

National AIDS Spending Assessment

RESOURCE FLOWS OF THE HIV RESPONSE
IN PAPUA NEW GUINEA IN 2016-2019

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UNAIDS – NACS – NDOH

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National AIDS Spending Assessment

Acknowledgement

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“If we would have new knowledge, we must get a whole world of new questions.”— Susanne K. Langer

TABLE OF CONTENTS

National AIDS Spending Assessment	2
Acknowledgement	2
Acronyms and abbreviations.....	7
Key indicators of HIV spending in Papua New Guinea	9
Introduction.....	10
Context	10
Objectives	11
Health system structure and health financing.....	13
Epidemiological context and HIV Response	15
Methodology and Process	17
NASA Framework	17
NASA Classification	19
Data Collection and Processing	20
Assumptions and Limitations	24
Assessment Results.....	27
Trends in HIV expenditure	27
Financial Flows and Funding Modalities	27
Funding Flows: from sources to service providers.....	27
Financing Entities	28
Financing Schemes	30
Sources of Revenue.....	30
Financing Agent-Purchaser	31
Programmatic Description of HIV Expenses	36
Expenditure per AIDS Spending Category.....	36
Expenditure per Beneficiary Population.....	45
Expenditure per Service Delivery Modality	52

Expenditure per Production Factor	54
Key cost drivers of the HIV Response	57
Analysis of Spending by Key Financers	61
Domestic Public HIV Spending	61
HIV spending portfolio of the Global Fund	63
HIV spending portfolio of the Government of Australia	67
HIV spending portfolio of the Government of the United States of America.....	70
Conclusions and Recommendations	73

List of Figures

Figure 1. NASA Accounting Framework.....	18
Figure 2. Funding flows: from sources to providers of services.....	28
Figure 3. Financing Entities of the HIV spending in Papua New Guinea, 2016-2019.....	29
Figure 4. Financing schemes (SCH) of the HIV Response in Papua New Guinea, 2016-2019.....	30
Figure 5. Sources of Revenues (REV) of the HIV spending in Papua New Guinea, 2016-2019.....	31
Figure 6. Financing Agents-Purchasers of the HIV Response in Papua New Guinea, 2016-2017.....	32
Figure 7. Providers of Services in the HIV Response in Papua New Guinea, 2016-2019	33
Figure 8. Providers of Services by AIDS Spending Category (1 st digit), 2016-2019	34
Figure 9 Trends in expenditure by AIDS Spending Categories (ASC), 2016-2019	36
Figure 10. Programmatic breakdown of the HIV Response in Papua New Guinea, 2016-2019.....	37
Figure 11. Programmatic breakdown of ASC.01 Five pillars of Prevention (excluding HTC), 2016-2019	38
Figure 12. Programmatic breakdown of ASC.02 HIV Counselling and Testing, 2016-2019	39
Figure 13. Programmatic breakdown of ASC.03 HIV Care and Treatment, 2016-2019 .	40
Figure 14. Programmatic breakdown of ASC.04 Social Protection and Economic Support and ASC.05 Social Enablers, 2016-2019	41
Figure 15. Programmatic breakdown of ASC.06. Programme Enablers and System Strengthening, ASC.07 Development Synergies and ASC.08 HIV-related Research, 2016-2019.....	44
Figure 16. Trends in HIV expenditure by Beneficiary populations (BP), 2016-2019	45
Figure 17. HIV spending in Papua New Guinea by Beneficiary Population (BP), 2016-2019.....	46
Figure 18. Beneficiary Populations of the key AIDS Spending Categories, 2016-2019 ..	50
Figure 19. Service Delivery Modalities (SDM) of the HIV Response in Papua New Guinea, 2016-2019	52
Figure 20. AIDS Spending Categories (ASC) by Service Delivery Modalities (SDM) in %, 2016-2019.....	53

Figure 21. Production Factors (PF) of the HIV Response in Papua New Guinea, 2016-2019.....	54
Figure 22. Breakdown of Current Expenditure, 2016-2019	56
Figure 23. Breakdown of Capital Expenditure, 2016-2019	57
Figure 24. Four largest AIDS Spending Categories by Financing Entities (in %), 2016-2019.....	58
Figure 25. Domestic public HIV spending by AIDS Spending Category (ASC), 2016-2019	61
Figure 26. Domestic public HIV spending by Beneficiary Population (BP), 2016-2019..	63
Figure 27. The Global Fund HIV spending in Papua New Guinea by AIDS Spending Category (ASC), 2016-2019	65
Figure 28. The Global Fund HIV spending in Papua New Guinea by Beneficiary Population (BP), 2016-2019	67
Figure 29 HIV spending of The Government of Australia in Papua New Guinea by AIDS Spending Category (ASC), 2016-2019.....	68
Figure 30. HIV spending of The Government of Australia in Papua New Guinea by Beneficiary Population (BP), 2016-2019.....	70
Figure 31. HIV spending of The US Government in Papua New Guinea by AIDS Spending Category (ASC), 2016-2019	71
Figure 32. HIV spending of The US Government in Papua New Guinea by Beneficiary Population (BP), 2016-2019	72

Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AFAO	Australian Federation of AIDS Organisations
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASC	AIDS Spending Category
BP	Beneficiary Population
CCHS	Catholic Church Health Services
CDC	Center for Disease Control and Prevention
COVID-19	Coronavirus disease caused by SARS-Cov-2 virus
C&T	Care and Treatment
DFAT	The Department of Foreign Affairs and Trade
FAP	Financing Agent-Purchaser
FE	Financing Entity
FSW	Female Sex Worker
GAM	Global AIDS Monitoring
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoPNG	Government of Papua New Guinea
HIV	Human Immunodeficiency Virus
HQ	Headquarters
HTC	HIV Counselling and Testing
IBBS	Integrated behavioral and biological survey
iNGO	International non-governmental organization
KP	Key Populations
M	Million
M&E	Monitoring and Evaluation
MARP	Most-At-Risk Population
MSM	Men who have Sex with Men
NACS	National AIDS Commission Secretariat
NASA	National AIDS Spending Assessment
NDOH	National Department of Health
NGO	Non-Governmental Organization
OSHF	Oil Search Health Foundation

OVC	Orphans and Vulnerable Children
PAC	Provincial AIDS Commission
PEPFAR	The United States President’s Emergency Plan for AIDS Relief
PF	Production Factor
PGK	Papua New Guinean Kina
PHA	Provincial Health Authority
PHC	Primary Healthcare
PNG	Papua New Guinea
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PR	Principal Recipient
PS	Provider of Services
PUDR	Performance Update / Disbursement Request
PWID	People Who Inject Drugs
REV	Revenue of the Financing Scheme
RST	UNAIDS Regional Support Team
RTT	NASA Resource Tracking Tool
SCH	Financing Scheme
SDM	Service Delivery Modality
SRHIP	Sexual and Reproductive Health Integration Project
STI	Sexually Transmitted Infection
TA	Technical assistance
TB	Tuberculosis
TG	Transgender
THE	Total Health Expenditure
TWG	Technical Working Group
UBRAF	The Unified Budget, Results and Accountability Framework
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children’s Fund
WVPNG	World Vision Papua New Guinea

Key indicators of HIV spending in Papua New Guinea

HIV spending and Key Macro indicators	2016	2017	2018	2019
HIV spending - PGK	63,326,450	49,221,393	59,613,581	78,533,625
HIV spending per capita ¹ – PGK	7.63	5.86	6.93	8.92
HIV spending per PLHIV ² - PGK	1,439.24	1,047.26	1,216.60	1,510.26
HIV spending -US Dollars	\$ 20,390,301	\$ 15,488,573	\$ 18,485,309	\$ 23,821,036
HIV spending per capita – US Dollars	\$ 2.46	\$ 1.84	\$ 2.15	\$ 2.71
HIV spending per PLHIV – US Dollars	\$ 463.42	\$ 329.54	\$ 377.25	\$ 458.10
HIV and AIDS Expenditure by Funding Sources				
Public HIV Spending - PGK	11,160,222	3,554,582	13,998,859	24,914,098
Private HIV Spending - PGK	-	-	199,980	242,600
International HIV Spending - PGK	52,166,228	45,666,811	45,414,741	53,376,928
Public HIV Spending – US Dollars	\$ 3,593,448	\$ 1,118,526	\$ 4,340,844	\$ 7,557,013
Private HIV Spending – US Dollars			\$ 62,011	\$ 73,586
International HIV Spending -US Dollars	\$ 16,796,854	\$ 14,370,047	\$ 14,082,454	\$ 16,190,437
Public HIV Spending - % of total HIV spending	18%	7%	23%	32%
Private HIV Spending - % of total HIV spending	-	-	<1%	<1%
International HIV Spending - % of total HIV spending	82%	93%	76%	68%
HIV and AIDS Expenditure by Programmatic Area %				
ASC.01 Prevention	17%	13%	10%	10%
ASC.02 HIV Testing and Counselling	19%	20%	16%	16%
ASC.03 HIV Care and Treatment	16%	20%	25%	33%
ASC.04 Social protection and economic support	-	<1%	1%	<1%
ASC.05 Social Enablers	1%	2%	0%	<1%
ASC.06 Programme enablers and systems strengthening	42%	41%	47%	39%
ASC.07 Development synergies	<1%	<1%	<1%	<1%
ASC.08 HIV and AIDS-related research	5%	4%	1%	1%
HIV Expenditure by Beneficiary %				
BP.01 People living with HIV	16%	19%	26%	33%
BP.02 Key populations	13%	10%	8%	10%
BP.03 Vulnerable, accessible and other target populations	19%	22%	6%	5%
BP.04 General population	5%	4%	12%	12%
BP.05 Non-targeted interventions	47%	45%	48%	40%

Introduction

Context

The government of Papua New Guinea has conducted three rounds of National AIDS Spending Assessment (NASA) covering the periods 2009 to 2015. The assessments have helped track HIV spending from international, public and private sources that contributing to the National Response to HIV in Papua New Guinea. The information proved valuable in facilitating strategic information for strategic action and decision-making, improving linkage and understanding of different actors and investors in the HIV response of the country and, at some level, in leveraging both technical and financial support for the development, implementation, management, monitoring and evaluation of PNG's national HIV response.

The NASA was aimed to be updated every two years and to be reported by the country to monitor its commitments to the 2020 Global and Country Targets of Ending AIDS by 2030. However, severe limitations were met in 2018 which hindered conduct of the exercise.

The demand for updated resource mapping and NASA information has been expressed repeatedly in the last 12 months especially during gathering of PNG stakeholders at the 2019 National HIV Summit. Most importantly for 2020, AIDS spending data and trends are needed for updating the costed annual plan of PNG's National STI and HIV Strategy (2018-2022) and for developing the following: the PEPFAR Incentives Funds for PNG (COP/ROP2020), the GFATM 2021-2023 Round of Grants, the 2020-2021 UN UBRAF, among others. In addition, NASA data will form part of PNG's 2020 update to the Global AIDS Monitoring (GAM) Report). This round of NASA will cover the years 2016 to 2019.

The National Department of Health, as chair of the HIV TWG, has requested this support from UNAIDS.

¹ Population estimates: UN World Population Prospects (2019 Revision)

² PLHIV estimates: Asia Pacific Data Hub <http://aphub.unaids.org/>

Objectives

The primary objective for this project is to collect data on HIV expenditures in Papua New Guinea from 2016 to 2019 using the National AIDS Spending Assessment methodology.

Specific objectives are:

1. To implement a methodology for systematic monitoring of HIV financial flows at national and provincial level using the NASA methodology in Papua New Guinea;
2. To adapt the NASA methodology, classification and tools to the Papua New Guinean context;
3. Build national level capacity for systematic monitoring of HIV and AIDS financing flows using the NASA methodology, with a view to a yearly, fully-institutionalized NASA.
4. To conduct an HIV spending assessment focusing on public and development partner (external) resources, and including private (both for-profit and not-for-profit) entities known to be contributing to HIV activities.
5. To identify and measure the flow of resources for HIV by the funding entity (FE), revenue (REV), financing scheme (SCH), financing agent-purchaser (FAP), service provider (PS), the service delivery modality (SDM), function/ intervention (ASC), cost components (factors of production, PF) and beneficiary populations (BP).
6. To prepare a report of expenditure trends that will be used (a) in facilitating strategic information for strategic action and decision-making; (b) in improving linkage and understanding of different actors and investors in the HIV response of the country and (c) in leveraging both technical and financial support for the development, implementation, management, monitoring and evaluation of PNG's national HIV response.

Specifically, the updated NASA will be used for:

- Updating the costed annual plan of the PNG STI and HIV Strategic Plan (2018-2022),
- The PEPFAR Funding for PNG (COP/ROP2020),

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- The GFATM 2021-2023 Round of Grants to Papua New Guinea,
 - The 2020-2021 UN UBRAF,
 - The 2020 update to the Global AIDS Monitoring (GAM) Report.

The NASA will answer the following questions:

- Who pays for HIV services in Papua New Guinea? Who pools funds? What funding schemes are used?
- Who purchases the HIV services?
- What mechanism allows payment?
- Who are the providers of HIV services in Papua New Guinea?
- What HIV services are being provided, and what is being spent on these?
- Who are the beneficiaries of the HIV spending in Papua New Guinea?
- What are the key cost drivers, the production factors, of the HIV spending in Papua New Guinea?

Health system structure and health financing

Health Financing System Assessment (HFSA) in Papua New Guinea, conducted by The World Bank and published in 2017 provides a thorough description of the country's health system³.

PNG has a government-funded health system throughout much of the country, supplemented by government-subsidized health services provided by various Christian missions. Since independence, when all healthcare was managed centrally by the National Department of Health (NDOH), GoPNG has made attempts to decentralize the provision of services to provincial and district governments, starting with the 1995 Organic Law which devolved primary health care (PHC) services to the provincial level. Hospitals (including their budgets, human resources, and payroll) are, however, managed by an autonomous board, which is independent of the NDOH.

To address health system fragmentation at the provincial level and bring together the provincial health departments, hospitals, and district health services under one management board, the 2007 Provincial Health Authority Act enabled provincial governments to establish a PHA to be responsible for both primary and secondary health care in their province.

According to both HFSA and NASA, church health services are the key partners in delivering health services in PNG. According to the World Bank's Assessment, an estimated 47% of primary health services and a significant share of secondary services, particularly in rural areas, is provided the faith-based service operators.

Despite steady growth, Total health expenditure (THE), as a proportion of GDP, has been stagnating between 4 and 5 percent since 2007. In 2014, THE (4.4%) was comparable to the low-middle-income country average of 4.5% and to other countries in the region. Health spending, as a share of general government spending, decreased from 13.2% in 2013 to 9.5% in 2014 (World Bank 2016). When compared to 2014

³ World Bank. 2017. "Health Financing System Assessment. Papua New Guinea." Available at: <https://documents1.worldbank.org/curated/en/906971515655591305/pdf/122589-WP-P154901-PUBLIC-23994-PNG-HEALTH-FINANCING-SYSTEM-ASSESSMENT-Web.pdf>

international and regional standards, PNG's health expenditure per capita (US\$92) is low in comparison with the low-middle-income countries average (US\$265), Fiji (US\$204), the Solomon Islands (US\$102), and Vanuatu (US\$158).

Health financing is predominantly centralized. In 2014, government spending—including government spending financed by external sources—accounted for over 80% of total health spending; the remaining 20% was attributed to private expenditure. Donor financing represents a large share of country's health expenditure and has been historically volatile.

PNG has relatively low out-of-pocket (OOP) expenditure on health by international standards. National Health Accounts⁴ exercise in Papua New Guinea indicated OOP at the level of 6% of the THE in 2014, however in 2015 it rose dramatically to 12.6%. Given comparatively low access rates to healthcare, low OOP does not necessarily mean financial protection. In fact, health care costs are cited as one of the main reasons the poor do not visit health facilities in the case of illness. As per Health System Financing Assessment, OOP expenditure was less than 30% of total consumption in every household in PNG.

According to The World Bank, on average, 20% of total annual health spending in PNG is from development partners and funding remains volatile with regards to levels, sources, and recipients. Australia is the largest bilateral donor. GFATM and GAVI have become increasingly important partners in health service delivery in PNG.

⁴ PAPUA NEW GUINEA NATIONAL HEALTH ACCOUNTS (calendar years 2014 and 2015). Summary of the Health Expenditure Report Findings.

Epidemiological context and HIV Response

The latest data from the Global HIV/AIDS Report demonstrates that an estimated number of 55,000 adults and children in Papua New Guinea live with HIV in 2020, the figure that rose dramatically from the estimated 33,000 in 2010⁵. With 0.9% of the adult population estimated by UNAIDS to be HIV-positive in 2020, although being much higher than the regional average of 0.2%, Papua New Guinea is classified as a concentrated epidemic, largely among Female sex workers (FSW), Men who have sex with other men (MSM) and transgender (TG). It is one of the most serious HIV/AIDS epidemics in the Asia-Pacific subregion. In the last 10 years the incidence rate went up from 0.53 to 0.61 cases per 1,000 population. On average 65% of children and adults with HIV are receiving ART (35,840 in 2020), although it is relatively higher for women (69%) than for men (63%).

The most recent bio-behavioural survey Kauntim mi tu (KM2)⁶ highlights the challenges among key populations, such as limited engagement of key populations with outreach workers, poor access to HIV testing and counselling and other healthcare services for both FSW and MSM/TG, experiencing trouble with the police, sexual violence from the partners etc.

According to KM2 findings, HIV prevalence among FSW in Port Moresby, Lae, and Mt.Hagen, the three cities included in the survey, was 14.9%, 11.9%, and 19.6% respectively, more than 10 times greater than the national PNG adult female estimate of 1.1%. Many FSW (32.1-43.9%) have never been tested for HIV, although the HIV treatment uptake among those who were tested and diagnosed with HIV is approximately 90%.

HIV prevalence among MSM/TG in Port Moresby and Lae was 8.5% and 7.1%, respectively, more than 7 times greater than the national PNG adult estimate of 0.9%. Only 23.3% of those HIV-infected MSM/TG in Port Moresby, the city with the largest

⁵ Country factsheets. Papua New Guinea 2020. AIDSinfo. Available at: <http://aphub.unaids.org/>

⁶ Kauntim mi tu. Multi-site summary report 2018. Key findings from the Key Population Integrated Bio-Behavioural Survey Papua New Guinea. Available at: <https://www.aidsdatahub.org/sites/default/files/resource/kauntim-mi-tu-multi-site-png-2018.pdf>

MSM/TG population, were aware of their infection. More than half of MSM/TG have never tested for HIV.

The authors of the KM2 are unanimous in their recommendations to the policy-makers and implementors, highlighting the need for enhanced HIV, health and social services for FSW, MSM, and TG:

- Expand the use of peer driven and social networks and other new evidence-informed HIV testing strategies to increase HIV testing yield.
- Strengthen linkages of people newly diagnosed with HIV to key population friendly clinics for immediate initiation of ART.
- Expand the use of peer navigators to support HIV treatment retention.
- Promote gender and sexual orientation and identity equality.
- Provide key population sensitivity training to healthcare workers at key health facilities and designate them as key population friendly.
- Ensure the availability of safe-spaces for the reporting of physical and sexual violence, and the provision of services for key populations.
- Integrate point of care STI testing and treatment in all sexual health services, including HIV testing and treatment facilities.
- Increase provision of condoms and lubricants at key population hotspots and sexual health facilities.
- Ensure women and girls who sell and exchange sex are tested for HIV and syphilis during pregnancy, receive treatment as needed, and are provided with comprehensive reproductive health care including family planning.

NASA, in its turn, is designed to demonstrate the distribution of HIV spending among various key and vulnerable populations and funds' allocation for programmes and services that make part of the HIV Response in Papua New Guinea. Methodologically, it relies on the level of precision and completeness of the primary data, its level of details and accuracy. With all these puzzle pieces in place, National AIDS Spending Assessment should be able to answer whether actual expenditure, its volumes and distribution among beneficiaries, really reflects policy recommendations and HIV Response objectives.

Methodology and Process

NASA Framework

National AIDS Spending Assessment measures spending for the final consumption of goods and services in the HIV responses worldwide by tracking the flow of spending from its origin to the final beneficiary, through nine classifications – Financing Entities (FE), Financing Schemes (SCH), Revenues of Financing Schemes (REV), Financing Agents-Purchasers (FAP), Providers of Services (PS), AIDS Spending Categories (ASC), Service Delivery Modalities (SDM), Beneficiary Populations (BP) and Production Factors (PF). NASA classifications and methodology were recently updated as a result of a continuous harmonization process with other policy instruments, such as National Health Accounts based on the System of Health Accounts 2011.

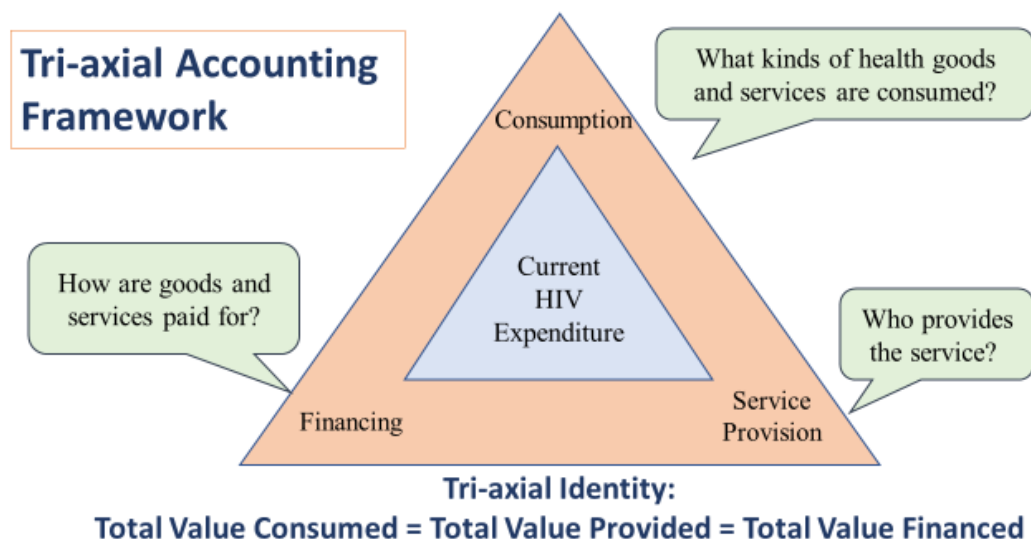
The NASA framework aims to include activities under the education, social development, welfare sectors, as well as for other activities which are beyond health care service delivery system.

As part of this methodology, NASA employs tables and double-entry matrices to represent the origin and destination of resources, thus avoiding double counting of expenses through the reconstruction of resource flows for all HIV transactions between different economic agents and reconciliation of the financing flows across three vectors of analysis, financing, provision and utilization.

NASA framework and accounting method is organized around a tri-axial system for the HIV expenditure tracking: (1) **Consumption** is represented by AIDS Spending Categories & Beneficiary Populations, (2) **Provision** is represented by Providers of Services, Service Delivery Modalities and Production Factors, and (3) **Financing** represented by Financing Schemes, their Revenues, Financing Entities and Financing Agents.

In practice, NASA Team collects data from various economic agents and reconstructs the resource flows in the form of transactions, following the money from their origin to the final consumption. As a result of the triangulation between these three vectors – Consumption, Provision and Financing -, a total value of resources consumed should be equal to a total value provided and a total value financed.

Figure 1. NASA Accounting Framework



For the resource tracking purposes NASA adopts accrual method of accounting. While cash disbursements may not be immediately accounted as expenditures, NASA aims at accounting for expenditure/costs involved in delivering services consumed by the resident population within a defined period of time (fiscal year/reporting cycle).

NASA can be presented by calendar year, or by fiscal year if it is different from the calendar. Ideally, expenditures from all financing entities have to be aligned to a single fiscal year/reporting period of a defined period of time. The estimates for several fiscal years are to be reported separately for each fiscal year.

Expenditures should only be counted in a single category or sub-category; they should never be double counted.

NASA tracks only the resources that were actually consumed by beneficiaries. Resources that were spent on procurement of goods which were not used and were kept in warehouses, are not included in the reporting. Whenever procurement data is used in place of utilization of goods, it should be clearly indicated in the Assumptions and Limitations section of the report.

NASA aims to include charitable donations, free rental of vehicles or premises (or part thereof), volunteer work, etc.

Whenever cash disbursements for the procurement or budget allocations are used in the place of actual expenditure (calculated value of the goods and services consumed), it should be clearly indicated in the Assumptions and Limitations chapter and avoided in the next assessments.

NASA Classification

As described above, NASA relies on nine classifications that describe actual spending in three key dimensions – Consumption, Provision and Financing.

FINANCING:

- Financing Entities (FE) are entities or pools that purchasers, providers of financial intermediation services tap or use to fund HIV services. An analysis of FE is of particular interest in countries where funding for the HIV response is heavily dependent on donors' support or when there are few management entities.
- Financing Schemes (SCH) are the main types of financing arrangements through which people obtain health services. Health care financing schemes include direct payments by households for services and goods and third-party financing arrangements. Third party financing schemes are distinct bodies of rules that govern the mode of participation in the scheme, the basis for entitlement to health and social services and the rules on raising and then pooling the revenues of the given scheme.
- Revenues of Financing Schemes (REV) describes specific contribution mechanisms of Financing Schemes, which are grouped by type of revenues into mutually exclusive classes.
- Financial Agents-Purchasers (FAP) are entities that collect financial resources to fund service provision programs and make decisions related to the program.

PROVISION

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- Providers of Services (PS) are entities that are engaged in the production, supply and provision of services related to HIV and AIDS;
 - Service Delivery Modalities (SDM) describe the way services are provided to beneficiaries. This classification has been introduced to reflect possible differences in costs of provision of the same services (described by ASC) through different modality, such as facility-based or community- or home-based.
 - Production factors (PF) are the inputs used to supply goods and services.

CONSUMPTION

- AIDS Spending Categories (ASC) are interventions and activities related to HIV and AIDS that are offered to the beneficiaries;
- Beneficiary Populations (BP) are direct intended beneficiaries of the interventions carried out, populations receiving services within the HIV Response.

Considering the level of details of the classification, NASA can provide broad selection of options for the analysis, exploiting the data to understand the role of specific funding sources, managers, providers, specific services or populations served in a variety of combinations.

Data Collection and Processing

Initial schedule for the National AIDS Spending Assessment in Papua New Guinea was planned for the duration of 4 months, however, due to the global COVID-19 pandemic it has been extended to over a year's period – from March 2020 to May 2021. Here is a brief description of the key steps undertaken to prepare and implement this NASA round in Papua New Guinea:

- 1. Planning, Mapping of Actors and Capacity Building:**
 - a. Awareness raising with key national HIV response stakeholders (UNAIDS Country Office);

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- b. Establishment/orientation of the steering committee:
 - the role of the Steering Committee has been assigned to the existing Strategic Information Technical Working Group;
 - c. Contracting international and national consultants;
 - d. Mapping of all actors involved in the HIV response in Papua New Guinea:
 - previous NASA Map of Actors has been taken as a baseline;
 - National consultant is responsible for updating the list of the organizations-respondents and their respective contact details;
 - e. Training-orientation on NASA principles and methodology:
 - Remote online training on March 18-19, 2020;
 - Participants representing the organizations in the extended NASA team: NDOH, NACS, UNAIDS, WHO, WVPNG, CDC, World Bank;
 - Shared folder containing presentations, materials, NASA Classification and NASA data collection form + Instruction has been made available to the participants;
 - f. Review and adjust/revise the NASA data collection tools:
 - Data collection form is updated reflecting four years of assessment – 2016, 2017, 2018 and 2019;
 - Data collection form is accompanied by an Instruction on how to correctly fill in each data entry point and the official letter from the National Department of Health explaining objectives of assessment and invitation for participation;
 - National consultant was responsible for the regular update of the data collection monitoring tool.

2. Data collection:

a. Data collection was decided to be rolled-out in three “waves”:

- Piloting of the data collection form through the first “wave” of data collection among the members of the extended NASA team, collecting available financial reports from NDOH, NACS and World Vision PNG (related to GFATM grant);
- Shortlisting the second wave respondents (key criteria – largest Financing Entities and Financing Agents-Purchasers from the previous NASA + possibility of the remote access to the financial records due to the pandemic-related lockdown). Included The Department of Foreign Affairs and Trade (DFAT) of The Government of Australia, UN agencies and big iNGOs;
- The third “wave” of data collection included all other national and international NGOs, Provincial AIDS Commissions, other state departments, private companies;

b. National consultant, Agnes Gege, monitored data collection in-country and provided necessary assistance to the organizations-respondents in completing the data collection form.

3. Data Processing and Quality Control:

- a. After receiving a completed data collection form or an expenditure report NASA consultant assigned NASA classification codes to each expenditure entry;
- b. Assess available data and conduct interviews with organizations-respondents to develop and apply necessary assumptions to achieve an adequate level of disaggregation according to the NASA standards. For instance, among the distribution keys that were discussed and applied were (see Assumptions and Limitations for more details):
- HIV counselling and testing split between target populations,
 - Providers’ split into faith-based and non-faith-based,

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- Providers' split of care and treatment services between public and private sector providers, etc.
 - c. Building up Excel-based dataset where each expenditure was mapped across all NASA classifications;
 - d. Internal quality control – identifying and removing inconsistencies in assigned NASA codes, control of double-counting, harmonization across classifications;
 - e. Preparation of the Data Consolidation Files.

4. Data Analysis, Validation and Report Writing

- a. Entry into the NASA Resource Tracking Tool (RTT):
 - Mini-training on the use of RTT from the external consultant, software functionalities, quality control,
 - External quality control of the data informing GAM matrices (from UNAIDS HQ),
 - External reviewer (provided by the TSM/HQ), and UNAIDS staff from HQ and RST assessed the NASA outputs for quality assurance and clearance.
- b. Generate from the RTT and submit double-entry FE x ASC matrices for the country's GAM report;
- c. Using "pivot table" function of Excel, develop visual PPT presentation, graphs and tables, for the stakeholders' validation workshop with the HIV TWG endorsement;
- d. Conduct online validation workshop and presentation of the draft NASA results to the extended NASA Team;
- e. Develop and agree upon the outline of the NASA Report;
- f. External review of the dataset and the report with the following update;

g. Produce NASA report.

Assumptions and Limitations

1. To fill in the gaps in national HIV expenditure data availability a four-year NASA has been implemented in Papua New Guinea (2016-2019), instead of a standard two-year assessment design (2018-2019). With the majority of data collection and processing having been done remotely, it proved difficult to collect, validate and process data which contains a good level of detail to be informative for NASA. The memory and retrospective data recall challenges were especially significant in the data collection for the year 2016 as most of the projects have ended and some of the implementing partners have either scaled down their HIV and health portfolio or entirely removed their presence from PNG. Thus, 2016 data remains the weakest part of this NASA round.
2. No data was obtained from the National Department of Finance regarding expenditure of healthcare providers, hospitals and outpatient clinics, in Papua New Guinea. Thus, no shared health system cost is included in the assessment.
3. Despite the efforts of the NASA team, it was not feasible to obtain the expenditure reports of the Provincial AIDS Commissions, except for the one from the Central PAC. Provincial AIDS Commissions manage the resources from a number of sources, including funding coming from the central and provincial government's revenues.
4. Due to the COVID-19 pandemic and the general limited availability of the out-of-pocket health and HIV expenditure data in Papua New Guinea, estimating OOPS was not included in this round of NASA.
5. Risk of double-counting has been controlled throughout the assessment. When the same resource flow was reported by various organizations, in consideration was taken the data at the final service consumption level obtained from the provider of service. Consecutively, the expenditure (cash

disbursement) reported by the Financing Entity or a Financing Agent-Purchaser has been excluded from the dataset.

6. Limitations in commodities' utilization data availability didn't allow the NASA team to cost the HIV consumption bottom-up. Procurement data has been used to estimate the expenditure on such HIV programmes as Antiretroviral therapy, HTC, ART-related laboratory monitoring and other.
7. Assumptions provided by NDOH to split between final service providers of publicly funded ART and ART-related laboratory monitoring:
 - a. Public sector providers: 70%
 - b. NGOs: 30%
8. Assumptions provided by NDOH to split between final service providers of publicly funded PMTCT:
 - a. Public sector providers: 60%
 - b. NGOs: 40%
9. Assumptions provided by Catholic Church Health Services (CCHS) to split Treatment and Care from Prevention (specifically, ASC.03.98 Care and Treatment, not broken down by type and ASC.01.02.04.98 Programmatic activities for vulnerable and accessible population not disaggregated by type) for the implementing partners of Sexual and Reproductive Health Integration Project (SRHIP):
 - a. Treatment and care, not broken down by intervention: 70%,
 - b. Prevention among vulnerable and accessible populations: 30%
 - c. Activities implemented by CCHS itself are coded under ASC.06.98 Programme enablers and systems strengthening not disaggregated by type.

-
10. Assumptions from NACS to split publicly-funded condom-related expenditure by beneficiary population in 2017-2019 based on iBBS number of sex workers and MSM reached with prevention services:
- a. 2017: 68% - FSW, 32% - MSM
 - b. 2018: 68% - FSW, 32% - MSM
 - c. 2019: 72% - FSW, 28% - MSM

Assessment Results

Trends in HIV expenditure

The resources available from all sources for the implementation of the HIV response in Papua New Guinea totaled PGK 63.3M in 2016, PGK 49.2M in 2017, PGK 59.6M in 2018 and PGK 78.5M in 2019. In comparison, previous NASA which was lower than in the period from 2009 to 2015.

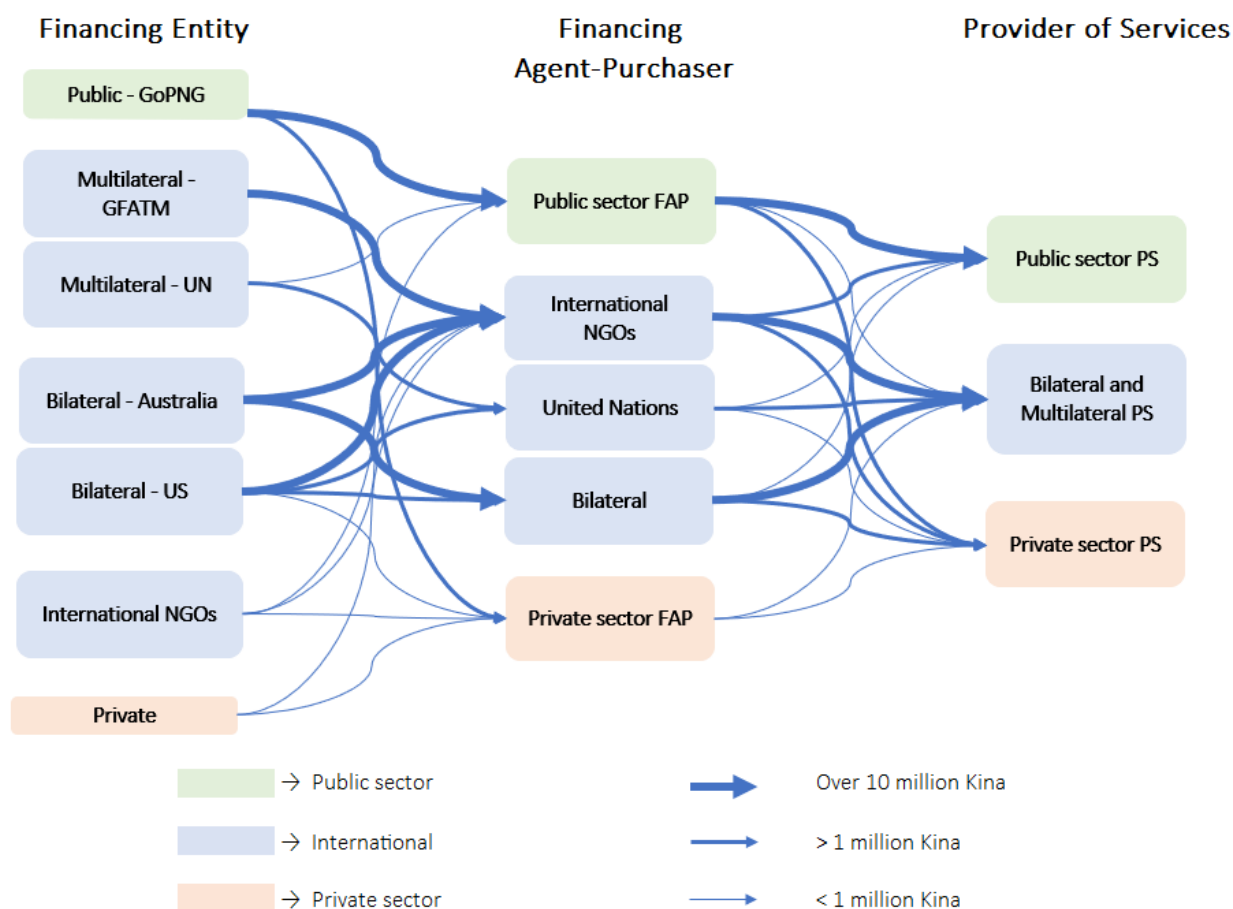
Financial Flows and Funding Modalities

Funding Flows: from sources to service providers

Financial flow chart represents an average of a four-year resource flow architecture in Papua New Guinea (see Figure 2).

While it may vary from year to year, the largest resources are made available by the Government of Papua New Guinea, The Global Fund, Governments of The United States and Australia. Public funds tend to stay in the public sector, while other Financing Entities prefer to disburse their HIV-related finances through the international NGOs or a vast network of private providers.

Figure 2. Funding flows: from sources to providers of services



Financing Entities

The particular types of financing entities that provide resources in HIV/AIDS to financing schemes and show the sources of HIV/AIDS spending categories used for final use in the given accounting period (see Figure 3).

The burden of HIV financing in Papua New Guinea rested dominantly on the shoulders of international organizations. International financing entities represent 82% of the total HIV expenditure or PGK 52.2M in 2016, 93% (45.7M) in 2017, 76% (45.4M) in 2018 and 68% (53.4M) in 2019.

Figure 3. Financing Entities of the HIV spending in Papua New Guinea, 2016-2019

Financing Entities	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
FE.01 Domestic public entities	11,160,222	18%	3,554,582	7%	13,998,859	23%	24,914,098	32%
FE.02 Domestic private entities					199,980	<1%	242,600	<1%
FE.03 International entities	52,166,228	82%	45,666,811	93%	45,414,741	76%	53,376,928	68%
<i>FE.03.01.01 Government of Australia</i>	<i>21,484,539</i>	<i>41%</i>	<i>10,140,415</i>	<i>22%</i>	<i>11,030,611</i>	<i>24%</i>	<i>11,472,478</i>	<i>21%</i>
<i>FE.03.01.30 Government of United States</i>	<i>13,930,922</i>	<i>27%</i>	<i>12,087,953</i>	<i>26%</i>	<i>12,107,149</i>	<i>27%</i>	<i>10,847,082</i>	<i>20%</i>
<i>FE.03.02.06 Regional Development Banks (Africa, Asia, Latin America and th</i>	<i>890,000</i>	<i>2%</i>			<i>7,755</i>	<i><1%</i>		
<i>FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria</i>	<i>14,024,819</i>	<i>27%</i>	<i>20,225,638</i>	<i>44%</i>	<i>19,372,786</i>	<i>43%</i>	<i>27,847,818</i>	<i>52%</i>
<i>FE.03.02.08 UNAIDS Secretariat</i>	<i>488,731</i>	<i>1%</i>	<i>591,296</i>	<i>1%</i>	<i>1,011,166</i>	<i>2%</i>	<i>1,445,007</i>	<i>3%</i>
<i>FE.03.02.09 United Nations Children's Fund (UNICEF)</i>	<i>939,914</i>	<i>2%</i>	<i>1,021,011</i>	<i>2%</i>	<i>665,889</i>	<i>1%</i>	<i>545,785</i>	<i>1%</i>
<i>FE.03.02.13 United Nations High Commissioner for Refugees (UNHCR)</i>	<i>31,057</i>	<i><1%</i>	<i>31,779</i>	<i><1%</i>	<i>32,249</i>	<i><1%</i>	<i>52,749</i>	<i><1%</i>
<i>FE.03.02.17 United Nations Population Fund (UNFPA)</i>	<i>270,000</i>	<i>1%</i>	<i>900,000</i>	<i>2%</i>				
<i>FE.03.02.20 World Health Organization (WHO)</i>	<i>32,872</i>	<i><1%</i>	<i>50,455</i>	<i><1%</i>	<i>74,049</i>	<i><1%</i>	<i>113,550</i>	<i><1%</i>
<i>FE.03.03.99 Other International not-for-profit organizations and foundations</i>	<i>73,373</i>	<i><1%</i>	<i>520,877</i>	<i>1%</i>	<i>644,832</i>	<i>1%</i>	<i>889,413</i>	<i>2%</i>
<i>FE.03.04 International for profit organizations</i>			<i>97,388</i>	<i><1%</i>	<i>468,254</i>	<i>1%</i>	<i>163,046</i>	<i><1%</i>
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

This NASA revealed, that The Global Fund is the single biggest source of funding for HIV programme in Papua New Guinea since 2017. Its resources have increased from PGK 14M in 2016, representing 27% of the overall HIV spending in the country, to a little less than 28M in 2019 – over a half of the PNG HIV response value.

Contribution of the Government of Australia has shrunk since 2016, but remained steady within PGK 10 – 11.5M annually. US Government injected almost PGK 14M into the HIV response or 27% of total HIV spending in 2016, although in the next years US-originated resources have somewhat shrunk to the annual 12.1M in 2017 and 2018, and 10.9M in 2019.

Cumulative UN resources amount to PGK 1.8M in 2016 and 2018, 2.6M in 2017 and 2.2M in 2019, varying from 4 to 6% of the total HIV spending annually.

Public financing entities, represented largely by the funds channelled through National AIDS Council Secretariat and National Department of Health, comprise 18% of the total HIV spending or PGK 11.2M in 2016, 7% (3.6M) in 2017, 23% (14M) in 2018 and 32% (24.9M) in 2019. Government funding of HIV Response in PNG has been cut significantly in 2017, both for NACS and NDOH.

Various challenges in the data collection process didn't allow for accessing the data from the Provincial AIDS Councils, which get their public finances both from the national revenues as well as provinces' own revenues. Only Central PAC has submitted their data for the analysis, stating an expenditure around PGK 50,000 annually that

informs FE.01.01.02 State/provincial government code. Even though it is unlikely that provincial revenues represent a significant portion in financing HIV response in Papua New Guinea, this limitation of analysis should be stated and addressed in the next NASA round.

Financing Schemes

The financing policy is established through the financing schemes, such as social security, governmental, insurance, NGO schemes and out-of-pocket payments set through laws, rules or practice. The scheme indicates how the revenue collection is to be made (see Figure 4).

Voluntary payment schemes were the dominant means of paying for HIV programme activities in Papua New Guinea, representing 82% in 2016, 93% in 2017, 77% in 2018 and 68% in 2019.

Government schemes paid for 18% of HIV expenditure in 2016, 7% in 2017, 23% in 2018 and 32% in 2019.

Remaining small amount of PGK 58.4 thousand in 2016 refers to a non-resident external scheme, which represents less than 1% of the total expenditure.

Figure 4. Financing schemes (SCH) of the HIV Response in Papua New Guinea, 2016-2019

Financing Schemes	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
SCH.01 Government schemes	11,160,222	18%	3,554,582	7%	14,006,614	23%	25,168,042	32%
<i>SCH.01.01.01 Central government schemes</i>	11,109,969	18%	3,483,634	7%	13,960,234	23%	24,864,921	32%
<i>SCH.01.01.02 State/regional/local government schemes</i>	50,253	<1%	70,948	<1%	46,380	<1%	49,177	<1%
SCH.02 Voluntary payment schemes	52,107,799	82%	45,666,811	93%	45,606,966	77%	53,619,528	68%
<i>SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.2.2.2)</i>	15,570,592	25%	23,341,055	47%	21,843,327	37%	33,424,521	43%
<i>SCH.02.02.02 Resident foreign agencies schemes</i>	36,537,207	58%	22,228,368	45%	23,137,761	39%	19,815,761	25%
<i>SCH.02.02.99 Not-for-profit organisation schemes n.e.c.</i>					189,980	<1%	217,600	<1%
<i>SCH.02.03.01 Enterprises (except health care providers) schemes</i>			97,388	<1%	443,654	1%	161,646	<1%
SCH.04 External schemes (non-resident)	58,429	<1%						
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

Sources of Revenue

Revenues of financing schemes (REV) are the types of revenues received or collected by financing schemes (see Figure 5). The classification provides comprehensive information about revenue-raising (how and what type of revenues are raised by the

financing schemes and – in combination with information on institutional units – from which institutional sectors of the economy).

Direct foreign transfers remain the largest source of revenues directed to HIV Response in Papua New Guinea. In 2016 they accounted for 82% of the total HIV spending, in 2017 – 93%, in 2018 – 76%, in 2019 – 68%.

Public sources refer to expenditure on health by all government agencies in the country and includes donor (external) funding passing through these agencies as direct budget support. Public financing of health was limited to 18% of total HIV expenditure in 2016, 7% in 2017, 23% in 2018 and 32% in 2019.

Figure 5. Sources of Revenues (REV) of the HIV spending in Papua New Guinea, 2016-2019

Sources of Revenues	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
REV.01 Transfers from government domestic revenues	11,160,222	18%	3,554,582	7%	13,998,859	23%	24,914,098	32%
REV.06 Other domestic revenues n.e.c.:					199,980	<1%	242,600	<1%
REV.06.01 Other revenues from households n.e.c.					189,980	<1%	217,600	<1%
REV.06.02 Other revenues from corporations n.e.c.					10,000	<1%	25,000	<1%
REV.07 Direct foreign transfers:	52,166,228	82%	45,666,811	93%	45,414,741	76%	53,376,928	68%
REV.07.01.01 Direct bilateral financial transfers	35,415,462	56%	22,228,368	45%	23,137,761	39%	22,319,559	28%
REV.07.01.02 Direct multilateral financial transfers	16,725,251	26%	22,820,178	46%	21,218,153	36%	30,004,910	38%
REV.07.01.98 Direct foreign financial transfers not disaggregated	25,515	<1%	371,989	1%	390,966	1%	639,516	1%
REV.07.01.99 Direct foreign financial transfers n.e.c.			246,276	1%	667,862	1%	412,943	1%
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

Financing Agent-Purchaser

HIV financing through government schemes is in general managed by government institutions/agencies while a significant proportion of donor funds are partly administered directly and partly channelled through their implementing partners or non-profit organizations serving households, thus reducing direct role of donors in HIV response financing (see Figure 6).

Public sector Financing Agents-Purchasers manage a total of PGK 12.6M or 20% of HIV spending in PNG in 2016, 4.5M (9%) in 2017, nearly 14.1M (24%) in 2018 and 25M (32%) in 2019.

Of that, NACS managed PGK 7.7M (12% of total HIV spending) in 2016, 2.4M (5%) in 2017, 10M (17%) in 2018 and 11.2M (14%) in 2019. HIV funding managed by NDOH

amounts to PGK 4.8M (7% of total HIV spending) in 2016, almost 2M (4%) in 2017, 4.1M (7%) in 2018 and 13.8M (18%) in 2019.

A majority of HIV spending has been managed through international organizations: PGK 50.8M (80% of total HIV spending) in 2016, 44.8M (91%) in 2017, over 45.3M (76%) in 2018 and 53.2M (68%) in 2019. The largest international FAPs are:

- Oil Search Health Fund, classified as an International NGO, managing 23% and 41% of the total HIV spending in 2016 and 2017 while being a Principal Recipient of The Global Fund grant;
- World Vision, managing 32% and 35% of the total HIV spending in 2018 and 2019 as a Principal Recipient of the new Global Fund grant that started in 2018;
- FHI 360, managing 19% of the overall country's HIV expenditure in 2016, 21% in 2017, 18% in 2018 and 11% in 2019.

Figure 6. Financing Agents-Purchasers of the HIV Response in Papua New Guinea, 2016-2017

Financing Agents-Purchasers	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
FAP.01 Public sector FAP	12,554,423	20%	4,494,341	9%	14,071,113	24%	25,032,783	32%
<i>National Department of Health</i>	4,730,890	7%	1,981,170	4%	4,057,513	7%	13,754,073	18%
<i>National AIDS Council Secretariat</i>	7,725,422	12%	2,442,223	5%	9,967,220	17%	11,229,533	14%
<i>Provincial AIDS Commission</i>	98,111	<1%	70,948	<1%	46,380	<1%	49,177	<1%
FAP.02 Private sector FAP					234,580	<1%	279,000	<1%
FAP.03 International FAP	50,772,027	80%	44,727,052	91%	45,307,888	76%	53,221,842	68%
<i>Bilateral</i>	20,948,087	33%	7,211,934	15%	163,757	<1%	253,945	<1%
<i>INGOs</i>	27,627,029	44%	34,440,672	70%	41,973,162	70%	49,072,064	62%
<i>Multilateral - UN</i>	2,196,910	3%	3,021,860	6%	2,692,165	5%	3,478,997	4%
<i>Projects within Universities</i>			52,585	<1%	478,803	1%	416,837	1%
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

Providers of Services

Most spending on HIV and AIDS in Papua New Guinea are carried out by international providers, which absorbed 57% (PGK 35.8M) in 2016, 70% (34.6M) in 2017, 63% (37.7M) in 2018 and 46% (36.5M) in 2019 (see Figure 7). Among international service providers International NGOs is the largest group of providers of HIV programmes and interventions.

Service provision in the public sector accounts for 24% (PGK 15.2M) in 2016, 20% (9.7M) in 2017, 25% (15.1M) in 2018 and 29% (23.1M) in 2019. National AIDS Council Secretariat, with an exception of 2017, was the largest public sector provider in the HIV Response in PNG.

Majority of resources channelled through the public sector providers traditionally come from public financing entities – PGK 10.1M in 2016, 3.6M in 2017, 12.2M in 2018 and 20M in 2019.

Figure 7. Providers of Services in the HIV Response in Papua New Guinea, 2016-2019

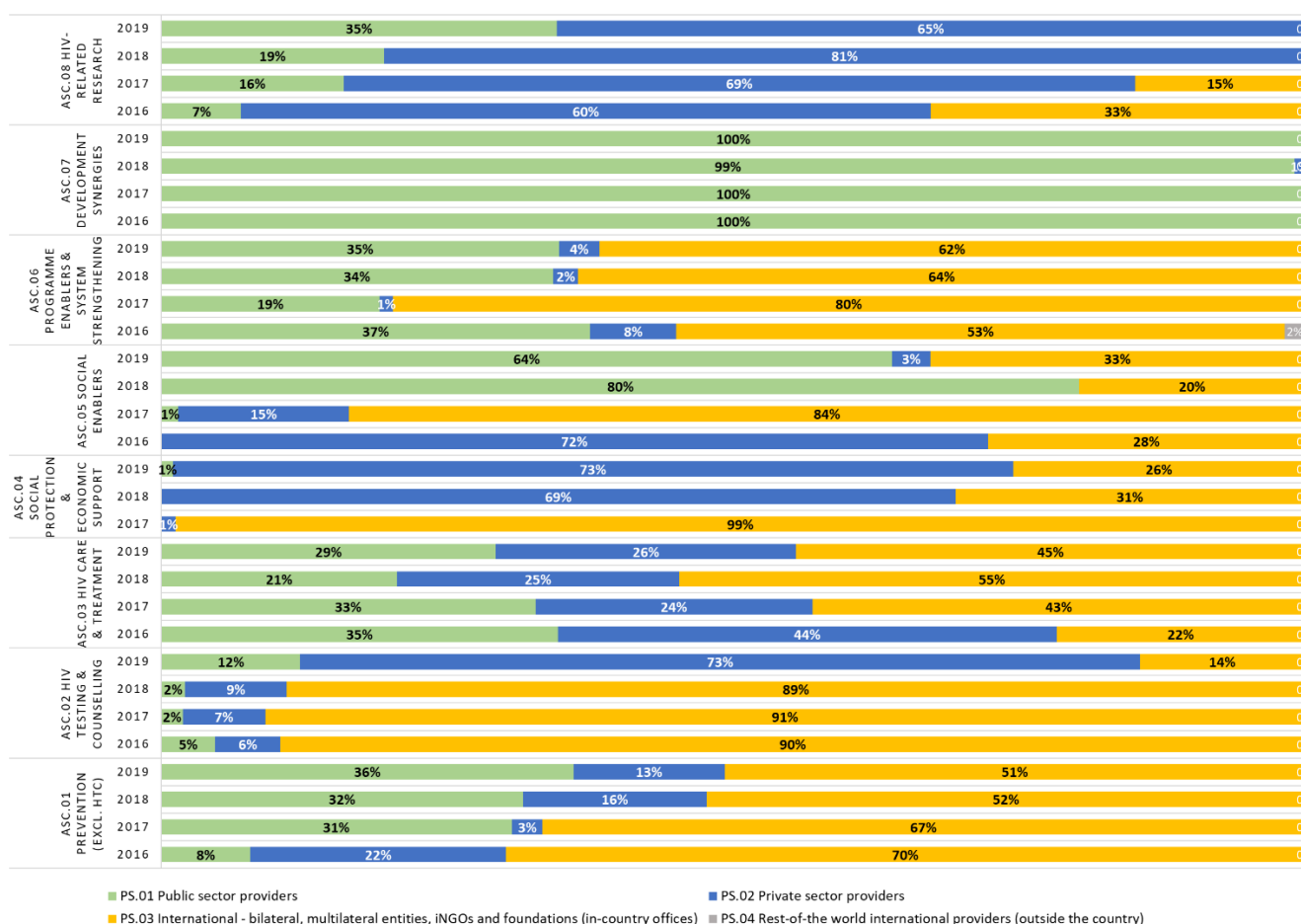
Providers of Services	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
PS.01 Public sector providers	15,185,731	24%	9,688,382	20%	15,079,486	25%	23,106,984	29%
PS.01.01.01 Hospitals (public)	57,141	<1%	62,682	<1%				
PS.01.01.02 Ambulatory care (public)	3,912,096	6%	1,592,978	3%	3,134,028	5%	9,094,250	12%
PS.01.01.04 Laboratory and imaging facilities (public)	621,143	1%						
PS.01.01.09.01 Primary education (public)							2,000	<1%
PS.01.01.09.03 Higher education (public)					40,000	<1%	10,000	<1%
PS.01.01.13.01 National AIDS Coordinating Authority (NACs)	7,808,458	12%	2,532,096	5%	9,130,568	15%	11,084,290	14%
PS.01.01.13.02 Departments inside the Ministry of Health or equivalent	2,664,597	4%	5,414,682	11%	2,652,602	4%	2,833,361	4%
PS.01.01.99 Governmental organizations n.e.c.	63,867	<1%					83,082	<1%
PS.01.02.99 Parastatal organizations n.e.c.	58,429	<1%	85,944	<1%	122,288	<1%		
PS.02 Private sector providers	11,878,541	19%	4,961,318	10%	6,804,280	11%	18,975,187	24%
PS.02.01.01.02 Ambulatory care (private non-profit non-faith based)	1,369,539	2%	347,204	1%	1,667,587	3%	13,738,073	17%
PS.02.01.01.09.01 Primary education (private non-profit non-faith based)					17,700	<1%		
PS.02.01.01.12 Research institutions (private non-profit non-faith based)	1,833,144	3%	1,369,396	3%	414,784	1%	453,461	1%
PS.02.01.01.14 Civil society organizations (private non-profit non-faith based)	2,953,175	5%	510,000	1%	1,263,642	2%	1,916,585	2%
PS.02.01.02.02 Ambulatory care (private non-profit faith based)	2,281,087	4%	1,863,863	4%	97,020	0%	694,993	1%
PS.02.01.02.13 Civil society organizations (private non-profit faith based)	3,441,596	5%	870,855	2%	3,341,494	6%	2,172,074	3%
PS.02.98 Private sector providers not disaggregated					2,054	<1%		
PS.03 International - bilateral, multilateral entities, INGOs and foundation:	35,796,321	57%	34,571,693	70%	37,729,815	63%	36,451,455	46%
PS.03.01 Bilateral agencies	1,197,212	2%						
PS.03.02 Multilateral agencies	1,403,534	2%	2,067,248	4%	3,303,371	6%	2,573,299	3%
PS.03.03 International NGOs and foundations	33,195,575	52%	32,504,445	66%	34,426,444	58%	33,878,156	43%
PS.04 Rest-of-the world international providers (outside the country)	465,857	1%						
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

Expenditure made available for the public sector service provision from the international funding sources amounted to PGK 5.1M in 2016, 6.1M in 2017, 2.9M in 2018 and 3.1M in 2019. The Global Fund is the largest international financier of the activities provided in the public sector with PGK 1.3M in 2016 and in 2018, approximately 3M in 2017, 1.6M in 2019.

The largest share of the HIV resources implemented by the private sector entities came from international organizations: PGK 10.9M in 2016, 5M in 2017, 4.8M in 2018 and 13.8M in 2019. The Government of Australia is the top funder of the private sector organizations with the contribution of PGK 8.1M in 2016, 2.5M in 2017, 3.4M in 2018 and 3.5M in 2019. Additionally, private sector providers implemented almost PGK 8M of government funds across 2016-2019.

The largest segment of the total HIV spending is being implemented by international NGOs and foundations, bilateral and multilateral in-country offices, which receive the majority of funds within their own financing arrangements. Australian government supplied PGK 12.7M in 2016, over 7M in 2017, 7.7M in 2018 and 7.9M in 2019, while US-originated funding to PS.03 providers accounted for PGK 11.8M in 2016, 10.8M in 2017, 10.9M in 2018, going down to 1.2M in 2019.

Figure 8. Providers of Services by AIDS Spending Category (1st digit), 2016-2019



International organizations demonstrated a strong presence in the service provision of prevention, HIV testing and counselling, HIV Care and Treatment and implementation of the policy-level programmes (see Figure 8 above).

Private service providers dominate the implementation of the ASC.08 HIV-related research and ASC.04 Social protection and Social Services, however these ASCs are not “heavy” in monetary terms.

Public sector service provision is present across most of the AIDS Spending Categories, except for ASC.04 Social protection and Economic support and partially ASC.05 Social Enablers (only in 2016-2017) where its presence is negligible.

Surprisingly, NASA reveals a relatively small participation of public service providers in ASC.02 HIV Testing and Counselling, which may be related to one of the limitations of this assessment – absence of data reflecting shared health system cost. Additionally, a majority of data informing ASC.02 has been obtained from FHI360⁷, which indicated Modilon General Hospital as the only public-sector provider of HTC services, and World Vision as a Principal Recipient of the GFATM grant⁸, which, according to their data, provided HTC services through its non-governmental partners.

ASC.01 Prevention (excluding HTC) and ASC.03 HIV Care and Treatment are two AIDS Spending Categories where public sector service provision occupies a sizable share. Particular progress is seen in the prevention service provision where public providers increased their presence from only 8% of the total expenditure on this ASC in 2016 to 36% in 2019.

⁷ FHI360 provided 77% of all expenditure data in ASC.02 HIV Counselling and Testing

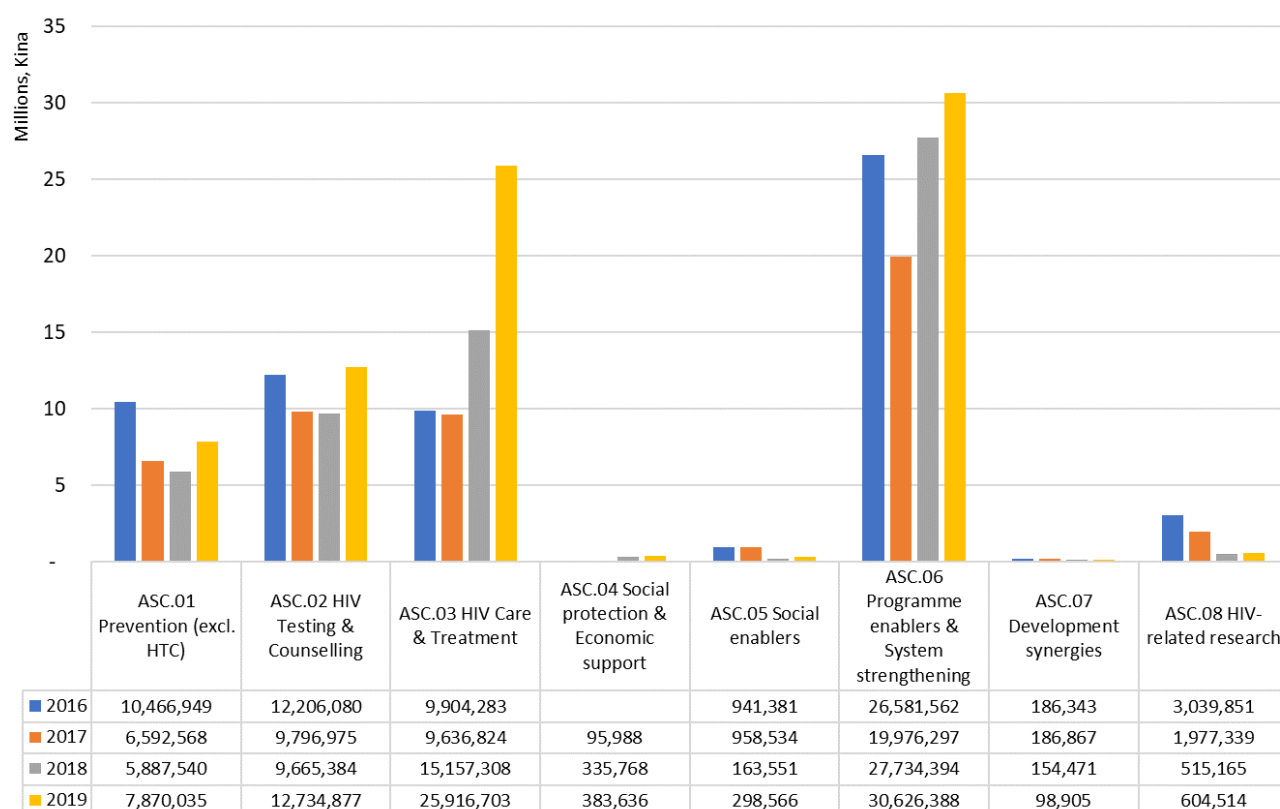
⁸ PR World Vision provided 7% of all expenditure data in ASC.02 HIV Counselling and Testing

Programmatic Description of HIV Expenses

Expenditure per AIDS Spending Category

Figure 9 below demonstrates the trend in resource distribution among various AIDS Spending Categories.

Figure 9 Trends in expenditure by AIDS Spending Categories (ASC), 2016-2019



Similar to the trends of the previous HIV spending assessments in Papua New Guinea, the majority of expenditure goes to the programme enablers and system strengthening (see Figure 10). In 2016 ASC.06 accounts for 42% of the country's HIV response (PGK 26.6M), 41% (20M) in 2017, and 47% (27.7M) in 2018 and 39% (30.6M) in 2019, while in the previous NASA round, covering the year 2012, this AIDS Spending Category was reaching almost PGK 70M, representing 57% of the total spending that year.

Expenditure on HIV response management has at least doubled-down since the last NASA round covering 2011-2012, while its portfolio – a variety of interventions and

their coverage - has expanded significantly, meaning that more was being done with the less money. Improved technical efficiency⁹ of the management of the HIV response since the last assessments and a reduction of the cost of doing business in Papua New Guinea observed in the primary data and in the interviews with the organization-respondents (lower prices on utilities, internet, travelling, security etc) were among main reasons of the lower overall national spending to tackle HIV.

Approximately 16% of total HIV spending in 2016 were spent on ASC.03 Treatment and care, 20% in 2017, 25% in 2018 and 33% in 2019. In decreasing order of expenditure share, the ranking of other broader AIDS Spending Categories was:

- ASC.02 HIV Testing and Counselling (19% in 2016, 20% in 2017, 16% both in 2018 and 2019),
- ASC.01 Prevention (excluding HTC) (17% in 2016, 13% in 2017, 10% in 2018 and 10% in 2019),
- ASC.08 HIV-related research (5% in 2016, 4% in 2017 and 1% in 2018 and 2019),
- followed by ASC.05 Social Enablers, and finally
- ASC.07 Development Synergies and ASC.04 Social protection and Economic Support (up to a maximum of 2% annually).

Figure 10. Programmatic breakdown of the HIV Response in Papua New Guinea, 2016-2019

AIDS Spending Categories	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
ASC.01 Prevention (excluding HTC)	10,466,949	17%	6,592,568	13%	5,887,540	10%	7,870,035	10%
ASC.02 HIV Testing & Counselling	12,206,080	19%	9,796,975	20%	9,665,384	16%	12,734,877	16%
ASC.03 HIV Care & Treatment	9,904,283	16%	9,636,824	20%	15,157,308	25%	25,916,703	33%
ASC.04 Social protection & Economic support			95,988	<1%	335,768	1%	383,636	<1%
ASC.05 Social enablers	941,381	1%	958,534	2%	163,551	<1%	298,566	<1%
ASC.06 Programme enablers & System strengthening	26,581,562	42%	19,976,297	41%	27,734,394	47%	30,626,388	39%
ASC.07 Development synergies	186,343	<1%	186,867	<1%	154,471	<1%	98,905	<1%
ASC.08 HIV-related research	3,039,851	5%	1,977,339	4%	515,165	1%	604,514	1%
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

Inside **ASC.01 Five Pillars of Prevention (which excludes HTC)**, the largest share of expenditure targets key populations: PGK 7.6M (12% of total HIV spending and 72% of

⁹ Although it should be noted that National AIDS Spending Assessment is not the tool to measure technical efficiency, we can use it as a piece of evidence.

the ASC.01) in 2016, 4.5M (9% of total HIV spending and 68% of the ASC.01) in 2017, 3.2M (5% of total HIV spending and 54% of the ASC.01) in 2018 and 4.5M (6% of the total HIV spending and 57% of the ASC.01) in 2019 (see Figure 11).

The largest portion of Prevention expenditure, an average of 43% across four years (55% in 2016, 26% in 2017, 42% in 2018 and 49% in 2019), supports the programmes targeting sex workers and their clients, though this amount may be even more substantial considering that a portion of it remained in the category ASC.01.01.02.98 Prevention services for key populations not disaggregated by type, which accounts for 15 and 37 per cent of the total ASC.01 Prevention (excluding HTC) in 2016 and 2017.

In 2018 and 2019 a quality and completeness of data reported in Prevention programmes has improved. Only 1% of services for key populations were not broken down by population type in those years, and no spending has been coded as ASC.01.98 Prevention activities not disaggregated by type. Although, a better level of details is still required for breaking down prevention programmes for vulnerable and accessible populations.

Figure 11. Programmatic breakdown of ASC.01 Five pillars of Prevention (excluding HTC), 2016-2019

AIDS Spending Categories	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
ASC.01 Prevention (excluding HTC)	10,466,949	17%	6,592,568	13%	5,887,540	10%	7,870,035	10%
ASC.01.01.01 Prevention among AGYW					1,510	<1%		
ASC.01.01.02.01 Prevention among sex workers (excluding HTC/PrEP/ART)	5,758,901	9%	1,743,406	4%	2,450,716	4%	3,830,890	5%
ASC.01.01.02.02 Prevention among MSM (excluding HTC/PrEP/ART)	183,076	<1%	328,383	1%	606,273	1%	681,628	1%
ASC.01.01.02.05 Prevention among inmates (excluding HTC/PrEP/ART)					70,918	<1%		
ASC.01.01.02.98 Services for key populations not disaggregated (exclusively for the five populations here described)	1,613,953	3%	2,433,595	5%	70,190	<1%		
ASC.01.01.03.98 Condom activities (for HIV prevention) not disaggregated	184,828	<1%						
ASC.01.01.04 Voluntary medical male circumcision (VMMC) programmes							273,054	<1%
ASC.01.02.01.98 PMTCT not disaggregated by activity	264,421	<1%	453,112	1%	365,683	1%	329,682	<1%
ASC.01.02.02-10 Prevention for populations other than key populations	2,461,772	4%	1,634,072	3%	2,322,251	4%	2,754,781	4%
ASC.02 HIV Testing & Counselling	12,206,080	19%	9,796,975	20%	9,665,384	16%	12,734,877	16%
ASC.03 HIV Care & Treatment	9,904,283	16%	9,636,824	20%	15,157,308	25%	25,916,703	33%
ASC.04 Social protection & Economic support			95,988	<1%	335,768	1%	383,636	<1%
ASC.05 Social enablers	941,381	1%	958,534	2%	163,551	<1%	298,566	<1%
ASC.06 Programme enablers & System strengthening	26,581,562	42%	19,976,297	41%	27,734,394	47%	30,626,388	39%
ASC.07 Development synergies	186,343	<1%	186,867	<1%	154,471	<1%	98,905	<1%
ASC.08 HIV-related research	3,039,851	5%	1,977,339	4%	515,165	1%	604,514	1%
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

ASC.02 HIV Counselling and Testing holds a third place in the share of HIV spending in Papua New Guinea – an average of 18% annually (see Figure 12). However, unlike in Prevention where activities are more focused on KP, in testing and counselling the expenditure is allocated around general population and vulnerable groups. HTC for Key

Populations comprise only PGK 0.5M (or 4% of ASC.02 HIV Counselling and Testing) in 2016, 0.5M (or 5% of ASC.02 HIV Counselling and Testing) in 2017, 1.9M (or 19% of ASC.02 HIV Counselling and Testing) in 2018 and 3.2M (or 25% of ASC.02 HIV Counselling and Testing) in 2019.

The reported data indicates a shift in the HTC spending focus from vulnerable populations (which went down from PGK 10.8M in 2016 to 2.5M in 2019) to general population (increased from PGK 0.8M in 2016 to over 7M in 2019).

Throughout the years of assessment, the non-disaggregated data in ASC.02 increases from almost PGK 0.4M in 2016 to 2.7M in 2019.

Figure 12. Programmatic breakdown of ASC.02 HIV Counselling and Testing, 2016-2019

AIDS Spending Categories	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
ASC.01 Prevention (excluding HTC)	10,466,949	17%	6,592,568	13%	5,887,540	10%	7,870,035	10%
ASC.02 HIV Testing & Counselling	12,206,080	19%	9,796,975	20%	9,665,384	16%	12,734,877	16%
ASC.02.01 HIV testing and counselling for sex workers	138,141	<1%	193,684	<1%	1,341,906	2%	2,349,007	3%
ASC.02.02 HIV testing and counselling for MSM	8,346	<1%	52,728	<1%	490,972	1%	820,322	1%
ASC.02.03 HIV testing and counselling for TG					472	<1%		
ASC.02.05 HIV testing and counselling for inmates of correctional and pre-trial facilities					15,640	<1%		
ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)	69,702	<1%						
ASC.02.07 Early infant diagnosis (EID) of HIV			79,518	<1%	96,748	<1%	503,245	1%
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	10,538,915	17%	8,172,831	17%	1,807,689	3%	2,023,311	3%
ASC.02.09 Voluntary HIV testing and counselling for general population	842,304	1%	439,726	1%	5,911,957	10%	4,383,443	6%
ASC.02.10 Provider initiated testing and counselling (PITC)	226,925	<1%	631,582	1%				
ASC.02.98 HIV testing and counselling activities not disaggregated	381,747	1%	226,906	<1%			2,655,550	3%
ASC.03 HIV Care & Treatment	9,904,283	16%	9,636,824	20%	15,157,308	25%	25,916,703	33%
ASC.04 Social protection & Economic support			95,988	<1%	335,768	1%	383,636	<1%
ASC.05 Social enablers	941,381	1%	958,534	2%	163,551	<1%	298,566	<1%
ASC.06 Programme enablers & System strengthening	26,581,562	42%	19,976,297	41%	27,734,394	47%	30,626,388	39%
ASC.07 Development synergies	186,343	<1%	186,867	<1%	154,471	<1%	98,905	<1%
ASC.08 HIV-related research	3,039,851	5%	1,977,339	4%	515,165	1%	604,514	1%
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

In **ASC.03 Care and Treatment** the largest portion of spending lacks detail to be assigned to a specific NASA sub-category: in 2016 fifty per cent of all Treatment and Care spending, equal to PGK 4.9M, was assigned to ASC.03.98 Care and Treatment services not disaggregated by type; in 2017 it comprised PGK 4.3M, in 2018 – 5.8M, and 5M in 2019 (see Figure 13). These results may be and, undoubtedly, should be improved in the next NASA round by gathering more detailed data about healthcare service utilization in Papua New Guinea from key implementors of these services and their funding agencies.

Antiretroviral therapy¹⁰ remains a large part of Care and Treatment spending in Papua New Guinea: from PGK 3.5M in 2016 – 6% of the overall HIV Response -, to 9.1M in 2019 – 12% of the country’s HIV spending.

ART procurement is predominantly funded by the GoPNG: 72% of total ART spending was public (over PGK 2.5M) in 2016, 98% or 0.9M in 2018 and 99% or over 9M in 2019. In 2017 due to an interruption in the Government funds’ allocation 29% of the ART procurements were covered by Australian Government through DFAT and 46% - by the Global Fund. In 2017 only 26% of the ART spending was publicly funded.

With the shift in the focus in the Global Fund grants, the composition of ASC.03 Care and Treatment has changed. More funding became available for TB-related interventions (from zero in 2016 and 2017 to PGK 4M in 2018 and 8.6M in 2019), as well as for ART adherence and retention on ART interventions.

Figure 13. Programmatic breakdown of ASC.03 HIV Care and Treatment, 2016-2019

AIDS Spending Categories	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
ASC.01 Prevention (excluding HTC)	10,466,949	17%	6,592,568	13%	5,887,540	10%	7,870,035	10%
ASC.02 HIV Testing & Counselling	12,206,080	19%	9,796,975	20%	9,665,384	16%	12,734,877	16%
ASC.03 HIV Care & Treatment	9,904,283	16%	9,636,824	20%	15,157,308	25%	25,916,703	33%
ASC.03.01 ART	3,518,035	6%	3,464,071	7%	4,767,955	8%	9,128,897	12%
ASC.03.02 Adherence and retention on ART - support and monitoring	679,128	1%			418,148	1%	1,150,488	1%
ASC.03.03 Specific ART-related laboratory monitoring	345,529	1%	1,787,732	4%	40,785	<1%	589,407	1%
ASC.03.04.01.02 TB screening, case detection and diagnosis					2,379,276	4%	6,526,692	8%
ASC.03.04.01.05 Nutritional support associated with TB treatment					108,766	<1%	179,784	<1%
ASC.03.04.01.98 TB activities not disaggregated by type					1,508,177	3%	1,921,497	2%
ASC.03.04.98 Other OI prophylaxis and treatment not disaggregated by type (excluding TB and hepatitis)	443,841	1%					1,239,099	2%
ASC.03.05 Psychological treatment and support service			54,100	<1%	97,020	<1%	142,041	<1%
ASC.03.98 Care and treatment services not disaggregated	4,917,751	8%	4,330,921	9%	5,837,180	10%	5,038,798	6%
ASC.04 Social protection & Economic support			95,988	<1%	335,768	1%	383,636	<1%
ASC.05 Social enablers	941,381	1%	958,534	2%	163,551	<1%	298,566	<1%
ASC.06 Programme enablers & System strengthening	26,581,562	42%	19,976,297	41%	27,734,394	47%	30,626,388	39%
ASC.07 Development synergies	186,343	<1%	186,867	<1%	154,471	<1%	98,905	<1%
ASC.08 HIV-related research	3,039,851	5%	1,977,339	4%	515,165	1%	604,514	1%
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

Expenditure on **ASC.04 Social protection and Economic support** was detected in three out of four years of assessment – 2017-2019 – and comprise less than 1% of the total national spending on HIV. This category contains programmes for OVC and social protection (other than for OVC). Among key Financing Entities for this AIDS Spending

¹⁰ In this NASA ART spending consists of expenses on drugs procurement, shipment and storage cost.

Category – international NGOs and domestic private and international corporations (see Figure 14).

The share of **ASC.05 Social enablers** is relatively low, representing 1% and 2% of HIV spending in Papua New Guinea in 2016 and 2017, and dropping 5-fold in 2018 and 2019.

The largest expenditure was detected in ASC.05.02.02 HIV-related legal services and ASC.05.02.05 Reducing discrimination and violence against women in the context of HIV. The origin of funds in this programmatic area shifts from the Global Fund, Governments of Australia and US in 2016-2017 to domestic public sources and the United Nations agencies in 2018-2019 (see Figure 14).

Figure 14. Programmatic breakdown of ASC.04 Social Protection and Economic Support and ASC.05 Social Enablers, 2016-2019

AIDS Spending Categories	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
ASC.01 Prevention (excluding HTC)	10,466,949	17%	6,592,568	13%	5,887,540	10%	7,870,035	10%
ASC.02 HIV Testing & Counselling	12,206,080	19%	9,796,975	20%	9,665,384	16%	12,734,877	16%
ASC.03 HIV Care & Treatment	9,904,283	16%	9,636,824	20%	15,157,308	25%	25,916,703	33%
ASC.04 Social protection & Economic support			95,988	<1%	335,768	1%	383,636	<1%
<i>ASC.04.01 Programmes for OVC</i>			1,200	<1%	233,180	<1%	279,000	<1%
<i>ASC.04.02 Social protection (other than OVC)</i>			94,788	<1%	102,588	<1%	104,636	<1%
ASC.05 Social enablers	941,381	1%	958,534	2%	163,551	<1%	298,566	<1%
<i>ASC.05.01 Advocacy</i>			14,166	<1%	75,845	<1%	110,409	<1%
<i>ASC.05.02.01 Stigma and discrimination reduction</i>	31,057	<1%	31,779	<1%	32,249	<1%	39,940	<1%
<i>ASC.05.02.02 HIV-related legal services</i>	540,685	1%			29,372	<1%		
<i>ASC.05.02.03 Monitoring and reforming laws, regulations and policies relating to HIV</i>					26,084	<1%	82,527	<1%
<i>ASC.05.02.04 Sensitization of law-makers and law enforcement agents</i>	21,697	<1%	24,085	<1%			909	<1%
<i>ASC.05.02.05 Reducing discrimination & violence against women in the context of HIV</i>	347,942	1%	811,297	2%			50,911	<1%
<i>ASC.05.02.06 Capacity building in human rights</i>							13,870	<1%
<i>ASC.05.98 Social enablers not disaggregated by type</i>			77,207	<1%				
ASC.06 Programme enablers & System strengthening	26,581,562	42%	19,976,297	41%	27,734,394	47%	30,626,388	39%
ASC.07 Development synergies	186,343	<1%	186,867	<1%	154,471	<1%	98,905	<1%
ASC.08 HIV-related research	3,039,851	5%	1,977,339	4%	515,165	1%	604,514	1%
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

ASC.06 Programme enablers and System strengthening remains the largest in the HIV response in Papua New Guinea. Key Financing Entities of the activities under the ASC.06 are:

- The Global Fund - comprising 28% of the ASC.06 in 2016, 49% in 2017, 41% in 2018 and 40% in 2019,
- Australian Government - with 33% of the ASC.06 in 2016, 30% in 2017, 20% in 2018 and 21% in 2019,

- Government of Papua New Guinea – representing 28% of the ASC.06 in 2016, 10% in 2017 (reduction in spending due to inactivity of the National AIDS Commission Secretariat), 27% in 2018 and in 2019, and
- Government of the United States of America – with a share of 7% of the ASC.06 in 2016, 6% in 2017, 7% in 2018 and 6% in 2019.

ASC.06.01 Strategic planning, coordination and policy development, which accounts for approximately 37% of ASC.06 Programme enablers and System strengthening on average across four years, is a single largest AIDS Spending Category in the National AIDS Spending Assessment in 2016-2019 (see Figure 15).

ASC.06.03 Programme administration and management costs (above service-delivery level) peaks in 2019 with PGK 7.1M, representing 23% of the ASC.06 and 9% of the total national spending on HIV.

High value of ASC.06 Programme enablers and System strengthening in this assessment, as well as in the previous NASAs, is likely related to the cost of doing business in Papua New Guinea, which remains high despite significant improvement over the last 10 years. Primary data collected in the last three spending assessments provides evidence of high costs of living (rent, utilities etc), building, vehicle and equipment maintenance, personnel and office security, internet etc. Part of these expenses is attributed to the service delivery in various activity-related NASA codes, however, the above-service level management cost comprises a significant share in the total HIV spending.

For instance, breaking down ASC.06 by Production Factors reveals that throughout 2016-2019 on average one quarter of ASC.06 was spent on PF.01.01.02.01 Labour costs - Program management, and another 7 per cent (a 4-year average) – on PF.01.01.02.02 Fringe Benefits - Program management. Presumably, some of it also ended up in PF.01.98 Current direct and indirect expenditures not disaggregated which represented 33% of ASC.06 in 2016, 29% in 2017, and 11% in 2018 and in 2019, adding to an already significant share of management-related labour cost in the total country's spending on HIV.

According to the NASA findings (NASA II and NASA III), the expenditure trend observed in 2016-2019 in ASC.06 in general and specifically under the codes ASC.06.01 and ASC.06.03 has gone down compared to what have been tracked for the years 2011-2012. Policy and coordination activities, previously captured under ASC.04.01 Policy development and coordination, now correspond to a NASA code ASC.06.01 Strategic planning, coordination and policy development. In 2011 it accounted for 27% of total HIV spending (corresponds to PGK 25.5M) and 20% in 2012 (corresponds to PGK 24M), compared to a 4-year average of 16% in 2016-2019.

Significant spending goes to ASC.06.04 Strategic information: the smallest investment was registered in 2018 (PGK 1.6M, or 3% of the national HIV expenditure) and the largest – in 2017 (PGK 4.5M or 9% of total national HIV expenditure that year). In the most recent assessment year – 2019 - strategic information represented 4% of the HIV Response in Papua New Guinea.

Public systems strengthening, which includes activities in the area of procurement and supply chain, laboratory system, institutional and organizational development, financial and accounting system strengthening etc, represents a large of the HIV Response in PNG: nearly PGK 3.3M or 5% of the HIV Response in 2016, 2.9M or 6% of the HIV Response in 2017, 3.6M or 6% of the HIV Response in 2018 and 4.6M or 6% of the HIV Response in 2019.

Investment in ASC.06.06.01 Civil society institutional and NGO development comprised 2% of the country's HIV spending in 2016, 1% in 2017, 4% in 2018 and 3% in 2019, the largest (over PGK 2M) compared to the previous years.

Trainings and pre-service capacity building tracked in the ASC.06.07 Health and community workforce interventions, although somewhat underestimated due to the specifics of the data collected, amount to PGK 1.4M in 2016 (2% of the total HIV spending in PNG), 0.7M (1% of the total HIV spending) in 2017, 1.5M (2% of the total HIV spending) in 2018 and 2.4M (3% of the total HIV spending) in 2019.

Not disaggregated spending in ASC.06 is relatively high – PGK 1.1M in 2016, 0.4M in 2017, over 1M in 2018 and 1.4M in 2019.

Figure 15. Programmatic breakdown of ASC.06. Programme Enablers and System Strengthening, ASC.07 Development Synergies and ASC.08 HIV-related Research, 2016-2019

AIDS Spending Categories	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
ASC.01 Prevention (excluding HTC)	10,466,949	17%	6,592,568	13%	5,887,540	10%	7,870,035	10%
ASC.02 HIV Testing & Counselling	12,206,080	19%	9,796,975	20%	9,665,384	16%	12,734,877	16%
ASC.03 HIV Care & Treatment	9,904,283	16%	9,636,824	20%	15,157,308	25%	25,916,703	33%
ASC.04 Social protection & Economic support			95,988	<1%	335,768	1%	383,636	<1%
ASC.05 Social enablers	941,381	1%	958,534	2%	163,551	<1%	298,566	<1%
ASC.06 Programme enablers & System strengthening	26,581,562	42%	19,976,297	41%	27,734,394	47%	30,626,388	39%
ASC.06.01 Strategic planning, coordination and policy development	10,249,731	16%	7,794,875	16%	10,988,154	18%	9,721,063	12%
ASC.06.02 Building meaningful engagement activities			79,988	<1%	226,584	<1%	349,303	<1%
ASC.06.03 Programme administration and management costs (above service-delivery level)	6,305,955	10%	2,966,808	6%	6,684,972	11%	7,069,891	9%
ASC.06.04 Strategic information	3,137,560	5%	4,514,987	9%	1,613,484	3%	3,068,261	4%
ASC.06.05 Public system strengthening	3,244,984	5%	2,908,502	6%	3,548,418	6%	4,624,278	6%
ASC.06.06.01 Civil society institutional and NGO development	1,144,876	2%	635,464	1%	2,202,510	4%	2,004,677	3%
ASC.06.06.02 Community worker education, training and support					210	<1%		
ASC.06.07 Health and community workforce intervention(s)	1,408,258	2%	726,385	1%	1,450,390	2%	2,442,113	3%
ASC.06.98 Programme enablers and systems strengthening not disaggregated	1,090,198	2%	349,288	1%	1,019,674	2%	1,346,803	2%
ASC.07 Development synergies	186,343	<1%	186,867	<1%	154,471	<1%	98,905	<1%
ASC.07.01 Formative education to build-up an HIV workforce and other trainings not related to any specific activity (e.g. pre-service) using HIV earmarked resources	186,344	<1%	186,868	<1%	151,571	<1%	98,906	<1%
ASC.07.02.01 Reducing violence against women and young girls					2,900	<1%		
ASC.08 HIV-related research	3,039,851	5%	1,977,339	4%	515,165	1%	604,514	1%
ASC.08.01 Biomedical research	45,957	<1%	70,538	<1%				
ASC.08.03 Epidemiological research	2,045,174	3%	1,343,312	3%	164,049	<1%	27,850	<1%
ASC.08.04 Socio-behavioural research	643,075	1%	288,688	1%	250,735	<1%	367,684	<1%
ASC.08.98 HIV and AIDS-related research activities not disaggr. by type	305,645	<1%	274,800	1%	100,381	<1%	188,980	<1%
ASC.08.99 HIV and AIDS-related research activities n.e.c.							20,000	<1%
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

ASC.07 Development synergies comprise less than 1% of the HIV Response in Papua New Guinea (see Figure 15. Programmatic breakdown of ASC.06. Programme Enablers and System Strengthening, ASC.07 Development Synergies and ASC.08 HIV-related Research, 2016-2019. Almost all the resources in this category (100% in 2016, 2017 and 2019, and 98% in 2018) come from the UN agencies.

ASC.08 HIV-related research represented 5% of the national HIV expenditure in 2016, 4% in 2017, and 1% in 2018 and 2019. Higher spending in 2016-2017 occurred due to the IBBS, conducted in that period (see Figure 15).

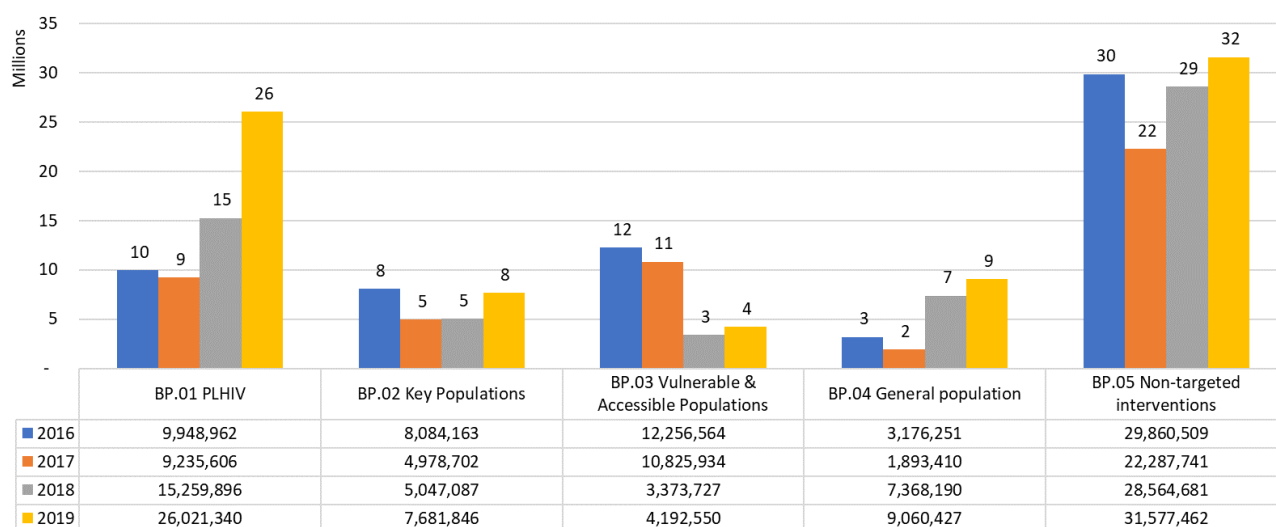
In 2016, 70% of the resources for HIV-related research came from The Global Fund, 21% - from Australian Government (a one-time allocation for IBBS), 5% - from UN, 2% - from the US Government and 1% - from international NGOs. In 2017 funding for research came: 68% - from the Global Fund, 19% - from iNGOs, 9% - from the US Government, 4% - from UN. In 2018 and 2019 the distribution of the origins of funding

for research was the following: 19% and 40% respectively came from the Government of Papua New Guinea, 76% and 44% - from iNGOs, 5% and 16% - from the UN agencies.

Expenditure per Beneficiary Population

In this section total national spending is broken down by intended beneficiary population of the implemented HIV programmes and services. Figure 16 below demonstrates a steady growth of spending targeting people living with HIV, which reflects the national effort to engage and retain more people on ART.

Figure 16. Trends in HIV expenditure by Beneficiary populations (BP), 2016-2019



In the table below the breakdown by Intended Beneficiary Population is presented both in absolute figures (PGK) and as a share of the annual HIV spending (see Figure 17).

Similar to the trends observed in the previous HIV spending assessments in Papua New Guinea, BP.05 Non-targeted interventions (which is applied to expenditure coded under ASC.06-08) comprise the majority of HIV spending: PGK 29.9M (or 47% of total HIV expenditure) in 2016, 22.3M (or 45% of total HIV expenditure) in 2017, 28.6M (or 48% of total HIV expenditure) in 2018 and 31.6M (or 40% of total HIV expenditure) in 2019. Non-targeted interventions' financing is divided between The Global Fund (appr. 40% of BP.05 across 4 years), Australian Government (25% of BP.05 across 4 years) and Government of Papua New Guinea (22% of BP.05 across 4 years).

Figure 17. HIV spending in Papua New Guinea by Beneficiary Population (BP), 2016-2019

Beneficiary Populations	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
BP.01 PLHIV	9,948,962	16%	9,235,606	19%	15,259,896	26%	26,021,340	33%
BP.02 Key Affected Populations	8,084,163	13%	4,978,702	10%	5,047,087	8%	7,681,846	10%
BP.02.02.01 Female sex workers and their clients	5,897,042	9%	1,937,089	4%	3,792,622	6%	6,179,897	8%
BP.02.03 Gay men and other men who have sex with men (MSM)	191,422	<1%	381,111	1%	1,097,246	2%	1,501,950	2%
BP.02.04 Transgender					472	<1%		
BP.02.05 Inmates of correctional facilities (prisoners) and other institutionalized persons					86,557	<1%		
BP.02.98 "Key populations" not broken down by type	1,995,700	3%	2,660,501	5%	70,190	<1%		
BP.03 Vulnerable & Accessible Populations	12,256,564	19%	10,825,934	22%	3,373,727	6%	4,192,550	5%
BP.03.01 Orphans and vulnerable children (OVC)			1,200	<1%	233,180	<1%	279,000	<1%
BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns	830,129	1%	1,028,636	2%	462,430	1%	832,927	1%
BP.03.03 Adolescent girls and young women in countries with high HIV prevalence	347,942	1%	811,297	2%			50,911	<1%
BP.03.13 Partners of people living with HIV (incl. sero-discordant couples)	24,373	<1%	18,356	<1%	17,393	<1%	14,688	<1%
BP.03.15 People attending STI clinics	491,098	1%	647,846	1%			338,505	<1%
BP.03.17 Junior high/high school students							6,424	<1%
BP.03.18 University students							10,000	<1%
BP.03.98 Vulnerable, accessible and other target populations not broken	10,547,956	17%	8,230,814	17%	2,627,549	4%	2,554,981	3%
BP.03.99 Other vulnerable, accessible & other target populations n.e.c.	15,066	<1%	87,785	<1%	33,175	<1%	105,113	<1%
BP.04 General population	3,176,251	5%	1,893,410	4%	7,368,190	12%	9,060,427	12%
BP.05 Non-targeted interventions	29,860,509	47%	22,287,741	45%	28,564,681	48%	31,577,462	40%
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

HIV programmes for **BP.01 PLHIV**, specifically secondary prevention, treatment and care and social support, account for 16% of the total HIV spending (or PGK 10M) in 2016, 19% (or 9.2M) in 2017, 26% (or 15.3M) in 2018 and 33% (or over 26M) in 2019.

The resources spent on the programmes targeting People Living with HIV were funded by:

- In 2016 – Government of Papua New Guinea (33% of the total 2016 spending on BP.01), Government of Australia (40%), US Government (1%), The Global Fund (21%), Asian Development Bank (4%);
- In 2017 - Government of Papua New Guinea (10% of the total 2017 spending on BP.01), Government of Australia (29%), US Government (1%), The Global Fund (59%), international NGOs (2%);
- In 2018 - Government of Papua New Guinea (31% of the total 2018 spending on BP.01), Government of Australia (28%), US Government (11%), The Global Fund (30%), iNGOs (1%);
- In 2019 - Government of Papua New Guinea (41% of the total 2019 spending on BP.01), Government of Australia (14%), US Government (6%), The Global Fund (38%), iNGOs (1%).

Spending dedicated to reaching **BP.02 Key Populations** was PGK 8.1M (13% of total HIV spending) in 2016, 5M (10%) in 2017, 5.1M (8%) in 2018 and 7.7M (10%) in 2019. It went down visibly throughout the years of assessment both in absolute values and as a share of the total country's HIV expenditure.

The resources spent on programmes benefiting Key Populations group were funded by:

- In 2016 – Government of Australia (69%), US Government (11%), The Global Fund (20%);
- In 2017 - Government of Papua New Guinea (1%), Government of Australia (16%), US Government (35%), The Global Fund (48%);
- In 2018 - Government of Papua New Guinea (9%), US Government (25%), The Global Fund (66%);
- In 2019 - Government of Papua New Guinea (12%), US Government (18%), The Global Fund (70%).

Starting from 2017 The Global Fund and the Government of The United States took over the lead from The Australian Government and became two key contributors to the programmes targeting Key Populations in Papua New Guinea, although a funding shift was also observed in the allocation of public resources towards risk groups.

A majority of the GFATM spending in 2018 and 2019 was directed to BP.02.02.01 Female sex workers and their clients (78% and 82% of all GFATM spending on Key Populations), followed by BP.02.03 Gay men and other men who have sex with men (MSM) (21% and 18% respectively).

In 2016 and 2017 84% and 80% of GFATM-funded expenditure on BP.02 Key Populations did not contain enough details to break it down into specific population, although in the new grant (2018-2019) the quality and level of details submitted to the NASA Team allowed for a proper disaggregation of Key Populations as per NASA requirements, thus reducing to zero expenditure under “not disaggregated” BP.02 code.

US Government support of Key Populations-related interventions is divided between BP.02.02.01 Female sex workers and their clients, BP.02.03 Gay men and other men who have sex with men (MSM) and BP.02.98 “Key populations” not broken down by type. Based on the data provided by organizations-respondents, BP.02.98 accounted for 27% of US-funded expenditure¹¹ on Key Populations in 2016, for 43% in 2017, and for 6% in 2018. Fifty-nine percent of the US funding for key populations in 2016 has been spent on interventions for female sex workers and their clients. In 2017 FSW-targeted funding was 41% of the total US-funded expenditure for KPs, in 2018 – 73% and 82% in 2019. Expenditure on BP.02.03 Gay men and other men who have sex with men (MSM) comprised 14% of US spending on Key Populations in 2016, 16% - in 2017, 21% - in 2018 and 18% in 2019.

There has been no domestic public spending to finance programmes for Key Populations in 2016, and in 2017 it comprised less than 1% of the BP.02 category. In 2018 and 2019 a share of KP-targeting interventions funded by GoPNG increased to 3% and 4%¹², although remaining low compared to other funding sources. Female sex workers (representing 68% of public expenditure on KPs in 2017, 57% in 2018 and 72% in 2019), MSM (32% of public expenditure on KPs in 2017, 27% in 2018 and 28% in 2019) and prisoners (15% of public expenditure on KPs in 2018) were in the focus of public expenditure on Key populations.

Expenditure on **BP.03 Vulnerable and Accessible Populations** represents 19% of the total spending (equal to PGK 12.3M) in 2016, 22% (or 10.8M) in 2017, 6% (or 3.4M) in 2018 and 5% (or 4.2M) in 2019. The resources spent on this beneficiary population group were funded by:

- In 2016 – Government of Papua New Guinea (1% of the total 2016 spending on BP.03), Government of Australia (4%), US Government (87%), The Global Fund (6%), UN agencies (2%);

¹¹ 100% in this case is all US-funded interventions for Key population

¹² 100% in this case is total national spending on Key Populations from all sources

-
- In 2017 - Government of Papua New Guinea (<1% of the total 2017 spending on BP.03), Government of Australia (5%), US Government (78%), The Global Fund (12%), UN agencies (5%);
 - In 2018 - Government of Papua New Guinea (1% of the total 2018 spending on BP.03), Government of Australia (26%), US Government (53%), UN agencies (14%), International for-profit corporations (1%), domestic private sources (6%);
 - In 2019 - Government of Papua New Guinea (10% of the total 2019 spending on BP.03), Government of Australia (21%), US Government (51%), UN agencies (11%), International for-profit corporations (1%), domestic private sources (6%).

Interventions benefiting **BP.04 General population** absorb PGK 3.2M (5% of total HIV spending) in 2016, 1.9M (4%) in 2017, 7.4M (12%) in 2018 and 9.1M (12%) in 2019.

Resources spent on HIV interventions targeting general population were funded by:

- In 2016 – GoPNG (7% of the total 2016 spending on BP.03), Government of Australia (62%), US Government (8%), UN agencies (9%), Asian Development Bank (14%);
- In 2017 - GoPNG (28% of the total 2017 spending on BP.03), Government of Australia (6%), US Government (18%), UN (48%);
- In 2018 - GoPNG (16% of the total 2018 spending on BP.03), Government of Australia (6%), US Government (76%), The Global Fund (3%);
- In 2019 - GoPNG (47% of the total 2019 spending on BP.03), Government of Australia (3%), US Government (45%), The Global Fund (4%).

Figure 18. Beneficiary Populations of the key AIDS Spending Categories, 2016-2019

AIDS Spending Category	Beneficiary population	2016		2017		2018		2019	
		PGK	%	PGK	%	PGK	%	PGK	%
ASC.01 Prevention (excl. HTC)	BP.02 Key Populations	7,555,929	72%	4,505,384	68%	3,198,097	54%	4,512,518	57%
	<i>KP - sex workers and their clients</i>	5,758,901	55%	1,743,406	26%	2,450,716	42%	3,830,890	49%
	<i>KP - Gay men and other MSM</i>	183,076	2%	328,383	5%	606,273	10%	681,628	9%
	<i>KP - Prisoners</i>					70,918	1%		
	<i>KP - not disaggregated</i>	1,613,953	15%	2,433,595	37%	70,190	1%		
	BP.03 Vulnerable & Accessible Populations	577,073	6%	633,500	10%	1,228,211	21%	1,336,083	17%
	<i>BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born and new borns</i>	264,421	3%	453,112	7%	365,683	6%	329,682	4%
	<i>BP.03.13 Partners of people living with HIV (including sero-discordant couples)</i>	24,373	<1%	18,356	<1%	17,393	<1%	14,688	<1%
	<i>BP.03.15 People attending STI clinics</i>	76,213	1%	16,264	<1%			338,505	4%
	<i>BP.03.17 Junior high/high school students</i>							6,424	<1%
	<i>BP.03.18 University students</i>							10,000	<1%
	<i>BP.03.98 Vulnerable, accessible and other target populations not broken down by type</i>	197,001	2%	57,983	1%	819,860	14%	531,671	7%
	<i>BP.03.99 Other vulnerable, accessible and other target populations n.e.c.</i>	15,066	<1%	87,785	1%	31,775	1%	105,113	1%
	BP.04 General population	2,333,947	22%	1,453,684	22%	1,454,733	25%	2,021,434	26%
	ASC.01 Prevention (excl. HTC) Total	10,466,949	100%	6,592,568	100%	5,887,540	100%	7,870,035	100%
ASC.02 HIV Testing & Counselling	BP.02 Key Populations	528,234	4%	473,318	5%	1,848,990	19%	3,169,328	25%
	<i>KP - sex workers and their clients</i>	138,141	1%	193,684	2%	1,341,906	14%	2,349,007	18%
	<i>KP - Gay men and other MSM</i>	8,346	<1%	52,728	1%	490,972	5%	820,322	6%
	<i>KP - Transgender</i>					472	<1%		
	<i>KP - Prisoners</i>					15,640	<1%		
	<i>KP - not disaggregated</i>	381,747	3%	226,906	2%				
	BP.03 Vulnerable & Accessible Populations	10,835,542	89%	8,883,931	91%	1,904,436	20%	2,526,556	20%
	<i>BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns</i>	69,702	1%	79,518	1%	96,748	1%	503,245	4%
	<i>BP.03.15 People attending STI clinics</i>	414,885	3%	631,582	6%				
	<i>BP.03.98 Vulnerable, accessible and other target populations not broken down by type</i>	10,350,955	85%	8,172,831	83%	1,807,689	19%	2,023,311	16%
	BP.04 General population	842,304	7%	439,726	4%	5,911,957	61%	7,038,993	55%
	ASC.02 HIV Testing & Counselling Total	12,206,080	100%	9,796,975	100%	9,665,384	100%	12,734,877	100%
ASC.03 HIV Care & Treatment	BP.01 PLHIV	9,408,277	95%	9,140,818	95%	15,157,308	100%	25,916,703	100%
	<i>BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born and new borns</i>	496,006	5%	496,006	5%				
	ASC.03 HIV Care & Treatment Total	9,904,283	100%	9,636,824	100%	15,157,308	100%	25,916,703	100%
ASC.04 Social protection & Economic support	BP.01 PLHIV			94,788	99%	102,588	31%	104,636	27%
	BP.03.01 Orphans and vulnerable children			1,200	1%	233,180	69%	279,000	73%
ASC.04 Social protection & Economic support Total				95,988	100%	335,768	100%	383,636	100%
ASC.05 Social enablers	BP.01 PLHIV	540,685	57%						
	BP.03 Vulnerable & Accessible Populations	347,942	37%	811,297	85%			50,911	17%
	BP.05 Non-targeted interventions	52,754	6%	147,237	15%	163,551	100%	247,655	83%
	ASC.05 Social enablers Total	941,381	100%	958,534	100%	163,551	100%	298,566	100%
ASC.06 Programme enablers	BP.05 Non-targeted interventions	26,581,562	100%	19,976,297	100%	27,734,394	100%	30,626,388	100%
ASC.06 Programme enablers & System strengthening Total		26,581,562	100%	19,976,297	100%	27,734,394	100%	30,626,388	100%
ASC.07 Development synergies	BP.03 Vulnerable & Accessible Populations					1,400	1%		
	BP.04 General population					1,500	1%		
	BP.05 Non-targeted interventions	186,343	100%	186,867	100%	151,571	98%	98,905	100%
ASC.07 Development synergies Total		186,343	100%	186,867	100%	154,471	100%	98,905	100%
ASC.08 HIV-related research	BP.05 Non-targeted interventions	3,039,851	100%	1,977,339	100%	515,165	100%	604,514	100%
ASC.08 HIV-related research Total		3,039,851	100%	1,977,339	100%	515,165	100%	604,514	100%
Grand Total		63,326,450		49,221,393		59,613,581		78,533,625	

In the table above (Figure 18) eight main AIDS Spending Categories are broken down by type of beneficiary population they reach.

Key populations remain in the focus of **ASC.01 Prevention** interventions – 72% of Prevention expenditure in 2016, 68% in 2017, 54% in 2018 and 57% in 2019 benefited various groups with a high risk of becoming HIV-infected, although the resources allocated for these services have significantly decreased since 2016. Vulnerable and accessible populations represent 6% of ASC.01 in 2016, 10% in 2017, but rapidly increased two-fold to 21% in 2018 and 17% in 2019 thanks to the funding from Government of Australia channelled through The Sexual and Reproductive Health Integration Project, implemented by Catholic Church Health Service (CCHS). General population (BP.04) represents 22% of ASC.01 Prevention in 2016 and 2017, 25% in 2018 and 26% in 2019.

The data collected during the assessment points towards a shift in the beneficiary population focus in **ASC.02 HIV Testing and Counselling**: from BP.03 Vulnerable and Accessible Populations, that comprised 89% (PGK 10.8M) and 91% (8.9M) of ASC.02 in 2016 and 2017 but dropped to 20% both in 2018 and 2019 (1.9M and 2.5M respectively). BP.04 General Population receiving HTC gained muscle throughout the years of assessment, from representing only 7% of ASC.02 in 2016 (PGK 0.8M) and 4% of ASC.02 in 2017 (0.4M), expanding to 61% of HTC spending in 2018 (PGK 5.9M) and 55% of HTC in 2019 (7M).

Expenditure on **ASC.03 Care and Treatment** is shared between two population groups: BP.01 People living with HIV (95% of ASC.03 in 2016 and 2017 and 100% of ASC.03 in 2018 and 2019) and BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born and new borns, although in 2018 and 2019 no expenditure was identified to target the latter.

In **ASC.04 Social Protection and Economic Support** the expenditure is divided between BP.01 People living with HIV (99% of ASC.04 in 2017, 31% in 2018 and 27% in 2019) and BP.03.01 Orphans and Vulnerable Children (1% of ASC.04 in 2017, 69% in 2018 and 73% in 2019). No dedicated expenditure for ASC.04 has been discovered in 2016.

As previously mentioned, a Beneficiary population code assigned to all the expenditure in ASC.05-08 is BP.05 Non-targeted interventions.

Expenditure per Service Delivery Modality

The breakdown of HIV spending in Papua New Guinea is presented in the **Error!**
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Figure 19. Service Delivery Modalities (SDM) of the HIV Response in Papua New Guinea, 2016-2019

Service Delivery Modalities	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
SDM.01 Facility-based	12,224,165	19%	10,965,010	22%	20,473,919	34%	21,080,480	27%
SDM.01.01 Facility-based: Outpatient	12,224,165	19%	10,965,010	22%	19,778,919	33%	21,080,480	27%
SDM.01.98 Facility-based not disaggregated					695,000	1%		
SDM.02 Home & Community-based	20,924,890	33%	15,189,124	31%	10,664,625	18%	25,710,636	33%
SDM.02.01 Community-based: center	12,586,781	20%	8,340,355	17%	719,434	1%	8,313,608	11%
SDM.02.03 Community-based: automated distribution/dispensing machine		0%	28,100	0%	390,787	1%	907,606	1%
SDM.02.04 Community-based: mobile unit	469,459	1%	756,540	2%	86,091	<1%	79,132	<1%
SDM.02.05 Community-based: outreach	6,951,880	11%	5,025,390	10%	9,230,142	15%	16,149,162	21%
SDM.02.06 Community-based: home-based (including door-to-door)		0%		0%	188,580	<1%	256,600	<1%
SDM.02.98 Home and community based not disaggregated	916,770	1%	1,038,739	2%				
SDM.02.99 Home and community based n.e.c.		0%		0%	49,591	<1%	4,528	<1%
SDM.03 Non-applicable	30,177,395	48%	23,067,258	47%	28,475,037	48%	31,742,509	40%
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

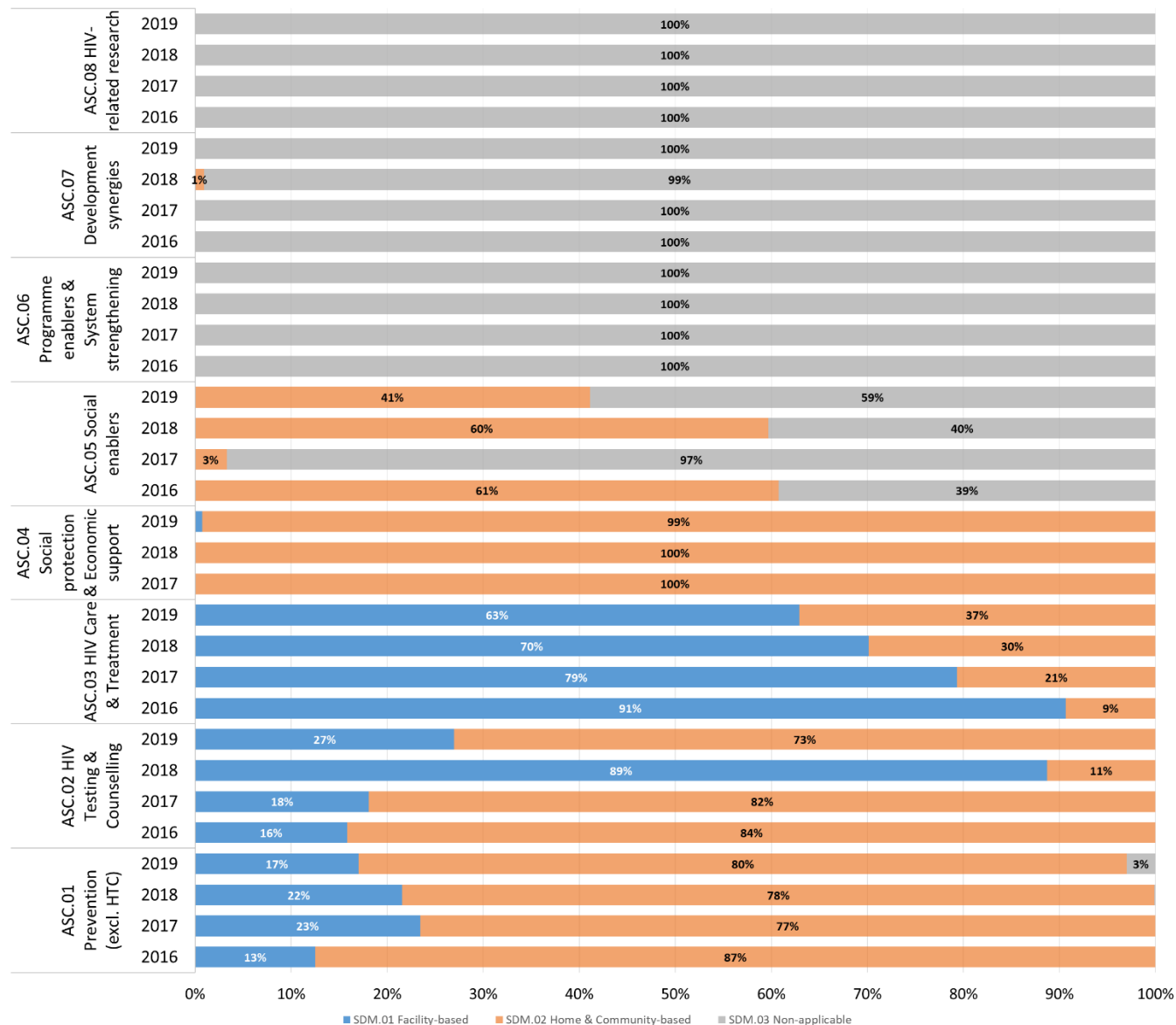
A significant part of HIV spending in Papua New Guinea goes towards policy interventions and other programme enablers which all target populations benefit from, thus making it methodologically inappropriate to assign a specific BP code. These activities were coded under the SDM.03 Non-applicable and represent 48% of total HIV spending in 2016, 47% in 2017, 48% in 2018 and 40% in 2019.

Home and Community-based service delivery represented 33% of the total spending in 2016, 31% in 2018, 18% in 2018 and 33% in 2019.

Facility-based service delivery represents 19% of the national HIV spending in 2016, 22% in 2017, picking at 34% in 2018 and gaining in monetary value but losing in terms (PGK 21.1M in 2019 compared to 20.5M in 2018) of a share to 27% of the total HIV expenditure in 2019.

Deconstruction of the AIDS Spending Categories by Service Delivery Modalities is presented in Figure 20 below.

Figure 20. AIDS Spending Categories (ASC) by Service Delivery Modalities (SDM) in %, 2016-2019



Home- and community-based service delivery dominate the **ASC.01 Prevention (excluding HTC)**: PGK 9.2M in 2016, 5.1M in 2017, 4.6M in 2018 and 6.3M in 2019 (an average of 81% of ASC.01 across four years), while facility-based service delivery mode has been identified to be a 4-year average of 19%.

ASC.02 HIV Counselling and Testing facility-based service delivery represents 16% of ASC.02 in 2016, 18% in 2017, 89% in 2019 and 27% in 2019. The remaining HTC services were delivered through a home- and community-based modality (84% of ASC.02 in 2016, 82% in 2017, 11% in 2018 and 73% in 2019).

ASC.03 HIV Care and Treatment service delivery is predominantly facility-based, representing 91% of the interventions in this AIDS Spending Category in 2016 (PGK 9M), 79% in 2017 (7.7M), 70% in 2018 (10.6M) and 63% in 2019 (16.3M). Home- and community-based service delivery modality represents a smaller but steadily growing part of treatment and care: while in 2016 it represented only 9% of services delivered amounting to less than 1M Kina, by 2019 it expanded to PGK 9.6M, which represented 37% of delivered treatment and care services.

Expenditure per Production Factor

In this section, the total HIV spending is evaluated in terms of factor inputs in healthcare production (see Figure 21).

Figure 21. Production Factors (PF) of the HIV Response in Papua New Guinea, 2016-2019

Production Factors	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
PF.01 Current direct & indirect expenditure	56,232,409	89%	46,401,572	94%	56,161,262	94%	70,734,630	90%
PF.02 Capital expenditure	1,305,110	2%	663,197	1%	3,252,711	5%	7,559,098	10%
PF.98 Production factors not disaggregated	5,788,932	9%	2,156,624	4%	199,608	<1%	239,898	<1%
Grand Total	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

Current direct and indirect expenditure represent the largest share in HIV spending in Papua New Guinea: 89% in 2016, 94% in 2017 and 2018 and 90% in 2019. Capital expenditure was fluctuating between one and five per cent in 2016-2018, and expanded in 2019 when it represented 10% of the total HIV expenditure in the country. A decrease in the amount of not disaggregated expenditure from PGK 5.8M in 2016 to a little over 0.2M in 2019 demonstrates a certain, although cautious, improvement of the quality and completeness of data collected from the organizations-respondents.

A breakdown of **PF.01 Current direct and indirect expenditure** reveals that a significant part of data could only be broken down into a single-digit code (see Figure 22). In 2016 current expenditure not disaggregated by type was PGK 28.4M, representing more than a half of the current HIV spending tracked in PF.01, although in the next years it shrank to 16.3M in 2019, approximately a quarter of Current direct and indirect expenditure.

Programme management labour cost (PF.01.01.02.01 “Labour costs – Programme management” + PF.01.01.02.02 “Fringe benefits – Programme management” + PF.01.01.02.04 “Program Management Consultants (external)” + PF.01.01.02.98 “Program management personnel not disaggregated”) is the next largest group of current expenditure amounting to nearly PGK 13.5M in 2016 (24% of the PF.01), 12.4M in 2017 (27% of PF.01), 10.1M in 2018 (18% of PF.01) and 10.6M in 2019 (15% of PF.01).

Human resources’ cost in the direct service provision (includes PF.01.01.01.01 “Labour costs – Direct service providers” + PF.01.01.01.02 “Fringe benefits – Direct service providers” + PF.01.01.01.04 “Consultants (external)” + PF.01.01.01.98 “Direct service providers not disaggregated”) was lower both in the absolute numbers and as a share of the overall Current expenditure compared to Programme management: PGK 5.2M in 2016 (9% of PF.01), 7.1M in 2017 (15% of PF.01), 7.2M in 2018 (12% of PF.01) and nearly 8.8M in 2019 (13% of PF.01).

Travel expenditure grew from PGK 1.7M in 2016 (3% of PF.01) to 4.4M (6% of PF.01) in 2019. Similar trend is observed in PF.01.08 Training- Training related per diems/transport/other costs, which increased from PGK 1.1M in 2016 (2% of PF.01) to 2.3M in 2019 (3% of PF.01).

Expenditure on ARV drugs including their logistics and storage was over PGK 2.5M in 2016 (4% of PF.01), 2.5M in 2017 (5% in PF.01), 4.7M in 2018 (8% of PF.01), 9M in 2019 (13% of PF.01).

Expenditure on HIV tests represents less than 1% of PF.01 in 2016 (PGK 0.07M) and growing to 3.1M in 2019. An anecdotal expenditure was tracked in PF.01.03.03.03 CD4 tests, which occurred due to the lack of details in the primary data collected, while PF.01.03.03.02 Viral Load tests was identified only in 2018 and 2019 and amounted to over PGK 154 thousand and 317 thousand correspondingly.

Figure 22. Breakdown of Current Expenditure, 2016-2019

Production Factors - Current expenditure	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
PF.01.01.01.01 Labor costs - Direct service providers	4,054,876	6%	4,952,334	10%	6,467,711	12%	5,518,849	8%
PF.01.01.01.02 Fringe Benefits - Direct service providers	245,676	<1%			111,145	<1%	41	<1%
PF.01.01.01.04 Consultants (external)	899,202	1%	2,145,732	4%	577,335	1%	699,094	1%
PF.01.01.01.98 Direct service providers not disaggregated							2,538,318	4%
PF.01.01.02.01 Labor costs - Program management	7,512,216	12%	7,346,308	15%	6,658,221	12%	7,952,222	11%
PF.01.01.02.02 Fringe Benefits - Program management	3,478,119	5%	1,306,130	3%	1,400,871	2%	1,618,801	2%
PF.01.01.02.04 Program Management Consultants (external)	131,947	3%	327,088	8%	1,912,623	3%	281,156	<1%
PF.01.01.02.98 Program management personnel not disaggregated	343,386	1%			163,757	<1%	738,425	1%
PF.01.02.01 Office rental costs	225,500	<1%			20,221	<1%		
PF.01.02.02 Office utilities costs (electricity, water, heating, etc.)	477,343	1%	27,378	<1%	276,786	<1%	345,509	<1%
PF.01.02.03 Travel expenditure	1,671,111	3%	1,566,644	3%	3,242,498	6%	4,390,205	6%
PF.01.02.04 Administrative and programme management costs	635,697	1%	540,062	1%	1,371,601	2%	1,715,275	2%
PF.01.02.98 Other current costs not disaggregated	1,477,590	2%	1,510,473	3%	4,226,038	8%	4,980,249	7%
PF.01.03.01.01 Antiretrovirals	2,526,023	4%	2,472,059	5%	4,680,260	8%	9,019,094	13%
PF.01.03.01.07 OI other than TB drugs							1,239,099	2%
PF.01.03.01.98 Pharmaceuticals not disaggregated	443,841	1%			3,764	<1%	4,706	<1%
PF.01.03.02.98 Medical supplies not disaggregated			168	<1%			2,838	<1%
PF.01.03.02.99 Medical supplies n.e.c.							36,186	<1%
PF.01.03.03.01 HIV tests screening/diagnostics	69,702	<1%	390,668	1%	29,076	<1%	3,078,983	4%
PF.01.03.03.02 VL tests					154,048	<1%	317,097	<1%
PF.01.03.03.03 CD4 tests	547	<1%	210	<1%				
PF.01.03.03.05 Diagnostic tests for TB (including rapid testing)					22,786	<1%	7,044	<1%
PF.01.03.03.98 Reagents and materials not disaggregated	345,547	1%			257,035	<1%	35,433	<1%
PF.01.03.04.01 Food and nutrients			7,655	<1%	91,760	<1%	292,216	<1%
PF.01.03.04.02 Promotion and information materials	200,646	<1%	319,429	1%	1,311,176	2%	1,257,266	2%
PF.01.03.04.98 Non-medical supplies not disaggregated					178,580	<1%	216,000	<1%
PF.01.03.05 Office Supplies	8,058	<1%	51,109	<1%	378,152	1%	168,447	<1%
PF.01.03.98 Medical products and supplies not disaggregated	236,604	<1%	162,362	<1%	203,085	<1%	204,800	<1%
PF.01.04 Contracted external services	914,357	1%	430,849	1%	280,664	<1%	1,208,646	2%
PF.01.05 Transportation related to beneficiaries					6,497	<1%		
PF.01.07 Financial support for beneficiaries	63,487	<1%			6,510	<1%	4,000	<1%
PF.01.08 Training- Training related per diems/transport/other costs	1,139,697	2%	1,307,940	3%	1,227,457	2%	2,280,379	3%
PF.01.09 Logistics of events, including catering services	529,762	1%	925,234	2%	3,061,003	5%	2,451,741	3%
PF.01.10.01 Financial intermediary services	2,319	<1%	11,596	<1%	333,876	1%	202,280	<1%
PF.01.10.02 Indirect cost rate	134,286	<1%			672,349	1%	393,667	1%
PF.01.10.98 Indirect costs not disaggregated	32,622	<1%	47,503	<1%	1,015,347	2%	1,274,321	2%
PF.01.98 Current direct and indirect expenditures not disaggregated	28,432,246	42%	20,552,643	35%	15,819,028	28%	16,262,243	23%
Sub-total PF.01 Current direct and indirect expenditures	56,232,409	89%	46,401,572	94%	56,161,262	94%	70,734,630	90%
Grand Total = Recurrent + Capital	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

Breakdown of Capital Expenditure is presented in the Figure 23. Expenditure on PF.02.02 Vehicles represent the largest portion of PF.02 in 2016 – PGK 0.9M or 66% of PF.02 – which goes down in the consecutive years.

A noticeable growth is observed in PF.02.03.01 Information technology (hardware and software) – from PGK 0.2M in 2016 to 1.5M in 2019, as well as in PF.02.03.02 Laboratory and other medical equipment – from PGK 0.2M in 2016 to 5.6M in 2019.

Figure 23. Breakdown of Capital Expenditure, 2016-2019

Production Factors - Capital expenditure	2016		2017		2018		2019	
	PGK	%	PGK	%	PGK	%	PGK	%
PF.02.01.02 Construction and renovation			1,058	<1%	29,171	1%	20,000	<1%
PF.02.02 Vehicles	857,215	66%	42,184	6%	720,414	22%	374,132	5%
PF.02.03.01 Information technology (hardware and software)	212,028	16%	135,724	20%	976,678	30%	1,476,535	20%
PF.02.03.02 Laboratory and other medical equipment	192,411	15%	376,017	57%	1,391,402	43%	5,571,861	74%
PF.02.03.03 Non medical equipment and furniture	43,455	3%	76,821	12%	128,944	4%	94,914	1%
PF.02.03.98 Other capital investment not disaggregated			31,393	5%	6,102	<1%	21,656	<1%
Sub-total PF.02 Capital expenditures	1,305,110	2%	663,197	1%	3,252,711	5%	7,559,098	10%
Grand Total = Recurrent + Capital	63,326,450	100%	49,221,393	100%	59,613,581	100%	78,533,625	100%

Key cost drivers of the HIV Response

In this section of the report, we provide a more in-depth look into the key cost drivers revealed during the spending assessment.

There are four AIDS Spending Categories that account for 41% of overall HIV spending in PNG across four years of assessment. These are (in the descending order):

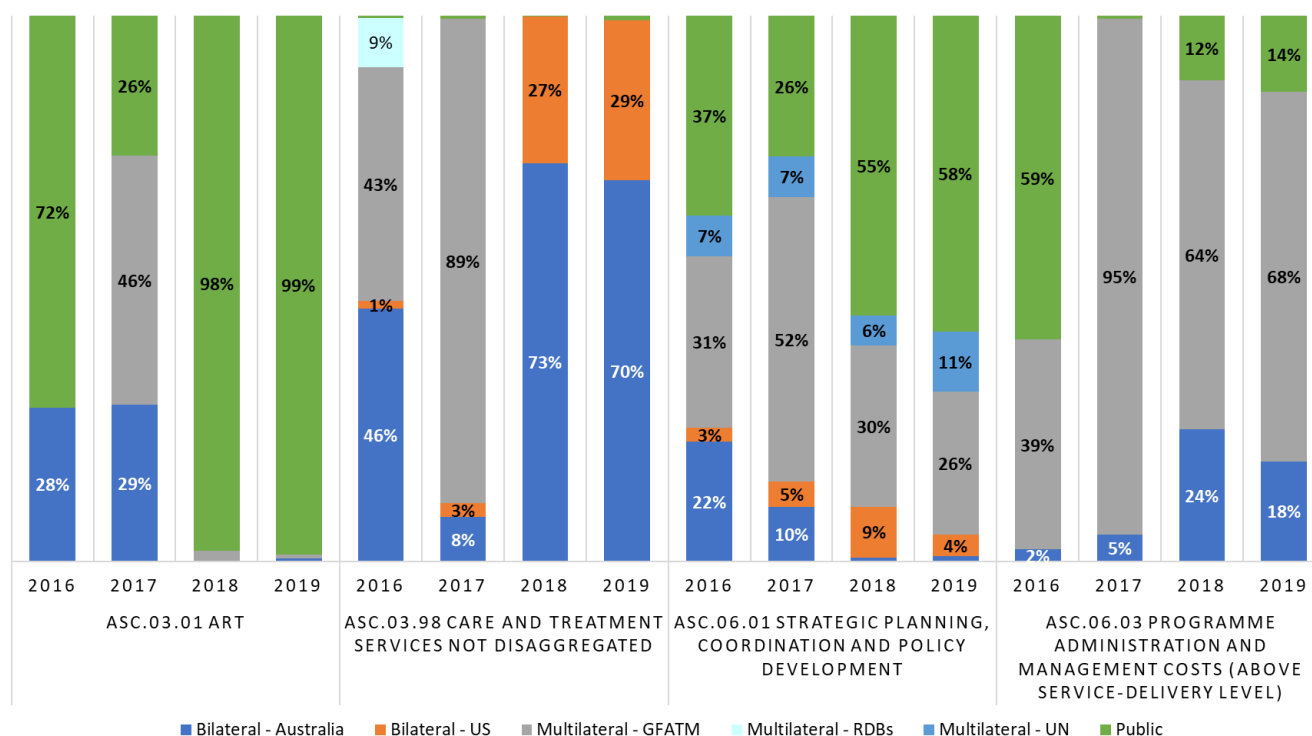
- ASC.06.01 Strategic planning, coordination and policy development:
 - 2016 – PGK 10.3M or 16% of total HIV spending;
 - 2017 – PGK 7.8M or 16% of total HIV spending;
 - 2018 – PGK 11M or 18% of total HIV spending;
 - 2019 – PGK 9.7M or 12% of total HIV spending.
- ASC.06.03 Programme administration and management costs (above service-delivery level):
 - 2016 – PGK 6.3M or 10% of total HIV spending;
 - 2017 – PGK 3M or 6% of total HIV spending;
 - 2018 – PGK 6.7M or 11% of total HIV spending;
 - 2019 – PGK 7.1M or 9% of total HIV spending.
- ASC.03.01 ART:
 - 2016 – PGK 3.5M or 6% of total HIV spending;
 - 2017 – PGK 3.5M or 7% of total HIV spending;
 - 2018 – PGK 4.8M or 8% of total HIV spending;
 - 2019 – PGK 9.1M or 12% of total HIV spending.
- ASC.03.98 Care and treatment services not disaggregated:
 - 2016 – PGK 4.9M or 8% of total HIV spending;
 - 2017 – PGK 4.3M or 9% of total HIV spending;

- 2018 – PGK 5.8M or 10% of total HIV spending;
- 2019 – PGK 5M or 6% of total HIV spending.

Their composition against Financing Entities (see Figure 24) is presented below.

While ASC.03.01 is largely financed by GoPNG, Government of Australia is present in both ASC.03.01 and in ASC.03.98. Specifically, category ASC.03.98 contains Care and Treatment spending for which organizations which submitted the data to the NASA Team did not provide enough details to break the expenditure down. The lack of details for treatment and care programmes was especially visible in the data submitted by the ex-PR for the GFATM grant, Oil Search Health Foundation, for the years 2016-2017. The PUDRs submitted by OSHF did not allow for a disaggregation and the contact people in the organization had very limited availability to support the NASA Team in the data processing. Notwithstanding the dedicated time and support from the staff of CCHS (recipient of the Australian Government funding) and FHI360 (recipient of the US Government funding), a similar problem occurred with the C&T data in 2018-2019, where the expenditure on various treatment and care interventions were reported in an aggregated manner.

Figure 24. Four largest AIDS Spending Categories by Financing Entities (in %), 2016-2019



In ASC.06.01, much less so in ASC.06.03, the dominating Financing entity is GoPNG (green colour on the graph above). There were two origins of the data that informs these AIDS Spending Categories: NACS and NDOH. Naturally, their key function is policy development and coordination of the HIV Response (ASC.06.01), as well as programme management above-service delivery level (ASC.06.03), although a more precise disaggregation was challenging. Even considering that all NACS and NDOH expenses were internally mapped across various variables, such as “Cost centre (Division)”, “Function”, “Item description” etc., utilization of these codes largely lacked consistency and details, making it difficult to understand what NASA code to assign to staff salaries, fringe benefits and so on. Additionally, high staff mobility between departments and units inside these institutions has added to an already challenging task. The NASA team conducted several rounds of email exchange and conference calls to validate expenditure mapping across NASA Classification of AIDS Spending Categories.

Another large share of expenditure under the codes ASC.06.01 Strategic planning, coordination and policy development and ASC.06.03 Programme administration and management costs (above service-delivery level) has been found in the spending reported by The Global Fund (grey colour in Figure 24). In 2016 it accounted for 31% of the total expenditure on ASC.06.01, 52% in 2017, 30% in 2018 and 26% in 2019. As for the ASC.06.03, GFATM-related share comprised 39% in 2016, 95% in 2017, 64% in 2018 and 68% in 2019.

The choice of the NASA code was based on the details indicated in the annual Performance Update and Disbursement Request (PUDR), which was provided by the Principal Recipient and was broken down by Sub-recipient. For each of the SRs and for the PR expenditure data contained the following variables: Module, Intervention, Activity description, Budget category and Implementing Partner. Grant management cost (in the “Budget category” breakdown) is what usually informs ASC.06.01 and ASC.06.03 in NASA. In this round of NASA, all SR-related Grant management expenditure was attributed to the actual services and interventions implemented by these SRs, not to ASC.06.03. Only a small part of SRs’ Grant management was coded under ASC.06.01, where it reflected their participation in policy development activities. Traditionally, GFATM-supported projects, especially in the part implemented directly the Principal Recipient, contain a large portion of activities dedicated to the overall

grant management and project administration above service-delivery level. Papua New Guinea is not an exception. Majority of Grant Management implemented by the PR itself was coded under ASC.06.01 or ASC.06.03.

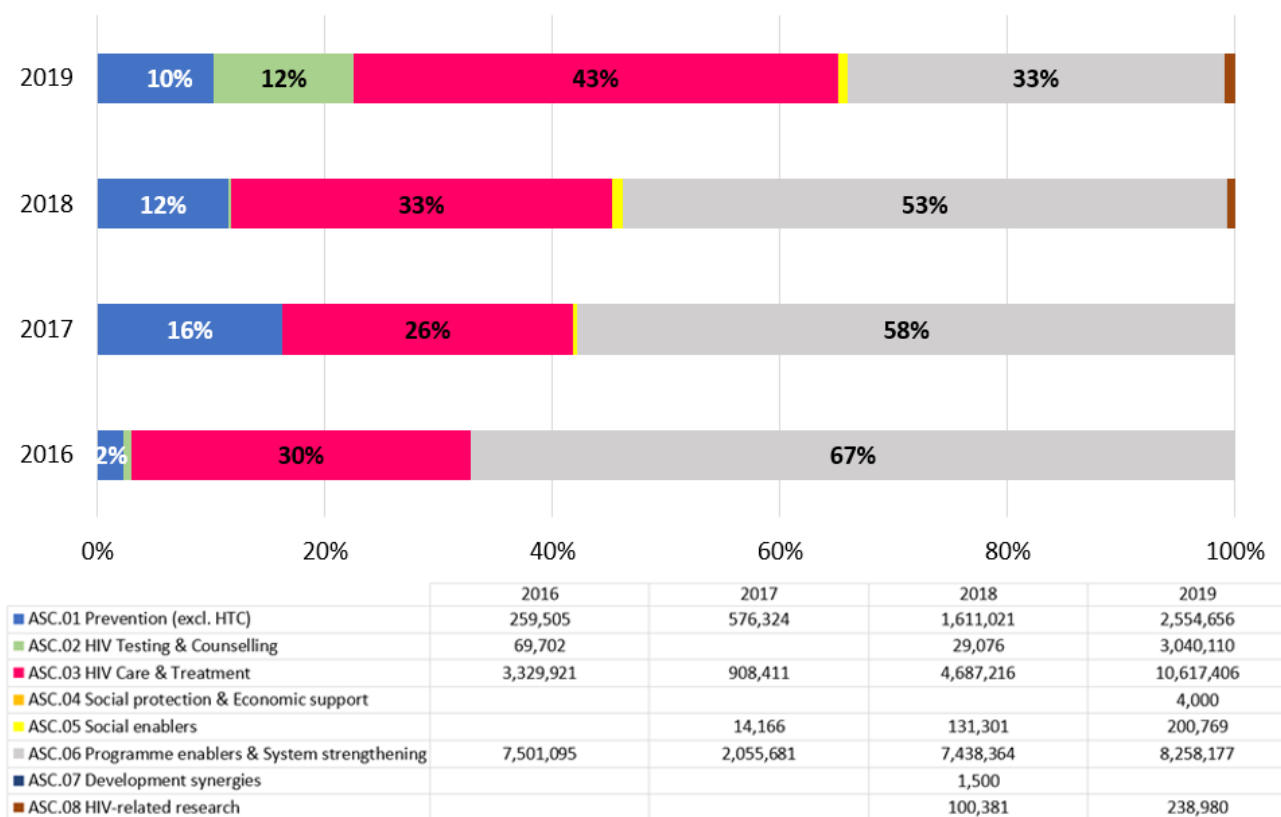
Analysis of Spending by Key Financers

Domestic Public HIV Spending

Domestic public spending is allocated by the Government of Papua New Guinea through the internal revenues, central or provincial. As mentioned in the previous sections, it represents 18% of the country's spending on HIV in 2016 (PGK 11.2M), 7% in 2017 (3.6M), 23% in 2018 (14M) and 32% in 2019 (25M). Figure 25 breaks down HIV spending of the Government of Papua New Guinea by the programmatic area it finances.

Two AIDS Spending Categories - ASC.06 Programme enablers and System strengthening and ASC.03 HIV Care and Treatment - dominate public HIV funding portfolio.

Figure 25. Domestic public HIV spending by AIDS Spending Category (ASC), 2016-2019



As shown above, Programme enablers comprise PGK 7.5M or 67% of public HIV spending in Papua New Guinea in 2016, shrinking in 2017 to nearly 2.1M, due to

inactivity of National AIDS Commission Secretariat, and increase to 7.4M and 8.3M in 2018 and 2019 respectively. Majority of spending on programme enablers occurred in ASC.06.01 Strategic planning, coordination and policy development – the main function of NACS -, except for 2016 when 50% of publicly funded ASC.06 activities were tracked under ASC.06.03 Programme administration and management costs (above service-delivery level).

HIV Treatment and Care programme expanded three-fold from PGK 3.3M in 2016 to over 10.6M in 2019. Antiretroviral therapy is the largest care and treatment programme supported by the GoPNG: in 2016 it represented 76% of Government-supported ASC.03, 97% in 2017, 100% in 2018 and 85% in 2019. Other care and treatment interventions supported by the Government of PNG were ASC.03.03 Specific ART-related laboratory monitoring and ASC.03.04.98 OI prophylaxis and treatment not disaggregated by type (excluding TB and hepatitis). Public funds in the category ASC.03.98 Care and Treatment not disaggregated by type comprised only 3% of the ASC.03 and only in 2017.

Prevention and HTC spending remain relatively low in the Government-funded portfolio, however in 2019 these two spending categories expanded, representing 22% of domestic public resources for HIV Response in Papua New Guinea. Very little public expenditure on ASC.02 HIV Counselling and Testing was discovered before 2019, when it scaled up to over PGK 3M. Due to the limitations of data, it proved challenging to disaggregate publicly funded HTC into more detailed AIDS Spending Categories, thus 87% of it was coded as ASC.02.98 HIV Testing and Counselling not disaggregated.

A breakdown of domestic public HIV spending by **Beneficiary population** (see Figure 26. Domestic public HIV spending by Beneficiary Population (BP), 2016-2019 Figure 26) reveals that the largest part of it supports non-targeted intervention, since all the expenditure tracked under ASC.06-08 cannot have a specific beneficiary population assigned. In 2016 non-targeted interventions represent 67% of public HIV expenditure, 58% in 2017, 55% in 2018 and 35% in 2019.

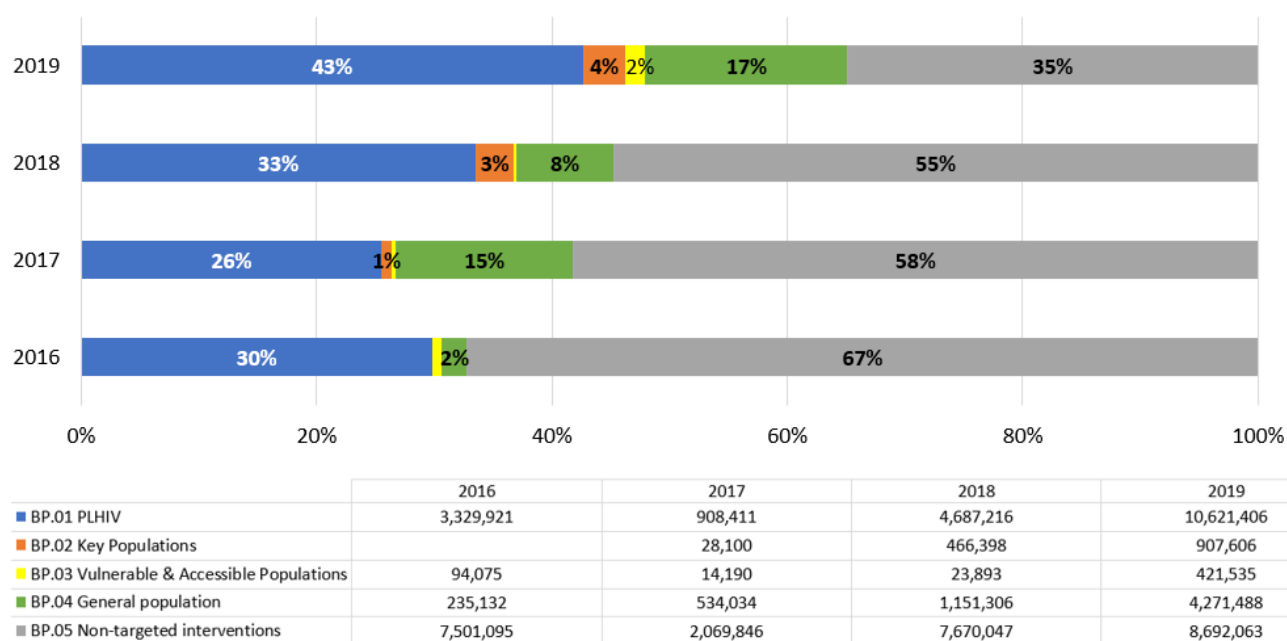
BP.01 People living with HIV is the second-largest beneficiary group targeted by the domestic public spending on HIV (being a Beneficiary population for all ASC.03 HIV

Care and Treatment resources): 30% of public funds targeted PLHIV in 2016, 26% in 2017, 33% in 2018 and 43% in 2019.

General population remains in the focus of publicly-funded prevention interventions. While in 2016 only 2% of available public resources benefited general population, in 2017 BP.04 General population represented 15% of Government HIV spending, 8% in 2018 and 17% in 2019.

Key populations received only 1% of Government funding of HIV Response in 2017, 3% in 2018 and 4% in 2019. GoPNG resources targeting KPs are split between female sex workers and MSM reached through the condom and lubricant programmes (installation of condom dispensers implemented by NACS).

Figure 26. Domestic public HIV spending by Beneficiary Population (BP), 2016-2019



HIV spending portfolio of the Global Fund

Between 2016 and 2019 the Global Fund resources to the HIV Response in Papua New Guinea were channelled through two grants and two different Principal recipients: Oil Search Foundation in 2016-2017 and World Vision International in 2018-2019.

Additionally, Papua New Guinea benefited from the regional grant, managed by Australian Federation of AIDS Organisations (AFAO).

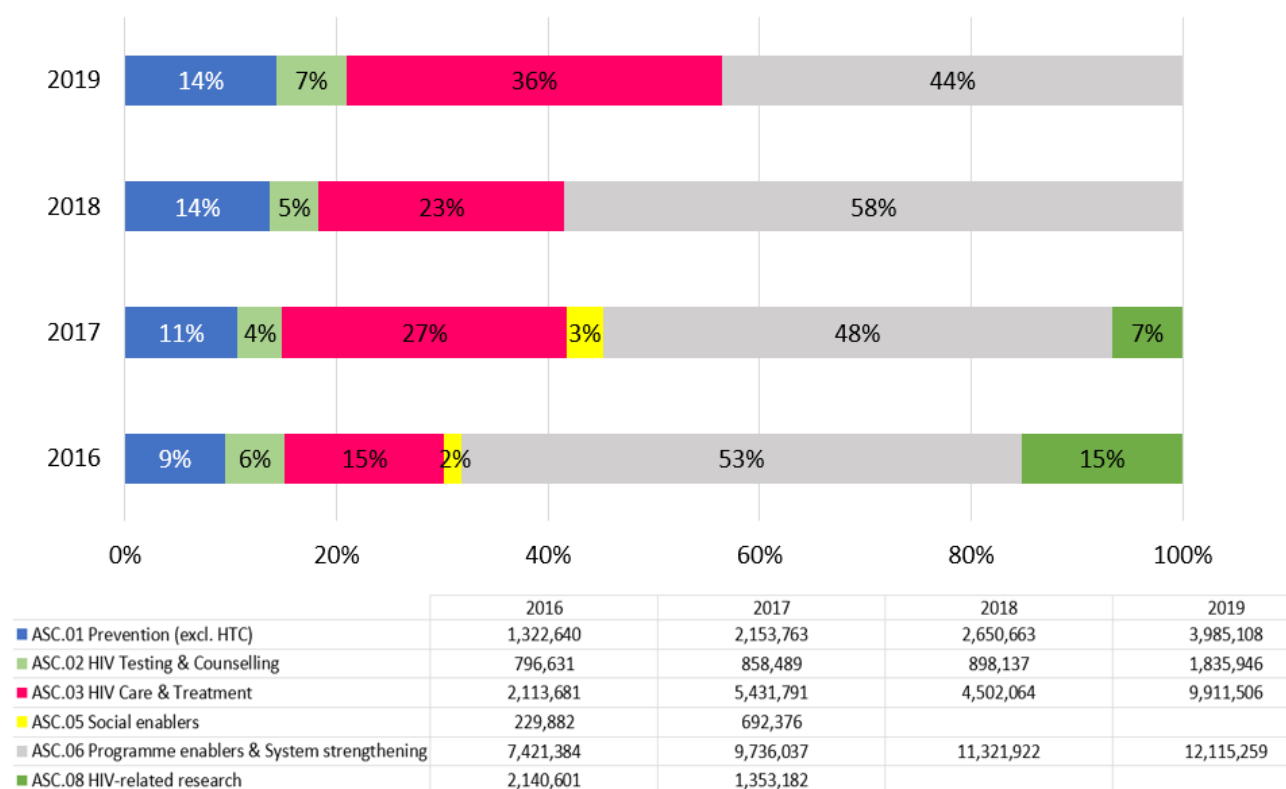
From 2017 The Global Fund retains its position as the single largest source of funding of the HIV Response in Papua New Guinea. While in 2016 it represented 27% of the total HIV spending in the country, providing a sum of PGK 14M, in 2017 its share increased to 44% with an investment of 20.2M, in 2018 – 43% with 19.4M and reached its peak in 2019 when it represented 52% of all national HIV expenditure equal to 27.9M.

The largest **AIDS Spending Category** was ASC.06 Programme enablers and System strengthening amounting to over PGK 7.4M in 2016 and expanding annually to reach a mark of 12.1M in 2019 (see Figure 27**Error! Reference source not found.**).

A majority of GFATM-funded ASC.06 expenditure occurs traditionally in ASC.06.01 Strategic planning, coordination and policy development (PGK 3.2M in 2016, 4.1M in 2017, 3.3M in 2018 and 2.6M in 2019) and ASC.06.03 Programme administration and management costs (above service-delivery level) (PGK 2.4M in 2016, 2.8M in 2017, 4.3M in 2018 and 4.8M in 2019). Other important programme enablers funded by The Global Fund were ASC.06.04.01 Monitoring and evaluation (PGK 0.9M in 2016, 1.9M in 2017, 0.6M in 2018 and 0.9M in 2019), ASC.06.05.01 Procurement and supply chain (PGK 1.2M in 2018 and 1.7M in 2019), ASC.06.07.01 Capacity building for health workers, excluding those at community level (PGK 0.6M in 2016, 0.5M in 2017, 1.3M in 2018 and 1.2M in 2019).

Further analysis of the GFATM-funded ASC.06 revealed a shift in the funding focus from Strategic information activities (includes M&E, serosurveillance and management information systems) in 2016-2017 to public system strengthening (includes procurement and supply chain, laboratory system strengthening and institutional and organizational development) in 2018-2019. Expenditure tracked under ASC.06.04 Strategic information amounted to PGK 1.2M in 2016, over 2.3M in 2017, and dropping to 0.7M in 2018 and 1.1M in 2019. Meanwhile, no GFATM-originated expenditure on ASC.06.05 Public system strengthening was identified in 2016 and 2017, however with the launch of the new grant the allocation in this ASC was PGK 1.4M in 2018 and 2.1M in 2019.

Figure 27. The Global Fund HIV spending in Papua New Guinea by AIDS Spending Category (ASC), 2016-2019



ASC.03 Treatment and Care is the second largest programmatic area in the Global Fund portfolio in Papua New Guinea. While in 2016 it amounted to only PGK 2.1M, by 2019 it expanded to almost 10M representing 36% of the GF investment. In 2019 GF-funded Treatment and Care programme represented 13% of the total national spending in Papua New Guinea. The data obtained for 2016-2017 (Oil Search Foundation as a Principal Recipient) does not allow to show the breakdown of Treatment and Care in great detail. In 2016-2017 majority of Care and Treatment spending from the Global Fund is not disaggregated, with an exception of the clearly defined spending on ARV of approximately PGK 1.6M in 2017. A better level of details was obtained for the next GFATM grant, where ASC.03 HIV Care and Treatment unfolds into the following categories: ART (PGK 87,695 in 2018 and 62,354 in 2019), Adherence and retention on ART (over 0.4M in 2018 and 1M in 2019), ART specific laboratory monitoring (PGK 0.2M in 2019), TB activities (PGK 4M in 2018 and 8.6M in 2019).

GFATM spending on ASC.01 HIV Prevention (excluding HTC) has increased since 2016: from PGK 1.3M in the first assessment year to 4M in the last. In 2016-2017 a significant

part of expenditure in ASC.01 lacks details about specific beneficiary population reached: services for key populations, not broken down by type amount to almost 0.5M in 2016 and over 1M in 2017, while 0.5M and 0.7M of HIV prevention interventions remained not disaggregated even by 1-digit beneficiary population category. In 2018-2019 the quality of details improved and revealed that PGK 2M in 2018 and 3.2M in 2019 went to prevention among sex workers and their clients, 0.4M in 2018 and in 2019 was spent on prevention among MSM and over 0.2M in 2018 and 0.4M in 2019 benefited vulnerable populations and general population.

A composition of ASC.02 HIV Testing and Counselling also varies between two GF grants. Expenditure on HTC for vulnerable and accessible populations was discovered only in 2016 and amounted to PGK 188 thousand. GF-supported Provider-initiated testing was PGK 227 thousand in 2016 and nearly 632 thousand in 2017. Nearly PGK 0.4M in 2016 and 0.2M in 2017 remained in ASC.02.98 HIV testing and counselling activities not disaggregated by type. In 2018 and 2019 HIV testing was focused primarily on sex workers and their clients (PGK 0.6M and 1.3M respectively), MSM (nearly 0.3M and 0.6M respectively) and inmates (PGK 16 thousand in 2018).

Resources allocated to ASC.05 Social Enablers amounted to PGK 0.2M in 2016 and 0.7M in 2017, representing 3 and 2% of the GFATM portfolio in those years. They were split programmatically between ASC.05.02.04 Sensitization of law-makers and law enforcement agents and ASC.05.02.05 Reducing discrimination and violence against women in the context of HIV.

Expenditure on ASC.08. HIV-related research amounted to PGK 2.1M in 2016 and 1.4M in 2017 and was related to the implementation of the IBBS.

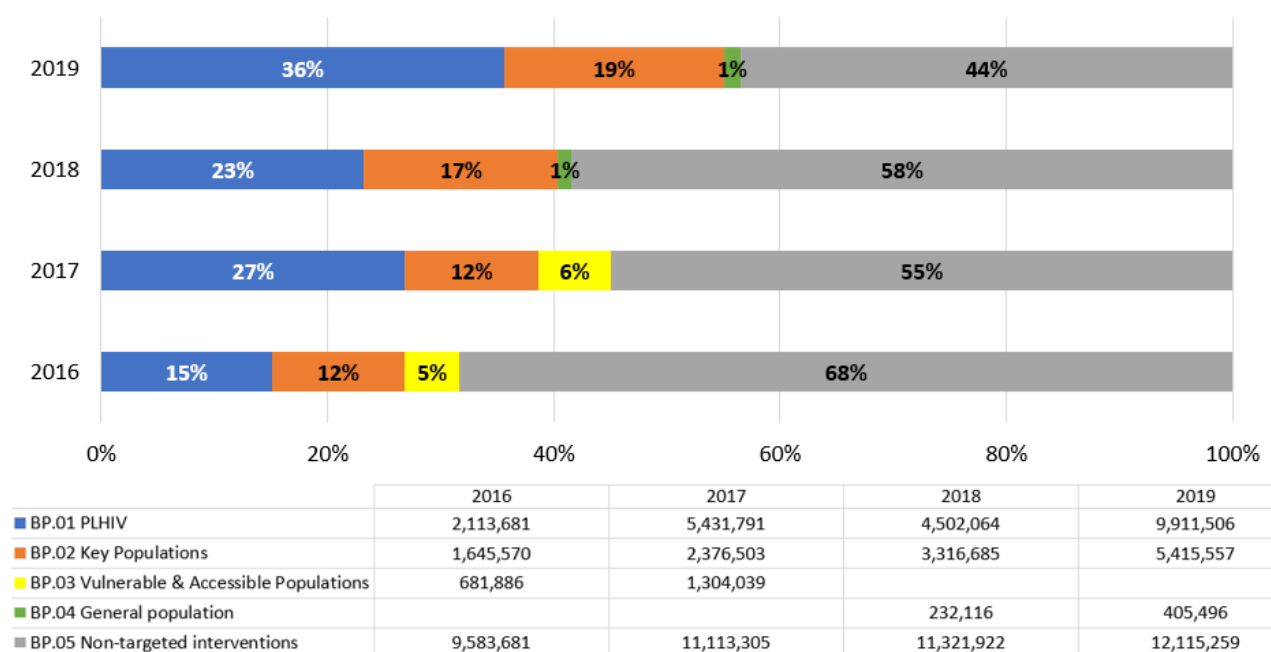
A breakdown of GFATM spending on HIV by **Beneficiary population** in Figure 28 reveals that, similarly to the composition of programmatic breakdown, the largest spending is tracked under BP.05 Non-targeted interventions (BP code assigned to expenditure under ASC.06 and ASC.08): PGK 9.6M in 2016, 11.1M in 2017, 11.3M in 2018 and almost 12.1M in 2019.

BP.01 People living with HIV is the second largest beneficiary category in the HIV portfolio of the GFATM in Papua New Guinea with the expenditure of PGK 2.1M in 2016, 5.4M in 2017, 4.5M in 2018 and increasing two-fold to nearly 10M in 2019.

Expenditure targeting Key Populations has been growing steadily throughout the implementation of both grants: from PGK 1.7M in 2016 and 2.4M in 2017 to 3.3M in 2018 and 5.4M in 2019.

Similar to what has been observed in Prevention and HTC interventions above, the data indicated a shift of the spending focus between two GFATM grants. No funding reaching BP.04 General population has been discovered in 2016 and 2017, while in 2018 and 2019 nothing has been tracked under BP.03 Vulnerable and Accessible Populations.

Figure 28. The Global Fund HIV spending in Papua New Guinea by Beneficiary Population (BP), 2016-2019



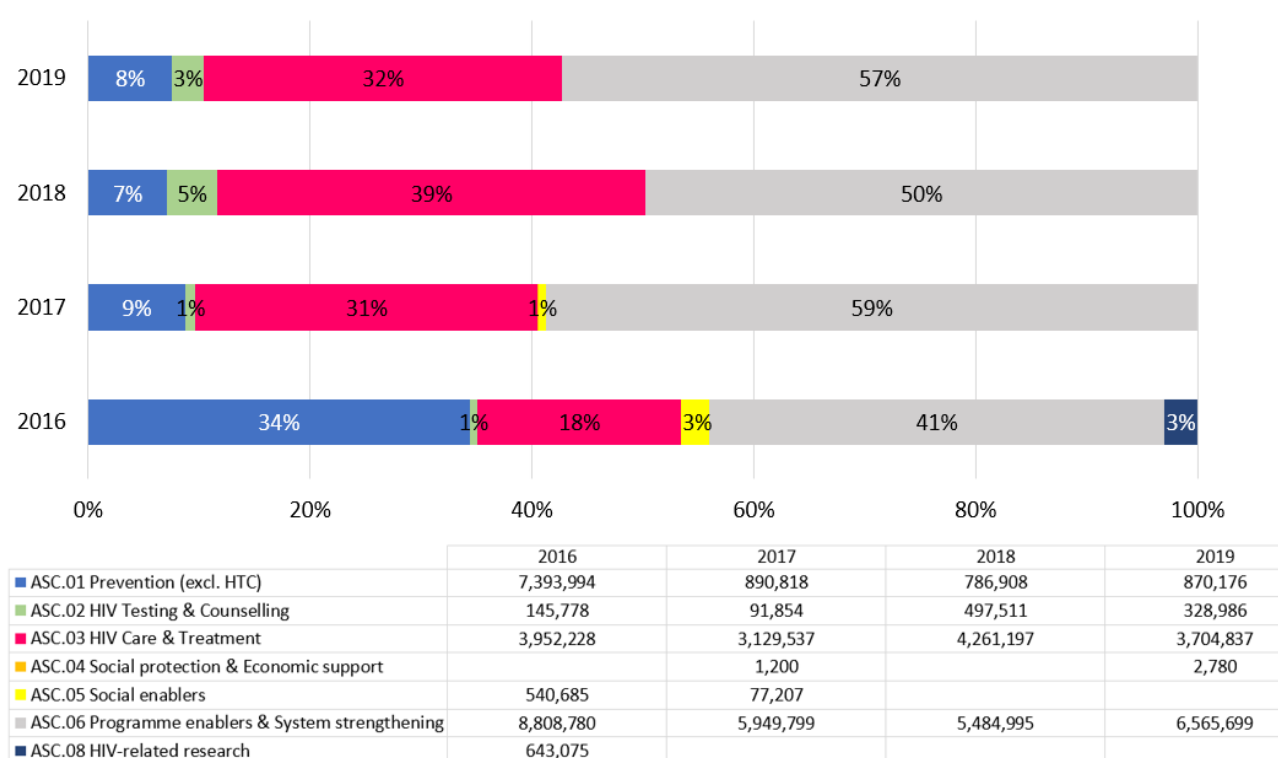
HIV spending portfolio of the Government of Australia

HIV funding from the Australian Government traditionally plays a big role in HIV Response in Papua New Guinea, channelling its support through The Department of Foreign Affairs and Trade (DFAT). In 2016 it represented 41% of the total national

spending on HIV, amounting to PGK 21.5M but slowing down in the following years. In 2017 its contribution was PGK 10.1M, representing 22% of the national HIV spending in PNG, in 2018 – 11M or 24% of the total spending, and in 2019 – 11.5M or 21% of the total spending.

Three broader **AIDS Spending Categories** dominate the HIV funding portfolio of the Australian Government: ASC.06 Programme enablers, ASC.03 HIV Care and Treatment and ASC.01 Prevention (excluding HTC) (see Figure 29).

Figure 29 HIV spending of The Government of Australia in Papua New Guinea by AIDS Spending Category (ASC), 2016-2019



Over a half of the Australian funding (except for 2016) goes to policy-level interventions tracked under ASC.06 Programme enablers and System strengthening.

The most consistently funded programme enablers throughout all four years of the assessment were ASC.06.05 Public system strengthening (PGK 2M in 2016, 2.6M in 2017 and 1.4M in 2018 and in 2019), represented by Procurement and supply chain and Laboratory system strengthening in 2016-2017 and Institutional and organizational development in 2017-2019, and ASC.06.06.01 Civil society institutional and NGO development (PGK 1.2M in 2016, 0.5M in 2017, 1.3M in 2018 and 1,6M in 2019).

ASC.06.01 Strategic planning, coordination and policy development received PGK 2.3M in 2016 and 0.8M in 2017, however the resources feeding this category dried up to a little over 70 thousand in 2018 and 87 thousand in 2019.

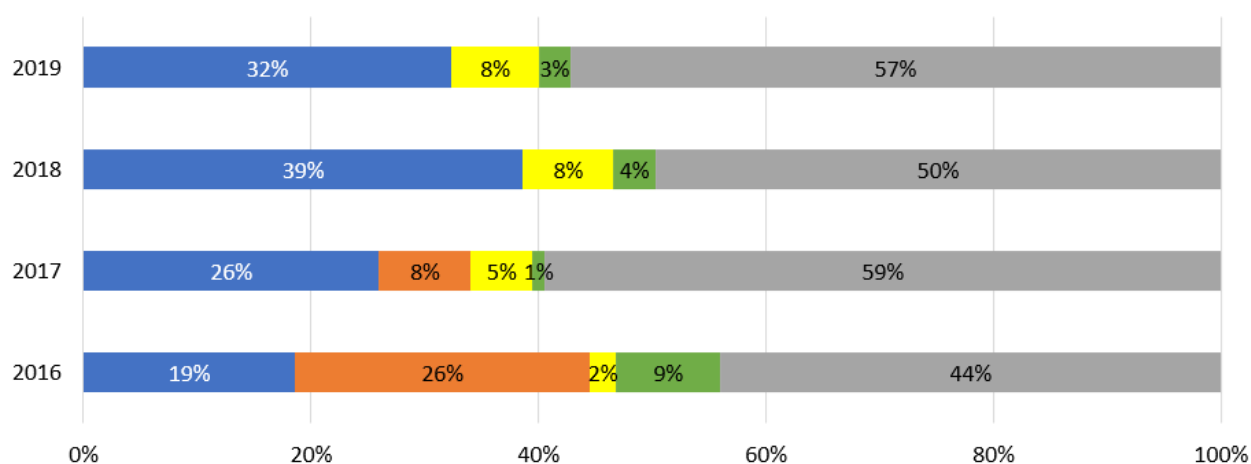
Similar trend is observed in ASC.06.04 Strategic information which amounted to PGK 1.6M in 2016 and 1.5M in 2017, shrinking to less than 0.2M in 2018 and just 42 thousand in 2019. ASC.06.07 Health and community workforce interventions accounts for PGK 0.6M in 2016, 11 thousand in 2017, almost 0.1M in 2018 and 0.7M in 2019.

According to NASA findings, HIV Care and Treatment is the second largest programme in the Australian Government's portfolio in Papua New Guinea, representing 18% of it in 2016, 31% in 2017, 39% in 2018 and 32% in 2019. While majority of it remains not broken down by a specific intervention, NASA team was able to track expenditure on ART programme, adherence and retention on ART and specific ART-related laboratory monitoring.

Prevention interventions largely focused on Key Populations (primarily female sex workers) in 2016, however starting from 2017 the majority of resources in this category were directed to vulnerable and accessible populations as well as to general population. HIV Counselling and Testing activities funded by the Australian Government benefit mainly general population.

A more detailed breakdown of Australian Government portfolio by **Beneficiary Population** reveals that besides non-targeted interventions, people living with HIV remain the key focus of DFAT support (see Figure 30). In 2016 BP.01 PLHIV accounted for PGK 4M, in 2017 – 2.7M, in 2018 – 4.3M and in 2019 – 3.7M.

Figure 30. HIV spending of The Government of Australia in Papua New Guinea by Beneficiary Population (BP), 2016-2019



	2016	2017	2018	2019
BP.01 PLHIV	3,996,906	2,633,531	4,261,197	3,707,617
BP.02 Key Populations	5,565,178	820,874		
BP.03 Vulnerable & Accessible Populations	496,006	547,500	879,026	888,812
BP.04 General population	1,974,593	111,504	405,393	310,350
BP.05 Non-targeted interventions	9,451,855	6,027,006	5,484,995	6,565,699

As described in the section above, the expenditure focus shifted from Key Populations, which represented 26% of total Australian Government's HIV spending in 2016, dropping to 8% in 2017 with no expenditure detected in 2018 and 2019.

Vulnerable and accessible populations lack details for a more precise breakdown, however in 2016 and 2017 the major part of the expenditure for this beneficiary population group was consumed by BP.03.02 Pregnant and breastfeeding HIV-positive women (not on ART) and their children to be born (un-determined HIV status) and new borns, those receiving PMTCT services.

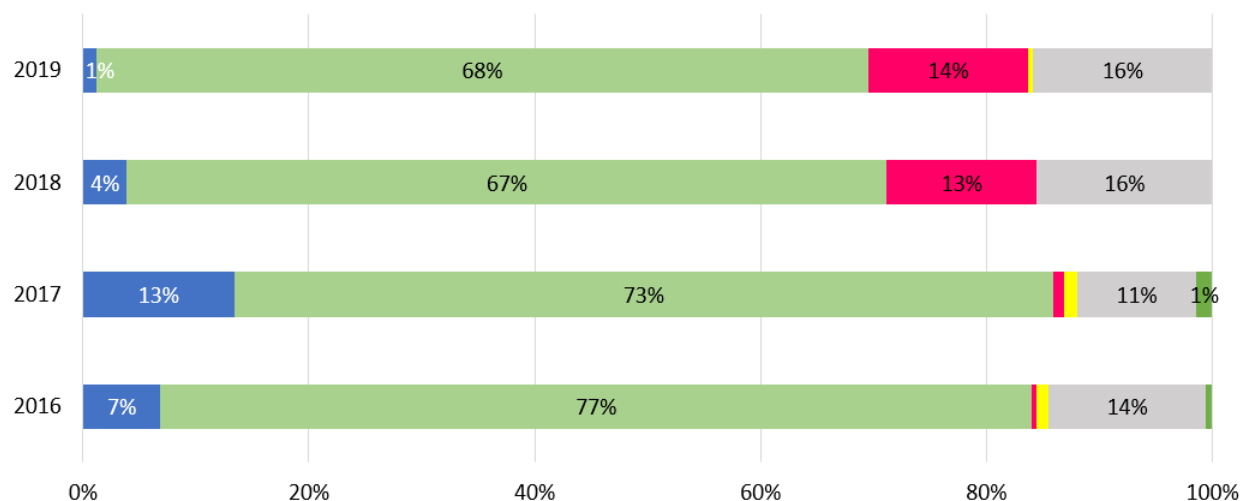
HIV spending portfolio of the Government of the United States of America

Resources provided by the US Government represent 27% of the total HIV spending in Papua New Guinea in 2016 (PGK 14M), 26% in 2017 (PGK 12.1M), 27% in 2018 (PGK 12.1M) and 20% in 2019 (PGK 10.9M).

The analysis of the **AIDS Spending Categories** of the US-originated HIV spending demonstrates the difference in funding focus as compared to other sources of funding (see Figure 31). ASC.02 HIV Counselling and Testing is the largest programme in the

USG's HIV portfolio. HTC expenditure of the US Government is divided between BP.02 Key Populations - FSWs and MSM - (PGK 0.146M in 2016, 0.246M in 2017, 1M in 2018 and 1.3M in 2019), BP.03 Vulnerable and Accessible Populations (PGK 10.4M in 2016, 8.2M in 2017, 1.7M in 2018 and 2M in 2019) and BP.04 General Population (over PGK 0.3M in 2016 and in 2017, 5.5M in 2018 and 4.1M in 2019).

Figure 31. HIV spending of The US Government in Papua New Guinea by AIDS Spending Category (ASC), 2016-2019



	2016	2017	2018	2019
ASC.01 Prevention (excl. HTC)	956,391	1,618,551	473,265	130,414
ASC.02 HIV Testing & Counselling	10,748,969	8,767,114	8,143,912	7,411,150
ASC.03 HIV Care & Treatment	63,454	112,985	1,609,811	1,540,913
ASC.05 Social enablers	139,757	143,006		45,048
ASC.06 Programme enablers & System strengthening	1,947,407	1,276,239	1,880,161	1,719,556
ASC.08 HIV-related research	74,945	170,057		

ASC.01 Prevention spending varies from year to year – from nearly PGK 1M in 2016, and 1.6M in 2017 to 0.5M in 2018 and 0.13M in 2019. It largely focuses on BP.02 Key Populations and BP.03 Vulnerable and Accessible Populations.

ASC.03 HIV Care and Treatment became a significant part of US-funded programmes only in 2018 and 2019, although the majority of it remains not disaggregated by type due to a lack of details in the expenditure reports collected by the NASA team.

In 2016 and 2017 the main **Beneficiary Population** targeted by the US-originated HIV expenditure was BP.03 Vulnerable and Accessible Populations (mainly not broken down by a specific population group) – 77% and 70% correspondingly (see Figure 32). In 2018 and 2019 this spending focus shifts towards BP.04 General population, which

represents 46% and 38% respectively, compared to 1% in 2016 and 2% in 2017. Programmes targeting BP.01 People living with HIV expand only in 2018-2019 with 13% and 14% of the US-funded HIV portfolio. Key Populations benefit from 6% of US expenditure in 2016, 15% in 2017 and in 2017, 10% in 2018 and 13% of the total US-originated investment in 2019.

Figure 32. HIV spending of The US Government in Papua New Guinea by Beneficiary Population (BP), 2016-2019



	2016	2017	2018	2019
BP.01 PLHIV	63,454	112,985	1,609,811	1,540,913
BP.02 Key Populations	873,414	1,753,224	1,264,004	1,358,684
BP.03 Vulnerable & Accessible Populations	10,720,177	8,427,575	1,773,797	2,154,836
BP.04 General population	251,526	347,872	5,579,376	4,073,093
BP.05 Non-targeted interventions	2,022,351	1,446,296	1,880,161	1,719,556

Conclusions and Recommendations

1. The results of the National AIDS Spending Assessment demonstrate a continuous increase of the HIV expenditure in Papua New Guinea since 2017 when the HIV spending was at its lowest point – less than PGK 50M. Both public funding and that of the key international financing entities - The Global Fund, Australian and US Governments – has been exposed to volatility.
2. Even with an increase in domestic public resources allocated for HIV, Papua New Guinea relies heavily on the international funding that comprises 82% of the total country's HIV expenditure in 2016, 93% in 2017, 76% in 2018 and 68% in 2019. Most of the internationally recommended effective interventions, especially those in the area of HIV prevention, remain highly dependent on the availability of the international funds and priorities set by the Development Partners.
3. Except for 2017, GoPNG has been consistently increasing its contribution in the past years, from PGK 11M in 2016 to 25M in 2019. Domestic spending has increased also as a share of the total HIV expenditure: from 18% in 2016 to 32% in 2019.
4. The funding focus of the GoPNG is on Care and Treatment programmes. Spending for ARV treatment is growing which is definitely a positive trend that reflects the strategic direction of the government to assure universal access to antiretroviral treatment. Publicly funded HIV Prevention is expanding too, however the assessment results revealed that such expansion is directed more towards general population, not key populations. Additionally, Prevention activities, including HIV Counselling and Testing, lack public sector engagement, both from the point of view of financing and that of the service delivery.
5. The Global Fund consistently holds the first place in the size of resource package allocated to tackle HIV in Papua New Guinea: in 2019 it reaches its 4-year high with almost PGK 28M which represent 52% of HIV spending in PNG. PLHIV and KAP remain in the focus of GFATM funding. In 2019 The Global Fund becomes the largest donor of the interventions targeting Key Populations with an investment of PGK 5.4M, which represents 70% of all interventions benefiting KP in Papua

New Guinea in 2019. In the medium-term Papua New Guinea is not ready for eventual graduation from GFATM.

6. The role of the US Government in the HIV Response in Papua New Guinea is of the high significance not only due to the size of the contribution – PGK 14M in 2016, 12.1M in 2017 and in 2018, 11M in 2019 – but also due to its implementation focus. Throughout all four years of assessment USG remains a single largest financier of the HIV Testing and Counselling in PNG. Although its share in the HTC-related funding as a share of total HTC expenditure went down rather drastically from approximately 87% in 2016-2018 to 58% in 2019, in the absolute figures it keeps at a rather high level – 10.8M in 2016, 8.8M in 2017, 8.1M in 2018 and 7.4M in 2019.
7. Most of the key international financiers of HIV response in PNG, namely US Government, Australian Government and The Global Fund, does not rely on public sector service providers in its implementation. The lack of involvement of public sector healthcare facilities is especially visible in the area of HIV Prevention and HIV Counselling and Testing. Although a lot of resources are focused on governance and health systems strengthening in the public sector, insufficient engagement of the public sector operators in the direct service provision may have a negative impact on the sustainability of many of the critical services that have an impact on the HIV epidemics in the future.
8. Alongside analysing funding consistency, NASA was capable of demonstrating shifts in the implementation focus throughout the years. While many projects funded by the Australian Government traditionally work in the area of health systems strengthening and other programme enablers, the tendency of moving away from the actual service delivery becomes clear. While in 2016 programme enablers represented 41% of the Australian Government's funding portfolio, in 2019 this share has increased to 57%. Treatment and care interventions took over Prevention activities and the remaining prevention programmes became more focused on general and vulnerable and accessible populations, rather than Key Populations, with dropped from representing 27% of the Australian Government HIV funding profile to only 1% in 2019.

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9. Remote work for the lead consultant on data collection, processing and validation, connectivity issues, multiple COVID-19 related lockdowns in PNG and limited access to the required data by the respondents in “smart working” has been a challenge throughout the assignment. While such “force majeure” circumstances could not have been avoided or properly leveraged, it clearly demonstrates how the country could benefit from institutionalizing the assessment into the routine function (even though happening once a year or once every two years) of NACS or other governmental entity. Conducting NASA annually or biannually could potentially prevent “recall loss” and outstretching team efforts by analysing more than 2-year span.
 10. NASA results are on a high demand among governments and donors which may help to fuel policy discussions with concrete data. To be able to use NASA for evaluating HIV Response performance and support future planning, more assistance may be required to improve understanding of the NASA process and results among policy-makers as well as to build/enhance national capacity to collect, process and analyse the NASA data in the future.
 11. There have been layers of expenditure analysis that haven’t been properly addressed or explained in this round of NASA. One of them, Out-of-pocket payments, represent a significant part of health financing in PNG (12.4% of total health spending in 2015, according to the National Health Accounts exercise published in 2019), but it’s HIV share is unclear and has not been properly researched. This NASA round did not include OOPS for HIV due to the absence of data and challenges due to COVID-19 pandemic. It is advised to launch a study of OOPS in coordination with NHA efforts even outside of the NASA exercise. Data on shared health systems cost – government expenditure on staffing, running and maintenance of health care facilities that provide HIV prevention and care - was too proved challenging to access in this NASA round. For the next NASA exercise, it is recommended to concentrate on filling up these gaps, conduct more in-depth discussions, preferably offline, with local stakeholders to improve quality of the assumptions and the final results.
 12. Although NASA itself, including RTT, allows for sub-national analysis it was proven difficult to, firstly, access the data on provincial revenues and HIV programmes

(only Central Provincial AIDS Commission have submitted the data), and secondly, to obtain the level of details enough to disaggregate all the available data from all the respondents by province. While many expenditure reports contained information to allow for sub-national disaggregation, it was not systematic or easy to process neither within one report nor across the organizations-respondents, and would require a lot of man-hours to make it usable for the National AIDS Spending Assessment. Experience of many countries who implemented sub-national NASA shows that policy-makers will certainly benefit from having province-level analysis, however a lot of effort must go into ensuring the availability of such data across all organizations, development of necessary assumptions when it is not part of the provided data and then, finally, validation of the results.