-based bio-behavioral survey in order to inform the next NSP planning cycle.

Priority for Focus area 4

- Some good progress has been made within the field of social and behavioural research with a capacity assessment stocktake and the development of a National Research Plan. However, impetus must not be lost within this vitally important field. A NAC endorsed **implementation plan should therefore be prepared for social and behavioural research**, which includes clear priorities, targets and timelines

Priority for Focus Area 5

- Leadership at all levels is central to the effectiveness of any national response towards HIV and AIDS. To facilitate this, there should be significant strengthening in leadership through the **appointment of Chairman and members of NAC, the establishment of a National Joint Coordinating Committee, and the establishment of a full PACSO secretariat**

Priority for Focus Area 6

- There exists a wealth of experience at family and community level to mount a positive and supportive response to HIV and AIDS. Church and community groups, together with the business sector and organisations of people living with HIV, have much to learn from one another. **Stakeholders with frontline experience of engaging families and communities should meet, share experiences and results, and develop appropriate approaches for PNG**

Priority for Focus Area 7

- Focus Area 3 highlights the need for an actionable joint NDoH-NACS-NHIS implementation plan for provincial surveillance, health and M&E data collection. Linked to this, and to take advantage of NACS restructuring, there is a need to **appoint competent management in the form of trained and experienced professionals to implement the national M&E plan** and to ensure the provision of regular information to stakeholders

Appendix 4 IRG identified priorities (September 2008)

Priority for Focus Area 1

- There should be a rapid development and implementation of the quality assurance plans included in the NDoH Health Sector Strategic Plan for STI, HIV and AIDS

Priority for Focus Area 2

- As a matter of urgency, the draft National HIV Prevention Strategy should be discussed, finalised and endorsed by NAC. An implementation plan in line with NSP objectives should be prepared

Priority for Focus Area 3

- Coordinated province-specific capacity development plans should be established between NACS, NDoH, NHIS for surveillance and monitoring and evaluation at the provincial level. These should address manpower needs, training, local data use, communication and funding

Priority for Focus Area 4

- The national research agenda should be implemented with the goal of commissioning social and behavioural research studies in each prioritised area

Priority for Focus Area 5

- There should be significant strengthening in leadership through the appointment of chair and members of NAC and the establishment of a National Joint Coordinating Committee

Priority for Focus Area 6

- Specific and measurable targets should be established for the meaningful involvement of people living with HIV and their families in individual and family counselling, home-based care, and in all aspects of the prevention-to-care continuum

Priority for Focus Area 7

- Coordinated province-specific capacity development plans should be established between NACS, NDoH, NHIS for surveillance and monitoring and evaluation at the provincial level. These should address manpower needs, training, local data use, communication and funding

Priority for Resource Allocation and Financial Management

- NACS should establish a clear, step-based timetable for completing the restructuring process. This should then be implemented with the aim of producing a well-managed and high performing organisation able to effectively coordinate the national response to HIV and AIDS in PNG

Appendix 5 IRG identified priorities (May 2009)

Priority for Focus Area 1

- Provinces should work together across boundaries to develop good quality scale-up plans supported by decentralized NDoH technical support, pooled resources and a reference laboratory

Priority for Focus Area 2

- The National HIV Prevention Strategy should be finalised and endorsed by NAC. An implementation plan should be speedily prepared

Priority for Focus Area 3

- The National HIV Surveillance Plan should be revisited to ensure that key questions regarding where new infections are likely to come from and how the direction of the epidemic is changing in different parts of the country can be understood

Priority for Focus Area 4

- The research capacity development plan for HIV-related social research should be implemented

Priority for Focus Area 5

- The assigned functions and responsibilities for HIV and AIDS at national, provincial and local level should be approved, and the creation of a separate function grant for HIV and AIDS is to be encouraged

Priority for Focus Area 6

- In order to enhance continuity of care in families and communities, current and new community and PLWHIV initiatives should be mapped with a view to building their resources and capacities and linking them to testing, care and treatment sites

Priority for Focus Area 7

- Coordinated province-specific capacity development plans should be established between NACS, NDoH, NHIS for surveillance and monitoring and evaluation at the provincial level. These should address manpower needs, training, local data use, communication and funding

Priority for Resource Allocation and Financial Management

- NAC should persist in vigorously addressing the severe management problems in NACS. The focus on appointing a NACS Director is appropriate. But, if this is further delayed, NAC might consider establishing a one year Transition Management Unit, using a similar model to that for FMIU. This would need a strong and clear mandate from NAC to (i) establish a lean and effective central secretariat; (ii) decentralise PACs to provincial administrations; (iii) establish effective small grants programmes in high prevalence provinces

Appendix 6 IRG identified priorities (May 2010)

Priority for Focus Area 1

- There should be a further scale up of HIV testing with a particular focus on higher prevalence areas, most-at-risk groups, STI and TB cases and pregnant women in order to give a human face to the epidemic, identify needs for care and treatment, and provide needed strategic information. In particular, PITC should be rolled out to 80% of the health facility testing sites within one year

Priority for Focus Area 2

- A National HIV Prevention Taskforce should be set up and an implementation plan to roll out the National HIV Prevention Strategy should be developed as quickly as possible

Priority for Focus Area 3

- The Surveillance Technical Working Group (STWG) and other partners should take advantage of the large collection of data available in the country (e,g. social mapping studies, BSS, IBBS, DHS, surveillance data and other *ad-hoc* investigations) to conduct an evidence-based geographic prioritisation of the response, which should also inform the design of the new surveillance plan under the NHS.

Priority for Focus Area 4

- There should be a speedy implementation of the revised social research capacity development plans to help both junior researchers and university academics undertake high quality HIV research. A second wave of social research studies should be funded.

Priority for Focus Area 5

- A collective and concerted effort needs to be made by stakeholders in the public sector to address HIV. The initiative by the Department of National Planning in conjunction with NACS and other key departments to kickstart discussions on the need for a public sector response is a positive way forward. An agreed set of procedures and a working agenda should be ready by the IRG's next review mission in 2011.

Priority for Focus Area 6

- Efforts to the development of HIV+ networks, community and family engagement and the continuum of services from facilities to communities, need to be expanded to achieve at least 50% geographical coverage in the highlands and NCD, and significant presence in other provinces. This should help 'personalise' the epidemic, reduce stigma, increase demand for HIV prevention, care and treatment, and provide support structures, particularly for care and treatment adherence

Priority for Focus Area 7

- NACS and development partners should ensure that an effective monitoring and evaluation system is prepared for when the NHS is rolled out. NDoH, in partnership with NACS, should start to publish mini-reports laying out the basics of what is known about the nature and progression of the epidemic in each province

Priority for Resource Allocation and Financial Management

- NAC and the NACS Acting Director should persist in vigorously addressing the severe management problems in NACS. There is an urgent need for a skilled and motivated senior management team that is able to establish and lead a high-performing staff team in NACS. Bottlenecks in assembling this team need to addressed to ensure the team is in place by the IRG's next mission in April/May 2011

Appendix 7 Objectives and scope of work for 2011

The following objectives for the IRG's work in 2010 were identified by the NHS Steering Group:

- Assess progress on implementation of the NHS both with respect to the strategy as a whole and with a special focus on the top 10 priority areas

- Assess progress to addressing the specific drivers of the HIV epidemic, especially:

    - gender based violence and inequality
    - multiple partnering
    - economic corridors and enclave development

- Review provision within the response for work with people and contexts that are vulnerable to HIV, and where effective interventions have the potential to arrest and turn back the epidemic, with specific focus on young people.

- Assess progress on the restructure and functions of the National AIDS Council Secretariat and provide guidance on its role in policy development and best practice guidance, coordination, monitoring and evaluation and the provision of technical assistance.

Appendix 8 IRG identified priorities (May 2011)

Priority Area 1

Over the next 12 months

- Develop actions to address the deeper structural drivers of the epidemic – including harmful cultural practices such as bride price, gender inequality, and domestic and sexual violence – and not merely focus on individual risk.
- Move beyond the piloting of promising prevention approaches to developing and implementing concrete programmes with clear objectives and measurable HIV prevention outcomes.
- Scale up prevention activities with sex workers and men who have sex with men for intensity and coverage, and simultaneously expanded to cover other unreached vulnerable groups.
- Create an enabling environment for HIV prevention by intensifying support for legal reform and stigma reduction.
- Increase the 'ownership' of HIV prevention by the groups and communities (sex workers, men who have sex with men and victims of violence) most affected, through support for community mobilisation and collective action through a coalition of partners including government, CSOs and key populations themselves

Priority Area 2

Over the next 12 months

- Ensure the dissemination process for the NHS is expedited and all players contributing to Priority Area 2 and PPTCT are aware of the priorities, targets and approaches, and focus on execution and delivery of services
- Begin the process of engaging all partners responsible for roll out of the GF Round 10 to ensure buy in, commitment and adequate planning to rapidly scale up
- Invest in leadership development and succession planning to ensure the response in PNG continues to be led by visionary leaders with the skill-sets to inspire, manage and innovate
- Invest in and strengthen sub-national service delivery ensuring that resources are made available to the health systems and the provincial structures and that technical assistance is focused on capacity building, supervision and mentoring that benefit service delivery
- Provide additional focus for those populations and services where there is current underperformance. This should include a nationwide expansion for HIV services for sex workers, men who have sex with men, prisoners, migrant populations (mobile men with money). Poorly performing services like STI treatment, TB/HIV co-management and sexual and reproductive health services should be prioritised and scaled up by all partners

- Develop a risk analysis and management plan for Priority Area 2 and PPTCT to understand key risks and potential bottlenecks in relation to demand for services and gaps in the service provider chain

Priority Area 3

Overall, the following priorities should be pursued over the next twelve months

Improving strategic information systems

- Establish a national working group on mapping and size estimation to assist the national and provincial levels in quantifying risk and prioritising and setting targets for the HIV prevention response.
- Bring at least four ProMEST teams in priority provinces up to speed in analysing and using data.
- Design and roll out to major HIV prevention partners, a set of national level indicators that are matched to defined packages of services and designed to measure coverage targets among key populations.
- Conduct a full and comprehensive independent review of the reasons for high numbers of reactive but unconfirmed HIV tests.

Strengthening the enabling environment

- Finalise and implement the draft volunteer policy so volunteers are recognised for their contribution and provided with financial support as well as other incentives.
- Develop and scale up leadership training at community and family levels to provide greater support for people living with HIV in their communities.
- Establish stronger links between NACS and the National Council of Women and the National Youth Commission.

Strengthening organisational and human capacity

- In the short-term, the priority for NAC should be ensuring that its finances are managed well by ensuring appropriate arrangements are made following the proposed closure of FMIU.
- In the medium term, the planned review of NACS is critical if the secretariat is to be energised to play a constructive role in coordinating the national response to HIV.
- In the longer term, NAC needs to ensure a safe and reliable way of providing grants to provinces, NGOs and other government departments, e.g. through the SPSN programme.

Appendix 9 List of Persons Interviewed

Sir Peter Barter	Chair, NAC
Rod Mitchell	NASFUND/BAHA and member of NAC
Sister Tarcissia Hunhoff	National Catholic AIDS Office and member of NAC
Lady Roslyn Morauta	Member of NAC
Clement Malau	Secretary, NDoH and member of NAC
Wep Kanawi	Director NACS
Moale Kariko	Deputy Director, National Care and Support, NACS
Philip Tapo	Deputy Director National Prevention Strategy, NACS
Michael Aglua	Manager, Corporate Services, NACS
Moses Kaigu	Manager, Policy and Planning, NACS
Sil Bolkin	Policy Planning Coordination, NACS
Joseph Mage	Manager, Human Resources, NACS
Victor Aisa	Manager, Finance, Administration and Procurement, NACS
Danny Beiyo	Monitoring and Evaluation, NACS
Julie Airi	Manager, Research, NACS
Valentine Tangoh	Regional Manager, Momase
Wilfred Kaleva	Research Coordination Unit, NACS
Tony Lupiwa	Research Coordination Unit, NACS
Ishmael Roberts	Provincial Liaison Officer, NACS
Ruth Beriso	Senior Policy and Planning Coordinator (Gender and Special Interest Groups), NACS
Martha Somo	Grants Officer, NACS
Lady Mina Siaguru	Independent Expert
Kirsty Laird	Manager, Deloitte
Dianne Peliokai	Assistant Manager, Risk Management Services, Deloitte
Rosa Tolewa	FMIU Team Leader, Deloitte
Dame Carol Kidu	Minister for Community Development
Julius Wargirai	Director, Performance Management Division, Department of Provincial and Local Level Government Affairs
Wayne Trappett	Adviser, Department of Provincial and Local Level Government Affairs
Esorem Daoni	Principal Technical Adviser STI/HIV/AIDS, NDoH
William Lagani	Manager, Family Health Services, NDoH
Fumihiko Yokota	Epidemiologist, ADB/NDoH Surveillance Unit
Stuart Watson	Country Coordinator, UNAIDS
Peterson Magoola	HIV/AIDS Programme Specialist, UNDP
William Adu-Crow	WHO Representative
Ali Feizzadeh	M&E Advisor, UNAIDS
Fabian Ndenzako	HIV Country Officer, WHO
Agatha Lloyd	Medical Officer, WHO
William Louis Gomes	Health Laboratory Specialist, WHO
Christie Moff	Chief HIV Specialist, UNICEF
Julie Bukikun	Country Programme Coordinator, UN Women
Maura Elaripe	Gender Equality and HIV Project Coordinator, UN Women
Stephanie Copus-Campbell	Minister-Counsellor, AusAid
Anne Malcolm	Senior Program Coordinator, PNG-Australia HIV and AIDS Program
Ninkama Moiya	HIV and AIDS Adviser, PNG-Australia HIV and AIDS Program
N'ik Plange	HIV Policy Adviser, PNG-Australia HIV and AIDS Program
Abraham Opito	Adviser, PNG-Australia HIV and AIDS Program
Angela Mandie-Filer	Gender and Social Development Adviser, PNG-Australia HIV and AIDS Program
Thomas Gowa	Manager, NGO Partnerships, PNG-Australia HIV and AIDS Program
Terry Opa	Knowledge Management & Communication, PNG-Australia HIV and AIDS Program

Jennifer Miller	Tingim Laip Coordinator, Madang
Jeremy Syme	Manager, ADB HIV/AIDS Prevention and Control in Rural Development Enclaves Project
Tania Olewale	Executive Officer, Clinton Health Access Initiative
Andrew Carmone	Director of Rural Programmes, Clinton Foundation
Dimitri Prybylski	US Centers for Disease Control, Bangkok
Cynde Robinson	Country Representative, Population Services International
Shiv Nair	Country Director, FHI, PNG
Ben	M&E Volunteer, VSO
John Mooney	Independent Consultant
Shane Martin	Independent Consultant
Peter Barron	Independent Consultant
Holly Aruwafu	HIV Behavioural Surveillance Specialist, National Research Institute
Francis Kupe	Researcher, National Research Institute
Angie Amos	Researcher, National Research Institute
Hene Meke	National Director, Anglicare PNG
Esiah Eino	Deputy Director, Anglicare PNG
Brenda Andreas	M&E Officer, Anglicare PNG
Lista Wayo	Centre Manager, Marie Stopes, Port Moresby
Christopher Hershey	Programme Manager, Poro Sapot
Annie McPherson	Coordinator, Igat Hope
Kenneth Igo	Igat Hope
Sam Wala	Igat Hope
Lucy Ravu	WABHA, Board Member
Linda Hoh	Gadona, NCD
Niton Daniel Akuia	President, Friends Ministry Association, Inc
Freddy Simo	Friends Ministry Association, Inc
Rory Sitapai	Friends Foundation
Pana Sitapai	Friends Foundation
Gabby Ranu	Friends Foundation
Tania Olewale	Executive Officer, Clinton Health Access Initiative, PNG
Schola Kakas	President, National Council of Women, PNG
Lily Tua	General Secretary, National Council of Women, PNG
Dickson Kiragi	Programme Coordinator, National Council of Women, PNG
Malcolm Culligan	Provincial Administrator, Western Highlands Province
Pym Mamindi	Deputy Provincial Administrator, Western Highlands Province
Philip Talpa	Provincial Health Adviser, Western Highlands Province
Elizabeth Aveling	Provincial HIS Officer, Western Highlands Province
Petronia Kaima	Regional Medical Officer Surveillance, Western Highlands Province
Mark Dupi	Provincial TB/HIV Response Coordinator, Western Highlands Province
James Koi	Chairman, PAC, Western Highlands Province
Joshua Meninga	HRC, PAC, Western Highlands Province
Apollos Yimbak	Care, Counselling and Training Coordinator, PAC, Western Highlands Province
Ruth Mark	M&E Officer, PAC, Western Highlands Province
Giri Kombati	Chair, ProMEST, Western Highlands Province
Davida Strojek	VCT Coordinator, Catholic Health Services, Rabiamul
Augustine Misak	Theatre Group Director, Mount Hagen
Michael Pagasa	HIV Projects Manager, Baptist Union
Steven Taka	President, Tru Warriors, Western Highlands Province
Teresita Waki	Team Leader, Susu Mamas, Western Highlands Province
Caroline Ninnes	Project Director, Susu Mamas, Western Highlands Province
Maggie Numdee	Secretary, MMS Lodge, Tingim Laip Entertainment setting, Mount Hagen
Robert Noke	Chairman, MMS Lodge, Tingim Laip Entertainment setting, Mount Hagen
Thomas Ten	Chairman, Whagi Transport, Tingim Laip setting, Western Highlands Province
Kelly Kumbra	Deputy Chair, Whagi Transport, Tingim Laip setting, Western Highlands Province
Bob Neringa	Treasurer, Whagi Transport, Tingim Laip setting, Western Highlands Province
William Pena	Kennan Care Centre, Western Highlands Province
Allan Kuma	Care and Counselling, Anglicare, Western Highlands Province
Steven Kiap	Anglicare, Western Highlands Province

Gilman Ivana	EPA Coordinator, Anglicare, Western Highlands Province
Kuni Kizeafa	VCCT Coordinator, Anglicare, Western Highlands Province
Cliff Rombok	Operations Manager, Anglicare, Western Highlands Province
Mary Grai	Officer in Charge, Homebase Care, Diugl Village, Simbu Province
Maria Waigl	Community Leader, Diugl Village, Simbu Province
Tiukee, Agatha, Joyce, Poiro, Gerta	People living with HIV, Diugl Village, Simbu Province
John Rasta and team	Iginem Theatre Group, Simbu Province
Michael Avirap	Commander, Barawagi Jail, Simbu Province
Harry Raepa	Welfare Officer, Barawagi Jail, Simbu Province
John Bolken	Aid Post Orderly, Barawagi Jail, Simbu Province
Nick Appa	HRC, Simbu PAC
Georgina Gende	KBE, Simbu PAC
John Bagel	M&E Officer, Simbu PAC
Margaret Ghunn	STI Coordinator, Mingende Catholic Health Centre, Simbu
Eileen Alolo	PPTCT Coordinator, Mingende Rural Hospital, Simbu
Marie Mondu	Caritas Australia, Mingende Rural Hospital, Simbu
Munare Uyassi	Provincial Administrator, Eastern Highlands Province
Moale Vagi-Kapi	Provincial Representative, AusAid, Eastern Highlands Province
Robert Kokao	Superintendent, Basic Education, EHP
Ruth Paliau	HRC, Eastern Highlands Province
Thomas Koimbo	Chairman, PAC, Eastern Highlands Province
Mary Drua	HIV Provincial Coordinator, Eastern Highlands Province
Jackson Appo	Provincial Health department, Chair, ProMEST, Eastern Highlands Province
Gabriel Aglua	M&E Officer, PAC, Eastern Highlands Province
Takeso Totaya	Counselling and Care Coordinator, PAC, Eastern Highlands Province
Angela Soso	President YWCA and PAC member, Eastern Highlands Province
Theresa Palau	Laboratory Manager, Goroka Base Hospital, Eastern Highlands Province
Helen Pok	Sister in charge, ANC Clinic, Goroka Base Hospital, Eastern Highlands Province
Prahlad Kumar Rana	Programme Manager, PASHIP, Save the Children, Goroka
Ghanshyamsinh Jethwa	Programme Manager, HIV/AIDS, Save the Children, Goroka
Sonia Gawi	Acting Senior Project Officer, PASHIP and Tingim Laip, Goroka
Tobi Mondia	Tingim Laip Training Officer, Goroka
Suzie Wahasoka	Senior Project Officer, Poro Sapot, Goroka
Peter Siba	Director, IMR
Claire Ryan	Team Leader, HIV/STI Laboratory, IMR
Andrew Vallely	Senior Research Fellow, IMR
Michael Mel	Pro-Vice Chancellor, University of Goroka
P Jeyarathan	Dean of Science, University of Goroka
Verena Thomas	Project Coordinator, Komuniti Tok Piksa, University of Goroka
Klimit Bary	Project Administrator, Komuniti Tok Piksa, University of Goroka
Alice Kauba	HIV Course Coordinator, University of Goroka
Angela Kaup	President, Minivava, Goroka
Charlie Mike	Vice-President, Minivava, Goroka
Ruth Teta	Minivava, Goroka
Kamana Onio	Acting Director Nursing Services, Kainantu Rural Hospital
Rhoda Eliab	HEO in charge STI/HIV/AIDS, Kainantu Rural Hospital
Felix Karpai	Health Extension Officer, Gusap Health Centre
Maggie Adam	STI/HIV Clinic Gusap Health Centre
Jimmy Asing	Retired Health Worker, Zero Tavern Tingim Laip Site, Morobe
Patilius Gamato	Deputy Provincial Administrator/Chairman PAC, Morobe
Steven Yafaa	Senior Project Officer, Poro Sapot, Lae
Emma David	Project Officer, Poro Sapot, Lae
Florence Momo	Counsellor, Poro Sapot, Lae
Ben Wakepi	Salvation Army, Lae
Albert Kaupa	HIV/AIDS Team Leader, Salvation Army, Lae
Grace More	Social Worker, Salvation Army, Lae
Nellie McLay	National Team Leader, Mobilising the Private Sector Response to Gender and

	HIV Issues, Lae Chamber of Commerce
Meredith Tutumang	National Technical Coordinator, Mobilising the Private Sector Response to Gender and HIV Issues, Lae Chamber of Commerce
Polapai Chalau	CEO, Angau Memorial General Hospital, Lae,
Elsie Ryan	Regional Medical Officer, Morobe, Madang, East & West Sepik Provinces
Caspar Poilele	Provincial Care and Counselling Coordinator, Morobe
Henriqueta Muchaite	Sister in Charge, Centre of Mercy VCT Centre, Morobe
Kim Nicholas	Nurse Manager, Anua Moriri VCT Centre, Angau Memorial General Hospital, Lae
Manu Haingae	Expert Client, Anua Moriri VCT Centre, Angau Memorial General Hospital, Lae
Rosemary Bundo	Regional HCT Officer, Anua Moriri VCT Centre, Angau Memorial General Hospital, Lae
Gibson Winston	Deputy Laboratory Manager, Angau Memorial General Hospital, Lae

Appendix 10 Background documentation examined

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