Independent Review Group on HIV/AIDS

Report from an assessment visit
22 April – 5 May 2010

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Introduction

As part of efforts to tackle the HIV epidemic, the Government of Papua New Guinea (GoPNG) has endorsed a National Strategic Plan (NSP) for HIV and AIDS, 2006-2010. A planning exercise for the implementation of this plan is undertaken each year which aims to bring stakeholders together with the goal of developing an approved GoPNG HIV Development Budget and Plan for the coming year, containing details of funded activities to support NSP implementation.

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

Four reviews have taken place so far:

- In August-September 2007, the IRG conducted an initial orientation visit and review of the year 2008 Development Budget submission. A report from this visit identified a number of specific priorities to be pursued in each NSP Focus Area (Appendix 2).
- In April 2008, an interim review of progress in each NSP Focus Area was carried out together with a baseline assessment of provincial and district response capability and the response of private sector and faith-based groups. The report on this review together with priorities (Appendix 3) was presented to the NSP Steering Group in May 2008.
- A third IRG review took place in August-September 2008 and involved a one year-on stock-take of accomplishments since 2007 and a review of the year 2009 Development Budget submission. The review highlighted important areas of progress as well as key priorities to be pursued in 2008-9 (Appendix 4).
- A fourth review took place in April-May 2009 to assess further progress in implementation and with a special focus on the education sector; care and support including a focus on orphans and vulnerable children; and options for scaling up the response at sub-national level. IRG priorities from this review can be found in Appendix 5.

A fifth review – reported on here – took place in April-May 2010. The goals of the mission were to conduct (i) a stocktake of progress against priorities identified in 2008 and 2009, (ii) a review and appraisal of NSP Annual Plan for 2010, and (iii) a review of the development of the National HIV and AIDS Strategy (NHS) 2011-15. In addition, the IRG was asked to comment on processes to strengthen NACS, and on interventions that have the potential to arrest and control of the epidemic. The objectives and scope of work for 2009 can be found in Appendix 6.

Five team members participated in the assessment visit. The team leader with overall responsibility for the IRG's work was Professor Peter Aggleton. Dr Alex Coutinho (Executive Director of the Infectious Diseases Institute, Makerere University, Kampala, Uganda) led the review of progress in treatment counselling, care and support (NSP Focus Area 1) and family and community support (NSP Focus Area 6).

Professor Shalini Bharat (Tata Institute of Social Sciences, Mumbai, India), led the review of activities in the areas of education and prevention (NSP Focus Area 2) and social and behavioural change research (NSP Focus Area 4). Felecia Dobunaba (Independent Consultant, Port Moresby, PNG) was responsible for the review of progress and activities relevant to leadership, partnership and coordination (NSP Focus Area 5). Dr Tobi Saidel (Independent Consultant, New Delhi, India) reviewed the areas of epidemiology and surveillance (NSP Focus Area 3) and monitoring and evaluation (NSP Focus Area 7). Dr Roger Drew (Independent Health and Development Consultant, UK), was responsible for the review of resource allocation and financial management.

In advance of the visit, an outline programme of activities was developed by the National AIDS Council Secretariat (NACS) on behalf of the NSP Steering Group. This included visits to two provinces (Sandaun and Southern Highlands), as well as meetings with national government departments, development partners, NGO stakeholders and other key players. Over the course of two weeks, it proved possible to talk and conduct interviews with over 120 key agencies and individuals (Appendix 7). Additionally, a substantial number of background documents were reviewed (Appendix 8).

This report begins with a review of the NSP Annual Plan for 2010, followed by an appraisal of progress, future planning and gaps and omissions in each NSP Focus Area. Where relevant, reference is made to ongoing work to develop the National HIV and AIDS Strategy (NHS) 2011-15, both with respect to the process of development and the contents of this strategy. Finally, the IRG has highlighted a number of key priorities for the coming year, both to build upon work already completed and to facilitate easy transition from the NSP to the NHS.

Review and Appraisal of NSP Annual Plan (2010)

A key element of the IRG's work was to review and appraise the NSP annual plan for 2010. As on the IRG's first visit in 2007, this was done by reviewing NACS' annual budget submission to parliament.

The budget is quite different in style from previous years. It is much shorter and more concise. It is reported to have been extremely well-received in the budgeting process as it fitted extremely well with what was needed for that process. Strengths of the document include:

- Better and more accurate analysis of financial data
- Clear statement of priorities (section 2)
- Clear presentation of budget allocations 2005-9 (section 3)
- Analysis and explanation of 2009 financial performance included in budget narrative (section 4)
- Clearer justification of budget submission (section 6)
- Some information on how the government recurrent and development budgets will be spent (section 5.4 and attachment 2)

However, the brevity of the document means that some issues, such as alignment with other international documents are less well-covered than previously. However, these issues are well-covered in the proposed new NHS. It is unclear if they need to be restated annually in the budget

submission. It does highlight the issue, identified previously by the IRG, that PNG does not produce an annual plan for the NSP, as such. Although the budget submission has some elements of an annual plan, it does not have others, e.g. an outline of the major activities to be conducted in 2010. Other IRG concerns about the document include:

- Reports that the budget simply consists of an aggregation of submitted budgets, e.g. from NGOs and provinces, without any consideration of the implications of any identified priorities within the national response. For example, should priority be given to any particular geographical area? Is the split of financial resources across focus areas consistent with the relative priority afforded to those areas?
- The consolidated resource framework lacks details of funding from the Global Fund and from the Government of PNG apart from funding to NACS
- The continued absence of any mechanism to track actual expenditure on the response to HIV and AIDS, such as a National AIDS Spending Assessment. As a result, Papua New Guinea failed to report on this UNGASS indicator in 2010. It is particularly disappointing that there was no progress on this between 2008 and 2010 UNGASS reports.

Table 1 analyses in more detail the extent to which the plans contained in the 2009 Development Budget are aligned with other national and international strategies.

Table 1: Alignment of 2010 Plans[1]

	2008	2009	2009
Millennium Development Goals			No mention of MDGs
UNGASS Commitments			No mention of UNGASS Commitments
PNG Medium-Term Development Strategy			Reprioritisation of HIV within the MTDS used as major justification for the budget submission in section 6.
NSP			Although the document refers to NSP priorities, there is no analysis of how resources are allocated to different NSP themes or priorities. There is no statement of major activities or expected achievements.
Gender Strategy			No mention of gender
Available Resources			The plan is well-framed in terms of likely available resources from both GoPNG and Development Partners
International Best Practice			No mention of international best practice

[1] Colour coding – green indicates plans are well-aligned; orange indicates some concerns over alignment; red indicates major concerns and/or limited alignment; grey indicates insufficient data to assess

The process in developing the budget for 2010 is briefly described in section 2 of the budget document. Strengths of this process included:

- Strong and knowledgeable leadership provided by NACS Acting Director
- Involvement of FMIU in development of overall NSP budget with a reduction in calculation errors from previous years
- Clear analysis and explanation of actual expenditure in 2009
- Budget submitted successfully and on time

However, weaknesses of the process included:

- Limited involvement of FMIU in developing NACS development and recurrent budget
- Consultation and participation limited by management problems within NACS
- Ceilings and historic allocation levels used to guide resource allocation rather than use of strategic priorities
- Financial implications of setting priorities unclear

Progress and Planning by NSP Focus Area

NSP Focus Area 1 – Treatment, counselling, care and support

Several key players were interviewed in relation to Focus Area 1. They included NACS and NDoH staff, laboratory heads at the Central Public Health Laboratory (CPHL) and at Port Moresby General Hospital, WHO, UNAIDS, UNICEF, the Esso Highlands LNG project, the ADB HIV Prevention and Control in Rural Development Enclaves Project, the Clinton Foundation, BAHA, Poro Sapot, Igat Hope, faith-based groups and development partners. Field visits were carried out to Southern Highlands and Sandaun provinces.

Current status and progress

The previous IRG visit in May 2009 recommended for prioritisation the adoption of a regional approach to responding to the epidemic, starting with the Highlands, to maximise resources and technical support and develop home grown approaches and models of relevance to other parts of the country. The Highlands region continues to bear the burden of most of the identified cases of HIV and has also the largest response in terms of the HIV testing, care and treatment response. On the current IRG visit, it was clear that while the exponential growth seen in these services in 2007 and 2008 has slowed down, there continues to be an impressive effort to sustain the previous achievements - at both the country and Highlands level. Numbers tested, registered for care and entered into treatment in 2009 are similar to the numbers of 2008.

The IRG was pleased to note some centres of excellence in treatment and care including the 5-star Mendi Provincial Hospital, which sets a standard to which all provincial hospitals and district hospitals should aspire to strengthen health systems and scale up the quality of HIV, STI and TB services. The Nina Clinic at that hospital, which currently has 91 HIV positive people registered, has the capacity to grow this number ten-fold, especially since there is a well functioning lab with

two CD4 FACS Count Machines. Catholic Health Services also carry out outreach HIV testing in some rural areas and ADB reports also show that Oil Search continues to support the province to upgrade its health services and introduce some aspects of HIV prevention and care. Other players, including faith-based organisations, have the capacity to scale up counselling and care, given additional resources and support from NACS, NDoH and development partners.

Nationally, the last 12 months have been a period of consolidation for this focus area, with the addition of only 50 additional accredited HIV testing sites and 3 additional ART sites. This has resulted into a flattening of the growth curve that may not reflect need and demand especially in rural and hard to reach places. NDoH technical support teams as well as regional teams and their partners have devoted time to quality assurance and improving data quality. Nonetheless, the IRG is concerned about four key issues in particular. First, despite a three year period to evaluate and approve the point of care (PoC) rapid 2 test algorithm, there has still not been a national roll out of this important approach to scaled-up HIV testing. Only eight sites (mostly Catholic Health Services) are currently using this technology. The NDoH reports insufficient capacity to train staff in the technique and to carry out quality assurance as ART roll-out proceeds. The IRG believes these are easily resolvable issues and should be prioritised.

Second, a large number of HIV positive people continue to be started on treatment and monitored without the benefit of laboratory results such as CD4 counts. In particular, there are some provinces that have no access to CD4 counts. Since the treatment initiation CD4 count was raised to < 350 last year, it is imperative that the national laboratory network has the capacity, the quality and the innovation to provide results in all provinces. During the last twelve months, the ADB HIV Prevention and Control in Rural Development Enclaves Project has supported additional sites in acquiring and maintaining 6 CD4 machines and the Clinton Foundation has provided PCR technology for 500 Paediatric HIV tests through dried blood spots couriered to Port Moresby. A priority must be a system to transfer blood specimens to regional and provincial labs for CD4 counts. The specimen transfer technology for this exists as does the courier service infrastructure.

Third, TB/HIV services in PNG continue to be sub-optimal. In 2009, of the reported 8989 TB cases only 4% had an HIV test, and of the 357 individuals tested 17.0% were reported to be HIV positive. This implies 1,450 missed cases of HIV in persons with TB that needed to be evaluated for ART. The area of TB/HIV co-management is clearly a priority area. Fourth, in 2008 there were 56,412 cases of STI reported nationally, but only 6% of these were offered or accepted an HIV test (implying 4,200 cases of HIV were not diagnosed). This is a missed opportunity and a huge threat as large numbers of individuals leave health services not knowing they are HIV positive.

Universal Access (UA) and UNGASS reports for 2009 indicate that ART access in PNG has reached 73% based on a CD4 initiation count of < 200. This calculation needs to be updated in light of the current guidelines of CD4 initiation of < 350, when it is expected to fall substantially. There is an ongoing exercise to physically verify the actual number of active ART patients which is further likely to reduce UA coverage percentage. Service coverage for other services including paediatric care and PPTCT remains low.

The draft PNG UNGASS 2010 report and the Universal Access 2009 PNG Final Report reveal that HIV counselling and testing in 2009 achieved 115,063 tests compared to 120,607 tests in 2008; and that 21% of pregnant women were tested in 2009 (43,942) identifying approximately 350

HIV positive individuals. Of these, 73 were evaluated for ART and 251 babies received ARVs for PPTCT. While national PPTCT coverage increased slightly from 11.1% in 2008 to 12.2% in 2009, further increase can only occur with significant investment in MCH services that give confidence to women to deliver in health facilities which offer HIV testing and PPTCT services. STI services continue to be the poor cousin of HIV with only 8% of pregnant women (8,339) tested for syphilis – a slight increase from the 6% tested in 2008. Finally, ART retention rates as reported in the UA report and national surveillance reports suggest a decline from 82% at 12 months to 70% at 36 months to 46% at 60 months. While these figures are comparable to regional outcomes for ART, there is scope for major improvement through interventions including an intensive inpatient induction period, improved first line drug regimens, nutritional support, better linkage to community support and to positive people's organisations for peer support, and systems to trace and find defaulters. Currently PNG utilises first line ART regimens for 99.7% of its patients but unless adherence is improved the need for second line and salvage therapies will grow.

There is large variation in quality within the national laboratory network to support HIV and TB testing, diagnosis, monitoring and surveillance. There is also an absence of a national strategy to guide the direction, growth and diversification of laboratory services and diagnostics. Nonetheless, CPHL staff are working hard to provide national leadership, establish and monitor quality standards, provide national training workshops, and run a reference HIV and TB laboratory. Efforts to develop a national laboratory policy will shortly begin. Critically, the further scale up of HIV/STI/TB services requires laboratory support able to provide static, PoC and specimen referral and transfer services. The potential of 'telepathology' services to support provincial hospitals, should be explored.

STI diagnosis and management continues to lag behind the prevalence of cases in the population. There is also no accurate national surveillance data on drug resistance and susceptibility. Esso Highlands LNG project has indicated that it will develop a partnership with the IMR in Goroka to carry out state of the art STI surveillance and this will be a welcome addition to national response. Nonetheless STI prevention and treatment needs to given greater priority given that in the early stages of the epidemic HIV rides on the STI epidemic and data (from Poro Sapot) show in the first quarter of 2010, an HIV prevalence of 8% among sex workers and men who have sex with men with an STI, which is virtually identical to year 2008 national statistics revealing 8.1% prevalence of HIV among 3,845 STI cases tested.

The ADB HIV Prevention and Control in Rural Development Enclaves Project continues to produce good results to support health systems strengthening in rural areas as well as a specific HIV/STI response. This, together with the work of BAHA, offer good examples of workplace programmes to improve service levels and quality for HIV, STI and TB. Discussion with the Esso Highlands LNG project indicates a desire to learn from and take to scale similar evidence based work in their areas of operations, and to impact upon the epidemic in the Highlands in particular.

During the IRG's visit it became apparent that stakeholders in this focal area were disturbed by the failure of the Global Fund Round 9 proposal and the impending expiry of the current Round 4 grant. While much effort has been put into developing a Global Fund application for continuity of services, there is a need for a back up plan in the event that the request is successful but there are delays in funding or, if the request fails completely.

Beyond this, plans need to be made to continue to scale up services based on continuing demand, while a new Global Fund proposal is presented and reviewed. Finally, there is a need to analyse current costs of HIV care and treatment, unit costs and effectiveness with a view to reallocating resources from low impact, resource intensive programmes to higher impact, more cost efficient ones. Without this, there is a risk that gains in the last three years will be severely impacted upon and potentially reversed.

Key gaps and priorities

There are four key gaps and priorities within this focus area requiring attention over the coming months. First, there is a need to quickly ensure sufficient resources to maintain current HIV testing, care and treatment services as well as additional resources to continue to scale up services. This will require a successful continuation of service request to the Global Fund, a successful Global Fund Round 10 proposal, and a higher level of resource commitment from the government of PNG. Additional support is also likely to be needed from current and new development partners in a form that prioritises service partners who can demonstrate good population coverage at lower unit costs. Second, it is important to set and achieve higher targets for national HIV testing especially in pregnant women, all STI cases, all TB cases, and all medical and paediatric admissions. This should be accompanied by targeted outreach testing for most-at-risk populations including migrant and mobile populations, uniformed services, women and men with multiple concurrent partners, sex workers and men who have sex with men. Third, there is a need for further investment in improving maternal and child health as well as in general health systems, particularly in high HIV prevalence areas, to provide the platform of service delivery that will be able to reach and provide good quality integrated HIV and STI services to many more individuals. Finally, it will be important to re-vamp and enhance the national laboratory network to achieve an equitable and responsive good quality service that meets the needs for HIV, STI and TB as well as other conditions. In the case of HIV, STI and TB, this will include using current and emerging technologies that allow sample transportation to a regional or central laboratory, as well as the use of rapid point of care diagnostics.

NSP Focus Area 2 – Education and Prevention

Stakeholders interviewed in relation to Focus Area 2 included management at NACS, NDoH, NDoE, the PNG-Australia HIV and AIDS Program and UNAIDS, officials in NHATU/IEA, representatives of faith-based groups, and the managers of programmes for most-at-risk groups. In Southern Highlands and Sandaun provinces, those interviewed included members of provincial administration and PAC officials, HIV positive persons, the field coordinator of Tingim Laip, counsellors, community health workers, staff at VCT and health clinics, religious leaders and representatives of faith-based groups. Documentation provided by NACS and other stakeholders was also examined.

Current status and progress

The most significant progress in this focus area has been the finalisation and endorsement of the NHS. This is a major step towards addressing not just the risk of HIV transmission but also the deeper social and cultural drivers that enhance vulnerability to HIV. Despite this advance, however, on the ground there remains much to be achieved.

In HIV prevention activities across the country, there remains an inadequate focus on the drivers of the epidemic, even in programmes designed for those who are especially vulnerable to HIV, for example Tingim Laip and Poro Sapot. Moreover, despite paper efforts to embrace a more comprehensive approach, HIV prevention particularly in the provinces, is still limited to basic HIV awareness and counselling, condom distribution to VCT attendees and selected risk populations, and a few activities with easy to access groups involved in transactional sex. Community outreach work is mainly limited to promoting VCT and home-based counselling and care. The use of theatre, cultural events and popular media for HIV prevention in provinces remains severely limited. The IRG has made similar observations now in three previous mission reports.

Additionally, PACS report setbacks and challenges in promoting condoms as part of HIV prevention work because of strong negative reactions by some church leaders who openly speak out against condom use. In some provinces, PAC staff are actively prevented by these leaders from promoting condoms and are reprimanded when found to be doing so. The response is further weakened by claims that prevention must begin with HIV positive people and that condoms are only meant for irresponsible individuals who lack self control. These actions work against the essence of the National HIV Prevention Strategy and are likely to create confusion in the minds of the public. Scientific evidence clearly indicates that when properly and consistently used, condoms provide good protection against HIV. Given difficulties surrounding condom use in some churches, a comprehensive approach to HIV prevention should perhaps become a key issue for discussion within the PNG Christian Leaders Alliance on HIV and AIDS in order to agree on the kind of partnership envisaged in implementing the HIV Prevention Strategy.

As indicated in earlier IRG reports, the education sector response remains strong in both policy and resource terms. Approximately 4,000 trainee teachers have been trained in HIV and reproductive health and about 50% schools have been reached with HIV-related resource materials. A National Behaviour Management Policy has been developed which holds the potential to protect children and young people, especially girls, from sexual harassment and HIV-related stigma and upholds the right to education for girls who become pregnant.

Some encouraging trends can be seen in HIV prevention related training over the last 12 months. The national culture of training alluded to in earlier IRG reports appears to have weakened, with the number of training sessions carried out by NHATU/IEA reduced by almost 50% – from 679 in 2007 to about 383 in 2009. The scope of training has also broadened, from basic HIV awareness to training in HIV theatre and Provider Initiated Counselling and Testing, and includes health workers as trainees. In response to a recent external review of training, all training manuals are under review to improve quality and standards. New manuals are also under preparation for HIV theatre work and for men's sexual and reproductive health. An annual implementation plan and budget for 2010 for national level training has been prepared by NHATU.

Key gaps and priorities

As indicated above, NAC's endorsement of the National HIV Prevention Strategy is a welcome step, but the absence of an HIV prevention task force and an implementation plan stalls its immediate implementation by national and provincial stakeholders. Efforts to ensure urgent implementation must be a priority.

Despite the IRG having advocated for it on several missions now, there remains no serious HIV prevention work underway nationally or in the provinces to address the structural drivers of the epidemic. These influences include gender inequalities, gender and sexual violence, and harmful cultural practices and traditions, as well as development-induced displacement and marginalization, income disparities, livelihood security, mobility and alienation. What is lacking is local capacity to link the local epidemic to the structural processes that are driving its growth. There are no HIV prevention programmes yet, for example, that aim to transform gender inequalities or support the informal sector to help vulnerable sections of society (including women and young people in rural and poor urban settlements) to deal with larger issues of livelihood and sustenance. Additionally, there is little evidence of HIV prevention programmes being used to address vulnerability among those (such as migrant populations and those with multiple concurrent sexual partners) who may be at particular risk of HIV. Put quite simply, HIV prevention cannot be effective and at scale unless the broader structural determinants of the epidemic are addressed and a comprehensive approach is adopted.

In the course of the mission, the IRG found evidence of some PAC staff being able to identify local risk groups and make broad, though largely unsubstantiated, observations on demographic and social factors affecting the local epidemic. In the provinces visited, these included male mobility induced by logging, mining and LNG project development. However, national and provincial players lack capacity and guidance in identifying the links between these trends and macro level factors influencing vulnerability to HIV, including gender inequality, poverty, livelihood issues, and displacement and marginalisation. As a result, HIV prevention efforts too often fail to focus on real local risk groups and risk factors. There remains little serious engagement on the part of PACs with local communities over the complex cultural and social factors creating conditions of risk and vulnerability to HIV. Legal reform in the form of recent amendments to PNG's family and sexual violence and child related laws have not yet been factored into HIV-related community level prevention work. This is largely due to HIV prevention work being carried out in relative isolation from work by other civil society groups and women's NGOs, a gap which needs to be closed.

While the education sector leads all other sectors in its prevention response, it lacks a strategy for scale-up to reach all schools with HIV-related course materials and to train the large body of teachers who are already in post. Equally, it lacks plans to evaluate the impact of its pre-service teacher training programme on the quality of HIV education being delivered in schools, and on students' knowledge and skills after receiving education based on the new HIV course curriculum. In relation to training, lack of coordination among various training providers means a duplication of effort and lack of quality control.

Condom availability, especially female condoms and lubricants and their timely and even distribution nationwide to HIV prevention programmes particularly for most-at-risk groups, remains problematic and is a cause for serious concern. Condom 'stock-outs' point out to major supply and distribution weaknesses which require urgent attention by NACS and NDoH to avoid an impending crisis of 'condom scarcity'.

NSP Focus Area 3 – Epidemiology and Surveillance

Interviewees for Focus Area 3 included representatives from NDoH and NRI, ADB, UNAIDS, WHO, and the PNG-Australia HIV and AIDS Program, the Esso Highlands LNG project and PSI. Field visits to Sandaun and Southern Highlands provinces enabled members of PACs to be consulted, along with provincial and district level administrators, local health facility staff, and members of faith-based groups.

Current status and progress

The HIV surveillance system within NDoH has been steadily improving. There has been good progress in the past year in expanding the number of HIV testing sites, including ANC, VCT, STI, TB and Blood Bank sites. This is a positive step in terms of detecting cases of HIV, and expanding access to treatment and care to those who need it. Expanding ANC sites in particular has moved PNG closer to having a more comprehensive picture of HIV prevalence in the general population, although information about rural areas and men is still insufficient.

The designation of a subset of HIV testing sites as sentinel surveillance sites in 2008, where an enhanced set of data is collected on a sample of ANC, STI or TB clients during a set period of time each year, means that there is now a set of prevalence data that can be interpreted in light of information on opt-out rates, district of current residence, migration status and, for ANC women, number of pregnancies. This information is helpful for knowing who the surveillance data represents and, equally important, who it does not represent.

The quality of HIV surveillance reporting has improved, with a greater number of sites reporting more complete information. The national surveillance report produced each year by NDoH is evolving to be a rich resource which can be used for many types of secondary analyses and data triangulation activities. Behavioural surveillance surveys have multiplied steadily, and local capacity to conduct and report on these surveys has been developing at the same time, particularly at NRI.

Key gaps and priorities

There are still major gaps in the surveillance system. The expansion of HIV testing sites, while helpful for detecting cases and improving access to treatment, should not be confused with the major objectives of an HIV surveillance system: namely, 1) to understand where new HIV infections are coming from, 2) to assess whether the epidemic is increasing, decreasing or stabilizing among those populations it is affecting, and 3) to generate and use strategic information to assist the national programme in prioritising the response. On these fronts, the surveillance system in PNG is still lacking, not only because it is missing certain types of key data (e.g. size estimates of most-at-risk populations), but also because data that are available are not being used to optimally guide the response.

The good news is that there is a considerable amount of relevant data in the country. There are many individual pieces of strategic information (e.g. findings from social mappings, qualitative research, *ad hoc* biological and behavioural surveys, behavioural surveillance, AIDS case reporting, etc.) which have greatly enhanced the understanding of social and structural determinants of HIV spread. Research agendas and surveillance plans have also been formulated to address information gaps.

What has been missing is the integration of these data in a systematic way that allows the country to see the bigger picture, and prioritise the response accordingly. An appropriate response, and indeed a well-designed surveillance system, should be informed by a working knowledge of who the most-at-risk populations are, and where those populations exist in large numbers. Although most-at-risk populations are not as clear-cut in the PNG context as they perhaps are in countries with more 'classical' concentrated epidemics, it is still important to acknowledge that not everyone is at equal risk.

Populations that have been identified by the surveillance technical working group (STWG), as most-at-risk include women sex workers and their clients (e.g. men working in private industry, truck drivers, and the military), men who have sex with men, and young people with multiple partners. Behavioural surveillance has recently been conducted with several of these populations in selected locations. However, surveys are not necessarily the most efficient means of working out who and where the biggest concentrations of risk may be. There are many steps that ought logically to come before (e.g. mapping, rapid situation assessments and data triangulation), from which one can estimate population sizes and levels of risk behaviour. Based on this information, not only can the need for BSS and IBBS surveys be better prioritised, but the response itself can be prioritised more appropriately.

What seems not to have been done in PNG as thoroughly as it might have been, is the bringing together of existing data to properly 'know the epidemic'. To improve this situation, data triangulation is needed to help the country prioritise what to do where, and with whom. Such an exercise might involve categorisation and ranking of all provinces in the country according to a few distinct epidemic scenarios. For example, scenario one provinces might include those with higher prevalence with significant multiple and/or commercial partner sex as the main driving force. Scenario two provinces might be characterized as having significant epidemic potential related to multiple and/or commercial partner sex, but with still low to moderate prevalence. Scenario three provinces might be low epidemic potential (based on absence of known most-at-risk populations or pockets of risk), and low HIV prevalence. Data that could be used for this categorisation would draw on existing sources, and might include variables such as the number of reported infections, the approximate sizes of at-risk populations, information on HIV prevalence and risky behaviour among at-risk populations, and contextual information to help situate the district in terms of potential for epidemic spread. Following this categorisation process, appropriate scenario specific response packages could be formulated to help form the basis of provincial level plans with different mixes of prevention, counselling and testing availability, treatment availability, and surveillance data requirements.

This example is illustrative of how evidence-based geographic prioritisation might look. As the country moves forward with the NHS process, now is an excellent time to conduct such an evidence-based geographic prioritisation activity, using existing data. Since the use of a broad range of strategic information to better know an epidemic and improve understanding is one of the top NHS priorities, an appropriate core NHS indicator would be to ensure that programmes are in place at scale, in all provinces with evidence-based potential for an epidemic.

There has been much discussion about a general population IBBS to help calibrate ANC testing data, so they can be used to better estimate the number of people infected in the country. Equally important objectives of this survey should be to help analyse the direction of the epidemic in

different regions of the country, and identify where most new infections are likely to come from in the future, to facilitate an evidence-based response. A design that allowed for both behavioural and biological data for men and women separately, in areas of the country with different epidemic patterns (i.e. different levels of prevalence, epidemic maturity and driving factors), would make a major contribution. Given the seriousness of the epidemic in the Highlands, and the limitations of existing testing data for understanding the situation, this region should be considered a priority for the IBBS, followed by NCD, and then the coastal and island provinces (possibly combining the latter two into a single sampling domain).

NSP Focus Area 4 – Social and Behavioural Change Research

Key stakeholders interviewed in this focus area included members of the Research Coordinating Unit (RCU) at NACS including the research manager, behavioural surveillance specialists at NRI, and officers within the Australia-PNG HIV and AIDS Program. Also interviewed were programme managers and staff working with most-at-risk groups and PAC staff in the provinces visited.

Current status and progress

In the last IRG mission, progress in this focal area was reported to be largely satisfactory with management structures such as, the RCU and the Research Advisory Committee (RAC) being established within NACS to implement the National Research Agenda for HIV/AIDS. The year 2009 was the first full year of operation of the RCU. During the last 12 months, however, progress in this area has been somewhat uneven. On the positive side, following an earlier IRG recommendation to prepare a comprehensive review of existing HIV research, a systematic review of all research on HIV, AIDS, STIs and STDs conducted or published between 2007 and 2008 was completed in late 2009. Notwithstanding the fact that the review is limited in scope to a two year period, this is the first analysis of its kind and data from it will prove immensely useful for PNG's future researchers in identifying gaps and weaknesses in existing research. This activity must be continued however to include all available HIV relevant research in the country.

The RCU has also been active in coordinating research activities, in disseminating information about the National Research Agenda and the application process to key institutions in the country, and in supporting the development of a research climate by initiating a seminar series at NACS and organising an HIV/AIDS Research Day at the Medical Symposium hosted by the PNG Medical Society. A total of 11 RAC endorsed papers based on ongoing and completed studies were discussed during this annual event which was attended by nearly 250 people.

Following the successful launch of the country's first ever research grants programme in early 2009, as a result of which 23 large grants applications and 26 small grants applications were received, a total of five proposals (three large and two small grants) have been approved for funding. Three of the successful large grant applications, worth a total of 2,852,910 Kina have now been funded by the PNG-Australia HIV and AIDS Program. Support for the remaining small grant awards (worth a total of K 344,757) has been committed by NACS. A few additional proposals are currently under review by the RAC.

Although the research output is still small, and so not a great deal can be said in terms of the topic coverage, interest in examining the cultural aspects of the epidemic for a more contextual analysis appears to be growing. One large grant proposal aims to explore masculinity, sexuality and agency among young men and another aims to integrate highland narratives into visual HIV prevention and education materials. Similarly among the small grants proposals, the focus on gender is encouraging.

The research capacity development plan has however been revised and trimmed back in the light of the financial downturn. The revised National Research Capacity Strengthening Plan 2010-2012 will provide intensive research training to PNG academics and offer three HIV research fellowships over a two year period through a partnership model involving twinning between national and international researchers. An annual activity plan with a budget and timelines for this focus area for year 2010 has been submitted to NACS. A three year Development Plan (2010-2012) has also been submitted for joint funding by the PNG-Australia HIV and AIDS Program and NACS. This aims to consolidate research support systems and build staff capacity within NACS to implement the NRA.

Finally, the Behavioural Surveillance Survey Round 2 has been completed and Round 3 is currently in progress in selected sites. Among the several reviews carried out by the RAC over the year 2009 was a review of the IBBS which is currently being discussed by major stakeholders including NACS and NDoH (see also Focus Area 3).

Key gaps and priorities

A promising start has been made and foundations laid to strengthen social and behavioural research in PNG to international quality standards. However, the success of such an initiative lies not in plans, research awards and disbursements alone, but in the timely completion of the approved research studies and an ongoing cycle of calls for new proposals. This cycle has already been broken with no call for large grants being issued in 2010 following the decision to commission studies in future rather than solicit proposals through a competitive peer review process. This change of strategy has been justified given the variable quality of proposals received to the first call for research awards. If well implemented, it has the potential to ensure that future research studies are commissioned where they are needed the most.

Financial cuts and delays in announcing research awards have affected the targets set for 2009 which specified the making of seven research awards. Only five of these were announced during the year. The commissioning of further research needs to begin urgently if the target set for year 2010 – a further seven research awards – is to be met. Other delays in this focus area have to do with resources development. The Research Handbook containing an important section on ethics in HIV research is still under revision. The handbook needs to be published and made available. The research data base planned for 2009 has not been established. It is now planned to be developed in 2010.

Strengthening the capacity of local researchers is central to achieving targets in this focus area. As the IRG noted before, research capacity in PNG is limited even among academics in local universities and publication trends are generally low. But capacity development plans have been seriously delayed due to financial constraints. No training was organised in the year 2009 and the revised capacity development plan is not yet operational.

Even so, full roll out will not occur until 2011 and in 2010 only short term training will be organised. The proposed new Fellowship scheme offers promise to young researchers, but without adequate and timely financial support it is unlikely to yield the desired results. Research capacity within provinces is very weak and must urgently be addressed. Previous IRG reports have stressed that good provincial plans require good knowledge of the local epidemic, yet there is no evidence in the capacity development plan of efforts to strengthen the skills of PAC or PROMEST members to help them identify factors driving the epidemic and vulnerable population groups.

As indicated earlier, the literature review on HIV and STI related research conducted in PNG makes an important contribution towards promoting good quality future HIV research. But the scope of activity is too limited. It needs to be expanded to include all existing research rather than only studies published in a two year period, given that PNG has had a rich history of socio-medico-anthropological research into cultural and traditional patterns of life. Studies going back of several years need to be mined to offer an insightful understanding of the cultural context of the HIV epidemic in PNG – both in terms of understanding epidemic drivers and individual and collective impact and response.

NSP Focus Area 5 – Leadership, Partnership and Coordination

Individuals interviewed in relation to Focus Area 5 included the Acting Director and staff of NACS, the Chair and members of NAC and the NSP Steering Committee, representatives from national and provincial government agencies, representatives of faith-based organisations, international and local NGOs, members of PACSO, development partners and trade union representatives. Regrettably, meetings with some central agencies could not take place due to clashes in timing and a protest march.

Current status and progress

A firm lead on national priority setting continues to be provided by the National Aids Council (NAC) which is meeting regularly to decide on policy and substantive concerns. However, beyond NAC and at the highest national and provincial levels, more active and collaborative political leadership on HIV is required.

Despite this, there have been some notable actions with respect to leadership. His Excellency, the Governor General Sir Paulius Matane launched the PNG Christian Leaders Alliance on HIV & AIDS in May 2010. Earlier, in March 2010 he launched the Pacific AIDS Commission Report and the National HIV Prevention Strategy. During the IRG's visit, there was also welcome news that the Prime Minister would intervene to enable the release of K6 Million funding for NACS previously agreed to by the National Government. In addition, the appointment by the National Executive Council of a Director of NACS (subsequent to the IRG's visit) is most welcome and should provide the leadership, stability and rehabilitation that the Secretariat needs.

Since the IRG's last review, there has been important progress with the approval of assigned functions and responsibilities for HIV and AIDS at national, provincial and local level, and the creation of a separate function grant. The Determination Assigning Service Delivery Functions and Responsibilities to Provincial and Local Level Governments (including HIV) was gazetted in

December 2009. The Acting Director NACS subsequently informed all provincial administrators about the steps NACS is taking to implement its service delivery functions after consultation with Department of Provincial and Local Level Government Affairs (DPLGA). Effective follow-up is critical in strengthening provincial support and co-ordination, and for line agencies in co-ordinating a national response to HIV.

Besides NACS submitting its restructuring proposal, PACSO and Igat Hope have also undergone a degree of re-organisation, with PACSO reviewing its constitution and mandate in order to function more effectively, and Igat Hope beginning to assume a coordination role. These are all positive steps which hold promise for the future.

BAHA, together with many faith-based organisations and some health and education agencies, continue to provide excellent leadership and services despite lack of timely funding. The launch of the Christian Leaders Alliance on HIV and AIDS mentioned earlier is a significant milestone for PNG's fight against the HIV epidemic. The Statement of Commitment signed by the leaders signals a cooperative and collaborative response by church leaders to work together in partnership in their communities. Beyond this, the IRG was impressed with the level of collaboration between faith-based organisations, government, and civil society and development partners in finalising the new National HIV Strategy.

Key gaps and priorities

The Review Team observed a sharp contrast once again between those provinces that have made HIV a priority and those that have not. Firm, decisive political and administrative leadership enables greater collaboration and inclusiveness by stakeholders as well as better co-ordination and management of resources so that HIV prevention, treatment and care can be delivered to where they are needed most. Strong advocacy on HIV issues and increased funding or budget support for HIV, provide positive indications of robust leadership.

The same observation can be made at national level. There is an urgent need for leadership at the highest level within government agencies to acknowledge and address HIV issues on two fronts: first, as it relates to their agency or sectoral responsibilities, and second with respect to updating their workplace policies or implementing them. The issuing of a standard public sector template by the Department of Personnel Management as requested by NACS will revitalise efforts in this regard. Opening up discussions with all departmental heads on how government departments will deal with and become an integral part of the solution on HIV would assist in framing a Special General Order that could guide all agencies including provincial administrations. The Personnel Management and National Planning Departments, together with NACS, should set the groundwork for future collaboration across the public sector.

A coherent and forward looking public sector response to HIV is a major gap that needs to be filled. The initiative by the Department of National Planning and NACS to hold an initial meeting with central and line agencies to determine the parameters of a National Joint Steering Committee or its alternative, in line with the decision by the National Executive Council, is long overdue. Stronger support is also needed from Department of Personnel Management and the Public Employees Association (PEA) to assist in setting up such a body and partnering with government in the national response to HIV. An agreed set of procedures and a working agenda ready by the IRG's next review mission in 2011 would indicate progress.

Church leaders who recently stressed a renewed sense of urgency and pledged to do more on HIV at the launch of the PNG Christian Leaders Alliance on HIV and AIDS are the exception, not the rule. Nationally and locally, there generally continues to be a poor understanding by leadership that business as usual will not suffice given the severity and impact of HIV, especially within the context of major development activities such as the LNG project. This absence of visionary leadership is further reflected in the need for more support and champions at community and family level. Parents, siblings and close relatives should be at the forefront in dealing with HIV in the family, championing efforts to care and support family members with HIV as they would for any other disease.

More attention needs to be given by national and provincial government leaders to the potential impact of major resource development projects on the growth of the HIV epidemic. It is the responsibility of national government to reach agreement with major developers to ensure research is conducted in advance into possible socio-economic impact including implications for HIV. This should be followed by concrete actions to address these issues. Advance planning to minimise the impact of HIV will reduce future costs in terms of human and financial resources, and ensure a healthier workforce and local communities. The partnership between government, the private sector and the Asia Development Bank through the HIV Prevention and Control in Rural Development Enclaves Project is a positive step to assisting communities, particularly in remote areas, with health facilities and services including HIV, and should be learned from in this respect.

As the IRG has commented several times before, there continues to be an overwhelming absence of people living with HIV, people with disabilities, women and young people in local and national decision making and leadership on HIV. Efforts must urgently be made to identify and nurture future leaders and to provide opportunities for their participation at local and national levels.

While significant progress has been made in developing a new National HIV Strategy to succeed the current National Strategic Plan, and while the IRG commends those responsible for the inclusive and participatory manner in which planning has taken place, important work to develop the NHS risks being sidelined unless efforts are speedily made to align the NHS to Vision 2050, the Development Strategic Plan, the Medium Term Plan and the Integrated Service Delivery Mechanism – all policy initiatives recently endorsed by NEC. It is essential that the NHS be considered part of a whole of government approach to policy making. Likewise, it will be important for transitional arrangements to be put in place to enable the endorsement and subsequent operationalisation of the NHS by all stakeholders, via a process that includes a role for an NHS Steering Committee or similar body.

NSP Focus Area 6 – Family and Community Support

A number of key players were interviewed in relation to Focus Area 6. They included senior staff at NDoH and NACS, UNICEF, faith-based groups, Igat Hope, Poro Sapot, individual people living with HIV, and PAC members in Southern Highlands Province and Sandaun Province.

Current status and progress

Since the IRG's last visit, Igat Hope has continued to develop its work and is supporting seven active networks of people living with HIV. The national conference of HIV positive people has taken place and Igat Hope and its membership have been active and involved in the consultations and development of the new NHS. Igat Hope working with others has also achieved national and regional visibility through its engagement with the recent launch of the Pacific AIDS Commission report which included presentations by HIV positive people. Igat Hope is however very concerned by the current uncertain situation of the future of funding for ART scale up in PNG and intends to make this a key focal issue for advocacy and action in the near future. All of this, together with the strengthening of the Igat Hope secretariat, provides confidence that the role of HIV positive people in PNG will grow from engagement to fuller participation at all levels of the response.

In the past year, the Lukautim Pikinini (Child) Act 2009 has been gazetted. Details of this, together with copies of the strategy document, *Protection, Care and Support for Children Vulnerable to Violence, Abuse, Exploitation and Neglect in the Context of the HIV epidemic in Papua New Guinea*, are being disseminated to provincial leaders and faith-based organisations, and it is hoped that this process will continue down to community levels so that a larger percentage of the population understands the contents of these documents and their rights and responsibilities. UNICEF, together with the Department for Community Development, is taking the lead in this effort. It is also gratifying to note that universal free basic education has commenced in 2010 although many schools continue to charge onerous 'user fees'. Education free at the point of access remains the most important support for vulnerable children and needs to be continuously advocated for by all partners.

Family and community support for HIV positive people and orphans and vulnerable children (OVC) in particular continues to be provided mainly by faith-based organisations and some HIV positive organisations. In 2009, 16 organisations were noted to be active in this area, a significant increase from the three in 2007. However, most of these are international NGOs whose methodologies and costs may not be scalable, replicable or affordable. Organisations that are supporting specific communities of either most-at-risk groups or HIV positive people need to be further strengthened to extend their coverage. These include Igat Hope, Friends Frangipani, Scarlett Alliance, Poro Sapot and Susu Mamas.

The IRG's visits to the provinces provided the impression that there continue to be high levels of stigma and fear in communities which pose the biggest barrier to effective and widespread family and community support. At the same time, unless this epidemic and its manifestations are given a human face at the individual and family level, then stigma, apathy and at worst violence will continue to isolate HIV positive people. Faith-based organisations and traditional leaders are important gatekeepers in PNG and continued engagement and encouragement needs to be provided to them to assume leadership in this focus area.

Key gaps and priorities

While there has been improved performance by Igat Hope and other players, challenges remain in achieving significant population and geographical coverage in this area. The current draft of the NHS captures previous IRG recommendations and it is hoped that over the next five years additional progress will be observed.

The key will be to reduce and eliminate the stigma, ignorance and hostility that continue to exist at community and even family level, to ensure that the human face of HIV is seen and appreciated by all citizens. This can be best achieved through the work of various church groups and/or civil society organisations working with traditional leaders. Both these types of agency need active engagement and encouragement to fulfill these roles.

Importantly, the full engagement of communities and families needs to be viewed not only as a means of providing care and support but also as a means of normalising, 'personalising' and de-stigmatising the epidemic. The visible, full and proper involvement of HIV positive people in the household and community response also offers a means of promoting HIV prevention, as people more fully understand how HIV is and is not transmitted. Beyond this, family and community involvement creates grassroots demand for HIV services, and will encourage adherence support to those on ART or TB treatment. The IRG is concerned, therefore, that work within this area is developed substantially over the next 12 months to be able to fully support the new NHS. Strong leadership by the Department for Community Development with the support of agencies such as UNICEF offers a positive way forward.

Despite the progress detailed above, key gaps within this focus area continue to be insufficient funding and lack of capacity to manage multiple community initiatives and be able to provide programmatic and financial accountability. Faith-based organisations in particular are ahead of the curve in many respects in this area and additional support for specific initiatives to de-stigmatise and 'personalise' the epidemic should result in further progress over the next 12 months. Igat Hope should also be supported to learn lessons from and build on its recent successes, recognizing that the needs of HIV positive people may vary from province to province depending on prevalence and the nature of the groups most affected. The Lukautim Pikinini Act, as well as the new strategy to address OVC issues in the context of the HIV epidemic, need to be mainstreamed in the education sector so that all teachers and school going children are aware of their implications and carry that knowledge with them.

NSP Focus Area 7 – Monitoring and Evaluation

Interviewees for Focus Area 7 included representatives from NACS and NDoH, ADB, UNAIDS, WHO and the PNG-Australia HIV and AIDS Program. Additionally, field visits to Sandaun and Southern Highlands provinces enabled members of PACs to be consulted, along with provincial and district level administrators, local health facility staff, and members of faith-based groups.

Current status and progress

The Monitoring and Evaluation (M&E) unit at NACS is still facing significant challenges in its efforts to coordinate compiling and disseminating of programme data at national level to allow stakeholders to identify progress against NSP targets. Likewise, in its support to the provinces, NACS does not seem to have identified an effective combination of guidance, training, tools, and support mechanisms to successfully enable PACs to engage partners in collective planning and management of the provincial HIV response. In particular, the plan to have ProMEST teams lead in coordinating the compilation, analysis and use of data within the provinces, and report it to the central level, has not materialised.

Much of the problem seems to stem from an absence of 'buy-in' by major partners, perhaps reflecting lack of confidence that anything useful will come from the process of sharing data. But there are also difficulties related to the integration of multiple plans and priorities of different partners into one cohesive framework and one cohesive system.

Going forward into the NHS, it is unclear that this situation will change without a collective call for cooperation and coordination by the major stakeholders. A tentative effort in that direction has been suggested by NACS, in the form of an HIV/AIDS national M&E coordination mechanism called the National Oversight Committee (NOC), with membership by most major partners and a representative of the Development Partners Forum. It is too soon to predict whether this mechanism will result in any positive change. However, no amount of effort on the part of M&E Unit will be effective without some kind of memorandum of understanding (or equivalent) between the major partners and NACS, acknowledging joint responsibilities for one national M&E system. By the same token, as long as the NACS M&E unit lacks the credibility to inspire confidence among other stakeholders, it will be difficult to move the agenda forward to create an improved M&E system. The various parties involved have expressed hope that new leadership at NACS will be a catalyst for alleviating some of the problems.

Key gaps and priorities

Irrespective of past difficulties, the ongoing NHS development process offers fresh opportunities to improve the national HIV M&E system. Experience from other countries suggests that developing a 'culture of data use' takes time, but grows stronger as people start to experience the benefits. As NHS planning progresses, the development of an M&E framework should happen simultaneously to ensure the definition of measures of programme success. The M&E framework should lay out the logic of the programme design, the indicators of programme performance, and the targets or expectations of what the programme is designed to achieve. There need to be a limited number of national level indicators, corresponding to the core priorities of the NHS, and designed to reflect high level progress.

In general, surveillance data, along with other strategic information, should be used to determine whether the NHS places emphasis on the 'right' programmes in the right geographic areas, (see the earlier description of geographic prioritisation in Focus Area 3), and to assess whether the programme ends up achieving its higher level objectives, along with the reasons for success or failure. In contrast, the monitoring system should be used to measure whether the programme is being implemented as planned (i.e. with acceptable quality, with coverage at planned levels, etc).

In developing the data collection systems related to measuring key indicators, it will be important to closely involve those who will be generating the data, making sure to build on systems that are already in place, and searching for common ground with what already exists. It will also be important to ensure at the outset, that systems for gathering information are costed, and that it is clear where the data will come from, how often it will come, what kinds of targets it will be measured against, and who will be responsible for reporting it. These issues should be agreed upon by all the partners, and tools for operationalising data collection should be piloted and finalised early in the process, in partnership with those who will be collecting the data.

The identification of headline indicators is a good idea. There is value in having a short list of these at the national level that reflect the priority programme areas. Some of these will likely coincide with UNGASS and/or UA indicators. It is not necessary however for countries to report on *all* UNGASS or UA indicators, especially the ones that do not coincide with programme objectives. However, for those that do coincide, it will helpful to use the UNGASS or UA standard indicator definitions.

Recognising that the main purpose of collecting monitoring data is to use it to inform management actions, and that reporting up to a higher level is only a very small part of how data are meant to be used, the idea of strengthening ProMESTs cannot be abandoned. However, given capacity limitations at the central level and the provincial levels, the strengthening cannot be done everywhere at once, and will have to be phased in on a priority basis, with higher prevalence provinces being strengthened first, and others being phased in gradually over time. Given this situation, it is strongly encouraged that NDoH and NACS play a proactive role in producing mini-reports that describe what is known about the epidemic in each province, and what the data suggest in an easy to understand language

Resource Allocation and Financial Management

Findings under this heading are drawn from an analysis of documents and from discussion with a number of key players including NACS staff and advisers, development partners, government agencies, and other national stakeholders.

Current status and progress

The proposed NHS is an impressive document that reflects a huge amount of work and a high degree of consultation. The process is well-documented and has been completed within a very challenging time frame. The NHS is built on IRG input and is well-aligned with other PNG and international priorities. The identification of ten key priorities is excellent. However, there is need for further work to develop tools and guidance to show what the NHS and its priorities mean for actors, resources and programmes

The 2010 NSP budget document is stronger and clearer than previous years. However, some key figures are lacking, such as Global Fund resources available in 2010, and any funds from Government of PNG (GoPNG) outside of NACS. Overall, budgets available for implementation of the National Strategic Plan have continued to rise. In 2009, the total budget available was K97.2m and this rose to K129.6m in 2010. Funds available from GoPNG through NACS rose from K10.7m in 2009 to K16m in 2010. Of this, K6.4m is in the recurrent budget and K9.6m in the development budget. Of the development budget, 81% is expected to be onward granted by NACS to provinces and stakeholder organizations. Of the remaining 19%, almost half (K906k) is allocated for celebration of World AIDS Day. It is unclear if the allocation of the development budget by activity category matches the allocation by expenditure category. It is of concern that FMIU does not appear to have been involved in the 2010 budgeting process within NACS.

There are major concerns over how costs of ART will be met once the Global Fund Round 4 grant ends in August 2010, given that PNG's proposal to Round 9 was unsuccessful. Various mechanisms for continued funding are being explored, including an application for continuation of services to the Global Fund. However, even if successful, this will not cover costs of all current activities.

At the time of the IRG review, it was encouraging to see that a new Director was in the process of been appointed at NACS and that he has begun to tackle longstanding issues of poor financial management and accountability within the secretariat. As a result, credibility has begun to be re-established within government and with development partners. Some activities have been possible, e.g. the development of the new NHS and submission of an UNGASS report. However, the progress made is relatively small and extremely fragile. The proposed new NACS structure has not yet been formally approved by the Department of Personnel Management and, as a result, there is currently no senior management team to support the Director. Morale and productivity among NACS staff are low.

The Financial Management Improvement Unit (FMIU) is continuing to work well. The IRG considers that concerns that the costs are too high may be over-stated. The extremely high value of having such a critical core function performed to a high standard in a very challenging context means that FMIU is considered by the IRG to be producing excellent value for money. Plans to save money by outsourcing to a local accounting firm may be premature, given the current uncertain situation in NACS. These plans carry a high degree of risk although this is mitigated, to some extent, by the phased nature of the plans. Precise details, such as a transition phase from one contractor to another and detailed delineation of duties, need further thought. It is absolutely essential that the high financial standards established by FMIU are maintained.

Key gaps and priorities

Although considerable information is available on budgets for HIV programming, much less information is available on how those budgets are spent and how this spending is aligned with NSP priorities. It is extremely disappointing to note that no National AIDS Spending Assessment (NASA) was conducted prior to this year's round of UNGASS reporting, as had been planned. It is encouraging that a NASA is planned but it is really vital that these plans are turned into action.

It is encouraging that plans are being made to submit an application to the Global Fund Round 10. However, it is crucial to ensure that adequate, skilled human resources for proposal development are in place in time to ensure the best possible chance of success. It is vital that the Round 10 application respond positively and clearly to feedback on the Round 9 proposal from the Global Fund's Technical Review Panel. It is the IRG's view that a modest proposal is more likely to be successful, given the availability of finances to the Global Fund and the difficulties faced by PNG in using all the resources allocated to it in Round 4. A budget 'ceiling' of US$20-22m over five years might be more appropriate than a higher figure. Great care is needed in identifying and selecting potential Principal Recipients as their financial track record will be closely scrutinized by the Global Fund. Weaknesses in this track record may put the success of the Round 10 proposal at risk.

The determination of service delivery function and responsibility assignment in provinces agreed in 2009 is extremely positive. However, the IRG remains concerned at the continued absence of an effective mechanism for channeling financial resources to the provinces.

A recent review (Tuckwell, 2010) 'confirmed that the NACS, and the National Grants Unit, in particular, are unable to fulfill mandated functions and extend sufficient support to the Provinces through the NACS-PACS structure.' Without adequate resources, provinces will be unable to fulfill the responsibilities assigned to them. On balance, the IRG believes that providing provinces with HIV function grants is an option that should be seriously explored.

The IRG has concerns about the current system of providing grants to other organizations through NACS. The Tuckwell review concluded 'NACS presents as being an organization that has consistently failed to successfully recruit, train, mentor, manage and maintain the performance of an effective and motivated NGU team since 2006…We cannot allow more of the same non-delivery.' The IRG considers that option 2, presented in that review, is worth considering. This would see NACS retain an involvement in approval and monitoring of grants but would see the finances managed by another body, such as the new AusAID-supported Strongim Pipol Strongim Nesen (SPSN) programme.

In conclusion

The present review highlights a number of areas in which there has been significant progress since the last IRG mission. It also provides an opportunity to reflect on progress made in each area of the NSP since the IRG first began its work in 2007. In this final section, therefore, key elements of this progress will be highlighted together with some of the challenges that remain.

With respect to Focus Area 1, over the last three years the major change has been the effective use of resources to significantly scale up HIV testing from a very low base to over 120,000 tests per year. This has resulted in identification of significant numbers of HIV positive people (>7000) who have been entered into care and treatment. Until recently, PNG could feel proud of an ART coverage rate of 73% based on a CD4 induction count of <200. These achievements have been brought about through mobilisation involving an alliance between development partners, public sector providers, the private sector, community and faith-based organisations. This partnership offers the foundation for future gains in other health related areas. Despite this success, there has been disappointing progress in mainstreaming and improving services for TB, TB/HIV co-infection, STI management and sexual and reproductive health services. Services provided have also been mainly facility-based and it is only very recently that outreach and community services are being provided mainly by key players such as Catholic Health Services.

In relation to Focus Area 2, the most impressive change has been the development and launch of a comprehensive National HIV Prevention Strategy. This strategy, which is currently available only in paper form and lacks an implementation plan, recognises the need to avert HIV transmission alongside the need to address the underlying structural drivers of the epidemic. Addressing gender inequalities, sexual and domestic violence, cultural practices that harm and place individuals at risk of HIV, and large economic disparities, are seen as critical to the success of prevention work. However, a paper strategy alone will not help unless there is a plan to implement it, and this must urgently be attended to by a National HIV Prevention Taskforce.

Key to success will be efforts to ensure a properly comprehensive response in line with the National HIV Prevention Strategy, which address both social vulnerability and individual risk using a range of evidence informed measures. The education sector response is an important element of the national response and leads ahead of many other sectors.

There have been a number of key elements of progress in Focus Area 3. These include the relocation of surveillance to NDoH and closer working between NACS and NDoH in relation to tracking the course of the epidemic and the national response. A sentinel surveillance plan for 2007-2010 was approved and most aspects have been implemented. The number of routine testing sites has greatly expanded, to cover all provinces, and to include an increasing number of rural sites. The recent designation of a subset of routine sites as sentinel sites provides the basis for more systematic surveillance data. Behavioural surveillance surveys have been implemented among high-risk groups in many locations, and there has been great improvement in capacity for conducting behavioural surveillance at NRI. Although the quality of surveillance data is steadily improving, it is still of concern that data are not being better utilised to guide a more optimal epidemic response.

The most striking development in Focus Area 4 has been the laying of foundations for the conduct of high quality social research in PNG. This is in recognition of the previous poor quality of evidence relevant to an effective response to the epidemic. The National Research Agenda for HIV/AIDS, and a capacity development plan to complement it, form the core of this foundation. Management structures have also been put in place within NACS which hold the potential to generate good quality data in line with accepted international standards of research. The focus on developing capacities among national academics and student researchers holds promise for the future. A healthy culture and ethos of research is palpable – evident in the creation of an HIV seminar series with a focus on sharing and learning from local research. Less positively, it is worrying that a second round of funded research studies has yet to get underway, and that plans for capacity building have been scaled back.

With respect to Focus Area 5, the IRG has witnessed steady progress being made. Members of National AIDS Council have been appointed and the Council itself is fully operational. A new Director has been confirmed to steer a hopefully restructured and leaner NACS, with key functions and responsibilities being devolved to provincial and local level. More work is needed, however, to enable NACS to become fully functional and follow due process with respect to the policy, planning and budgetary processes. Other encouraging signs of partnership and leadership can be seen in the actions of BAHA, in the private sector, and among faith-based organisations and groups. Partnership and leadership in the public sector is however still lacking with no sector wide response to HIV. Individual agencies have developed workplace policies, but many of these need revising in the light of treatment advance. PACSO is reorganising to provide a stronger civil society voice in the epidemic, as is Igat Hope. Recent consultative workshops for the development of the NHS offer evidence of growing support and ownership of the national response.

In Focus Area 6, the major changes over the last three years have been in three main areas. Despite a slow start, Igat Hope has established itself as a legitimate instrument to rally and support HIV positive people in PNG. Several active networks of HIV positive people have now been established with over 1,000 members despite high levels of stigma and intolerance. In addition, the faith-based sector and a number of community-based organisations have initiated systems of

community-based and home-based care and support. At a national level, the Lukautim Pikanini Act has been gazetted providing a legal framework to protect all vulnerable children. Nonetheless, there remains much to be done in this area and current actions and interventions have limited geographical coverage.

In Focus Area 7, NACS has established a high-level national M&E coordination mechanism called the National Oversight Committee (NOC), with the goal of achieving better cooperation and coordination between NACS and the development partners in generating the key strategic information required to monitor the epidemic and inform the response. Albeit late, the NACS' M&E Unit eventually developed programme monitoring indicators and guidelines, and modified reporting forms for non-health indicators, in concert with the NDoH development of surveillance and NHIS reporting formats. In order to monitor the local scope and response of the epidemic ProMEST teams have been formed in the majority of provinces, though most are not yet functioning in the manner envisaged.

Finally, in relation to resource allocation and financial management, the budgets available for the national HIV response have risen by almost 50% from K87m in 2007 to K129.6m in 2010. NACS' financial management has improved in the short-term due largely to the establishment of the Financial Management and Procurement Improvement Units (FMIU and PIU). The adoption of GoPNG financial systems by NACS is positive. Improvements in the governance of NACS through the re-establishment of NAC, the establishment of a finance sub-committee of NAC and the appointment of a new NACS Director are all positive steps in creating a conducive environment for resource and financial management. Less positively, there has been no progress in ensuring budgets and expenditure reflect strategic priorities, and it is still extremely difficult to establish what financial resources are actually expended on the national response to HIV. There is a pressing need to adopt a budgeting process based on strategic priorities rather than arbitrary ceilings and historic allocations. Finally, significant bottlenecks remain in ensuring financial resources reach provinces and implementing partners. As a result, there is a significant disconnect between the resources available centrally and the grassroots delivery mechanisms that are effectively starved of financial resources.

Overall, over the time the IRG has been conducting its work, the landscape has changed dramatically, both in terms of understanding of the epidemic in PNG and in relation to an appropriate response. While challenges remain to be overcome, substantial progress has been made over the last three years. The IRG has been privileged to work alongside some extraordinarily committed groups and individuals, offering feedback and setting priorities. For it is only be trying to stay one step ahead of the HIV epidemic that lasting progress can be made, and it is only by not being afraid to speak out openly about HIV that the consequences of the epidemic can be understood. The IRG looks forward to further supporting the response to HIV in PNG, and to taking up its work again in 12 months time.

IRG identified priorities (April 2010)

In support of NSP implementation and an effective transition to the new NHS, the IRG has identified a series of priority issues where it is believed that significant progress can be made prior to year 2011 follow-up review. These are detailed below, one for each NSP Focus Area and one of particular relevance to resource allocation and financial management.

Priority for Focus Area 1

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

Priority for Focus Area 2

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

Priority for Focus Area 3

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

Priority for Focus Area 4

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

Priority for Focus Area 5

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

Priority for Focus Area 6

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

Priority for Focus Area 7

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

Priority for Resource Allocation and Financial Management

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

Appendix 1 Core Functions of the Independent Review Group

The core functions of the IRG are to:

- Conduct an independent annual review of the performance of the response to HIV from sectors against key indicators of the Monitoring and Evaluation Framework, and to contribute to the periodic higher level of monitoring at an outcome and impact level as detailed in the NSP 2006-2010, UNGASS and Millennium Development Goals. To do this, the IRG will:
    - Assess the progress of HIV prevention, care, treatment and support activities
    - Assess constraints and facilitators to implementation.
- Assess mechanisms for planning, coordination, stakeholder engagement, resourcing/financing and reporting in relation to implementation of the NSP.
- Conduct /collaborate with Development Partners in specific reviews/evaluations of aspects of multi-sectoral performance as requested by the NAC, or through joint NACS/HIV Donor Forum meetings.
- Review the consistency of allocations and expenditure against priorities of NSP and their translation into the annual implementation plans.
- Assess the effectiveness of donor harmonization/coordination, including the alignment of support among themselves and with Government for national policies, strategies, systems, cycles and plans.
- Periodically assess the quality and adequacy of monitoring and evaluation systems in NACS, identify strategies to strengthen the analysis and collection of data and use of this information.

Appendix 2 IRG identified priorities (September 2007)

Priority for Focus Area 1

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

Priority for Focus Area 2

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

Priority for Focus Area 3

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

Priority for Focus area 4

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

Priority for Focus Area 5

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

Priority for Focus Area 6

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

Priority for Focus Area 7

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

Priority for Resource Allocation and Financial Management

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

Appendix 3 IRG identified priorities (April 2008)

Priority for Focus Area 1

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

Priority for Focus Area 2

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

Priority for Focus Area 3

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

Priority for Focus area 4

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

Priority for Focus Area 5

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

Priority for Focus Area 6

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

Priority for Focus Area 7

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

Appendix 4 IRG identified priorities (September 2008)

Priority for Focus Area 1

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

Priority for Focus Area 2

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

Priority for Focus Area 3

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

Priority for Focus Area 4

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

Priority for Focus Area 5

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

Priority for Focus Area 6

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

Priority for Focus Area 7

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

Priority for Resource Allocation and Financial Management

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

Appendix 5 IRG identified priorities (May 2009)

Priority for Focus Area 1

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

Priority for Focus Area 2

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

Priority for Focus Area 3

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

Priority for Focus Area 4

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

Priority for Focus Area 5

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

Priority for Focus Area 6

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

Priority for Focus Area 7

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

Priority for Resource Allocation and Financial Management

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

Appendix 6 Objectives and scope of work for 2010

Following discussion with the NSP Steering Group, the following objectives for the IRG's work in 2009 were identified:

Element 1. Stocktake of progress against priorities identified in 2008 and 2009

Review of implementation and achievements in each NSP focus area to date, with emphasis on attainment of priorities recommended in previous mission reports, especially in areas were there has been slow or uneven progress, such as HIV prevention, organisational changes in NACS, and monitoring and evaluation.

Element 2. Review and appraisal of NSP Annual Plan (2010)

A review of the NSP Annual Plan for 2010 was not undertaken prior to its submission to Government. This review will therefore focus on its alignment with: the Millennium Development Goals, UNGASS commitments, the PNG Medium-Term Development Strategy, the NSP Gender Strategy, the National Leadership and Prevention Strategies, available resources, and international best practice in HIV prevention, treatment, care and impact mitigation.

A review of the process(es) of developing the NSP Annual Plan for 2010 will be conducted with a focus on: perceived appropriateness and usefulness of the planning guidelines; parties and processes of involvement in the planning processes including the role of the NSP Technical Working Group; timescale allowed for planning; level of technical support available to the planning process; equity and involvement in the planning process (especially the involvement of affected groups and communities); and the extent to which the process has taken account of available evidence in prioritising interventions

Element 3. Review and appraisal of development of new National Strategy on HIV

From November 2009, a process for developing the new National Strategy to replace the NSP is underway. It is expected that a draft framework for the Strategy will be available for assessment during the mission. This review will focus on alignment with:

- GoPNG strategies currently being developed to replace MTDS
- MDGs and UNGASS commitments
- Sub-national priorities
- National Prevention Strategy
- National Leadership Strategy
- National Gender Policy – new government policy
- International best practice in prevention, impact mitigation, treatment and care.

A review of process(es) for the development of the new national Strategy will focus on:

- Consultation processes and their inclusiveness of PNG stakeholders, particularly vulnerable populations and provincial stakeholders
- Parties and processes of involvement in the planning processes including the role of the NSP Core Working Group
- Level of technical support available to the planning process
- Equity and involvement in the planning process (especially the involvement of affected groups and communities)
- The extent to which the process has taken account of available evidence in developing the framework.

Element 3. Specific areas for assessment

The IRG will undertake assessments of a number of specific areas which present strategic significance to the attainment of the NSP objectives. Priority fields for 2010 include:

- Processes to strengthen NACS including the restructure and systems for improved governance and coordination
- Specific interventions that have the potential to arrest and control of the epidemic, especially among groups and contexts most vulnerable to the epidemic.

Element 4. Other activities

Finally, within the constraints of time and available resources, the IRG will periodically review working papers, scoping documents and reviews of relevance to the development and implementation of the NSP and other supporting policy documents.

Appendix 7 List of Persons Interviewed

Sir Peter Barter	Chair, NAC
Rod Mitchell	NASFUND/BAHA and member of NAC
Sister Tarcissia Hunhoff	National Catholic AIDS Office and member of NAC
Lady Roslyn Morauta	PACSO and member of NAC
Wep Kanawi	Acting Director NACS
Michael Aglua	Manager, Monitoring and Evaluation, NACS
Doreen Mandari	Monitoring and Evaluation, NACS
Wilfred Kaleva	Manager, Research Coordination Unit, NACS
Tony Lupiwa	Research Coordination Unit, NACS
Gabriel Poiya	Procurement and Logistics Officer, NACS
Joseph Sil	Peer Education and BCC Manager, NACS
Louis Mara	Provincial Liaison Officer, NACS
Ruth Beriso	Provincial Liaison Officer, NACS
Elsie Oreke	Gender Adviser, NACS
Kenneth Pakaka	Short Term HR Manager
Philip Tapo	Provincial Programmes Manager, NACS
Bomal Gonapa	Legal Adviser, NACS
Joachim Pantumari	Medical and Surveillance Adviser, NACS
Louise Edwards	Strategic Management Adviser, ASF, NACS
Lindsay Sales	Policy Adviser, ASF, NACS
Deb Wheeldon	Human Resources Adviser, ASF, NACS
Kirsty Laird	Manager, Deloittes
Gamini Walisinghe	Finance and Audit Adviser, JTAI
Arai Pula	Deputy Secretary Policy, DPM & NEC
Rhoda Yani	SPO HIV and AIDS, DNPM
Paison Dakulala	Acting Secretary for Health NDoH, PNG
Esorem Daoni	Principal Technical Adviser STI/HIV/AIDS, NDoH
Isimel Kitur	Epidemiologist, NDoH
Fumihiko Yokota	Epidemiologist, HIV/AIDS Prevention and Control in Rural Development Enclaves Project
Erama Ugaia	Assistant Secretary Human Resources, NDoE
Daniel Isaac	HIV/AIDS Strategy Officer, NDoE
Bill Kua	Director General, PSRMU
Michael Malabag	President, PEA & TUC
David Lowe	Independent Consultant (NHS Technical Group member)
Richard Jones	PNG-Australia HIV Program (NHS Technical Group member)
Shane Martin	Independent Consultant (NHS Technical Group member)
Christine Bradley	Independent Consultant, Gender and Development
Dimitri Prybylski	Centers for Disease Control, Bangkok
Cynde Robinson	Country Representative, Population Services International
Tim Rwabuhemba	Country Coordinator, UNAIDS
Ali Feizzadeh	Monitoring and Evaluation Adviser, UNAIDS
Eigil Sorensen	WHO Representative
Fabian Ndenzako	HIV Country Officer, WHO
Agatha Lloyd	Medical Officer, WHO
Juliet Attenborough	Project Officer, UNICEF
Anne Malcolm	Senior Program Coordinator, PNG-Australia HIV and AIDS Program
Ninkama Moiya	HIV and AIDS Adviser, PNG-Australia HIV and AIDS Program
N'ik Plange	HIV Policy Adviser, PNG-Australia HIV and AIDS Program

Abraham Opito	Adviser, PNG-Australia HIV and AIDS Program
Angela Maudie-Filer	Gender and Social Development Adviser, PNG-Australia HIV and AIDS Program
Nidia Roya Martinez	Senior Knowledge Management and Communications Advisor, PNG-Australia HIV and AIDS Program
Terry Opa	Knowledge Management and Communications, PNG-Australia HIV and AIDS Program
Stephen Deklin	Communications Officer, PNG-Australia HIV and AIDS Program
Maura Elaripe	GIPA Advocacy Officer, PNG-Australia HIV and AIDS Program
Ben Havenga	JTAI
Kinivanagi Karo	Senior Consultant, Training and Development Programs, NHATU
Thomas Lissenia	Senior Consultant, Training and Development Programs, IEA
Isaac Ake	Commissioner St John Health Service
Don Matheson	ADB Consultant from Massey University
Evelyn Lavu	Senior Specialist Medical Officer i/c of CPHL, Port Moresby
SR Dutta	Chief Pathologist and Microbiologist, Port Moresby General Hospital
Tania Olewale	Executive Officer, Clinton Health Access Initiative
Christopher Hershey	Programmme Manager, Poro Sapot
Stephen Yoifa	Senior Project Officer, Poro Sapot
Moale Kariko	Secretary, PACSO
Erica Ogaba	Operations Coordinator, BAHA
Dominica Abo	Anglicare
Holly Aruwafu	HIV Behavioural Surveillance Specialist, National Research Institute
Peter Momo	President and Chair of Board, Igat Hope
Annie McPherson	Coordinator, Igat Hope
Tania Olewale	Executive Officer, Clinton Health Access Initiative, PNG
Jeremy Syme	Project Manager, ADB HIV Prevention and Control in Rural Development Enclaves Project
Kel Browne	Deputy Project Manager, ADB HIV Prevention and Control in Rural Development Enclaves Project
Joe Burton	Occupational Health Manager, Esso Highlands Limited
Dr Gary Krieger	Principal, Newfields (contracted to Esso LNG project)
Ms. Marci Bulge	Health consultant, Newfields, Colorado
Ms Christina Mitchell	Public and Government Affairs, Esso Highlands Ltd
Joe Sungi	Provincial Administrator and Chair, PAC, Sandaun Province
Ricky Saren	Acting HIV Response Coordinator, Sandaun Province, Sandaun Province
Paul Weriyai	Tingim Laip Coordinator, Sandaun Province
Pauline Banis	Training for HIV Counselling, Vanimo
Dulcie Charo	Administrative Officer, PACS, Sandaun Province
Gideon Laho	Peer Education Trainer, PACS, Sandaun Province
Pauline Inayoi	Home-based Care Trainer, PACS, Sandaun Province
Lucas Gawe	Acting Director, Nursing Services, Odi Clinic, Vanimo General Hospital
Sr. Josepha Sakine	Community Health Worker, Odi Clinic, Vanimo General Hospital
Belinda Yamkeok	Health Extension Officer, Odi Clinic, Vanimo General Hospital
Derrick Tiram	Nursing Officer, Odi Clinic, Vanimo General Hospital
Charlie Sumei	Community Health Worker, Odi Clinic, Vanimo General Hospital
Susan Yenpiti	Nursing Officer in Charge, Dapu Clinic, Vanimo General Hospital
Susan Kimson	Nursing officer, Dapu Clinic, Vanimo General Hospital
Max Yawi	Trainer for HIV Counselling, Dapu Clinic, Vanimo General Hospital
Danny Wait	Provincial Health Information Officer, Dapu Clinic, Vanimo General Hospital
Sister Rosme	Missionaries of Charity, Vanimo
Bishop Cesare Bonivento	Bishop, Catholic Diocese of Vanimo
Father Thomas	Vicar General, Catholic Diocese of Vanimo
William Powi	Provincial Administrator, SHP
Ambe Keleli	Deputy Provincial Administrator, SHP

Sai Pilyo	Deputy Provincial Administrator, SHP
Rim Kanea	Provincial Planner, SHP
Thomas Anda	Provincial Health Adviser, SHP
Jacob Veveloga	Provincial Education Adviser, SHP
Henry Hapen	HIV Response Coordinator, SHP
Rev David Sikar	Chair, PAC, SHP
Sr. Godentsia Meia	Epeabda VCT Centre, SHP
Manfred Thomas	CWO, Epeabda VCT Centre, SHP
Sr. Maria Koke	Epeabda VCT Centre, SHP
Claire Kopipi	CHW, Epeabda VCT Centre, SHP
Joseph Turian	CEO, Mendi Hospital
Nancy Aloitch	HEO Nina Clinic, Mendi Hospital
Rev. Joshua Mikelo	Walpumemin Care Centre
Sr. Elizabeth Seto	Deputy Principal, Mendi School of Nursing
Siemu Bate	HRC, Milne Bay, PAC
Ray Himata	HRC, Autonomous Region of Bougainville, PAC

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