



Papua New Guinea
National
Strategic
Plan
on HIV/AIDS

2004-2008

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Foreword

I note with concern that the worldwide HIV/AIDS epidemic is fast becoming a threat to the lives of people and the economy of our nation. On a global scale, the rapid rise of HIV/AIDS has shown that the epidemic has serious implications for social and economic development. Every day 8,000 people lose their lives to HIV/AIDS and another 14,000, (that is 10 people every single minute) become newly infected by HIV. *“For there to be any hope of success in the fight against HIV/AIDS, the world must join together in a great global alliance”* was one of several messages by Kofi Annan, Secretary-General of United Nations. Early in 2001 he also embarked on a campaign to raise the profile of HIV/AIDS and to spur a large-scale mobilisation of political commitment and funding to strengthen the global response to the epidemic. In Papua New Guinea, HIV/AIDS has been declared a generalised epidemic. The epidemic has already taken the lives of many of our people and many more are living with the virus. Socio-economic and cultural determinants that drive the spread of HIV must be addressed with vigor. Within a period of fifteen years, the spread of this epidemic could have been contained but our efforts have not measured up to expectation. We must do something now, because within the next 10 to 15 years we will be witnessing our own family members taken away by this horrible disease. The impact of the epidemic at family and household levels will have spiraling impact on the national economy. Our labour force will be reduced, and every basic health and other social indicators we have invested so much into will be severely affected. Complacency and denial of the epidemic is inexcusable. We must also end the increasing discrimination and stigma associated with people who are living with the virus. *“We need to care, treat and protect people infected and affected by HIV/AIDS. Papua New Guineans living with HIV/AIDS could be our brothers, sisters, sons, daughters, and wantoks. Let us give out support and care.”*

The threat of this epidemic has brought together many people and organisations to put together a strategic plan of action that will guide our efforts in the fight against the epidemic. Doing things together in times of human threat is very “Papua New Guinean” so we must all work together in implementing what we have put together.

Political leadership is paramount in turning the course of the epidemic. I have publicly pledged *“the support of every member of my government, and myself to make the eradication of AIDS one of the government’s highest priorities.”* It is equally important that leaders at all levels, within organisations, unions, and churches and NGOs take an active role in supporting the national response. We are not fighting a lone battle. We have had considerable support from our donor partners and the need to further strengthen these partnerships becomes more imminent. Therefore, the role of the National AIDS Council must be strengthened considerably to effectively coordinate a nation wide response.

The National Strategic Plan (NSP) for HIV/AIDS 2004-2008 builds on from the foundations of previous plans and further reflects the broader development aspects the epidemic possesses. It offers the broad framework to address issues in seven key priority areas under which specific programs can be

developed by various sectors and organisations that are relevant to their specific needs.

The goals and objectives highlighted in the National Strategic Plan can only be realised with the commitment and cooperation of all section of society working together. I commend everyone who has contributed in putting this document together and recommend the document to policy makers, administrators, business managers, donor organisations, church leaders, NGOS and other partner agencies for use as a framework in guiding their specific responses. I also urge all our development partners, nationally and internationally in supporting the implementation of this Strategic Plan to prevent a potential national tragedy.

The Right Hon. Sir Michael Somare, CMG
Prime Minister of Papua New Guinea

Acknowledgements

The PNG *National Strategic Plan for (NSP) HIV/AIDS 2004-2008* has been produced through the collaborative effort of many individuals and organisations. The NSP reflects the contributions of professionals and volunteers working in the field of HIV/AIDS prevention and care, as well as people whose experience in HIV/AIDS work is limited but who recognise the importance of a multi-sectoral approach to meet the challenges of the epidemic in Papua New Guinea.

The NSP process began in June 2003 with the staging of the situation analysis workshop within which seven (7) focus areas were identified to form the basis of the strategic planning process. These were; Treatment, counselling, care and support; Education & prevention; Epidemiology & surveillance; Social and behavioral change research; Leadership, partnership and coordination; Family & community; and Monitoring and evaluation. On the basis of these focus areas, seven (7) working groups were established and tasked to go through the process of developing a strategic framework for each focus area. Terms of reference (annexed) were developed to guide the different working groups in performing their respective tasks.

The process of developing the NSP was inclusive and highly participatory. It involved a total of 112 individuals representing different organisations from all sections of the community. The NSP Steering Committee provided the overall direction and guidance on the work of the different working groups supported by a Secretariat established basically to support the Steering Committee as well as providing secretariat and logistics support to the seven working groups.

The outcome of this document is the result of countless number of meetings and workshops organised and attended by dedicated individuals and organisation representatives. Without the leadership and commitment of the Group Facilitators the development of this document would not have been possible. I sincerely thank each and every facilitator for their time and input.

On behalf of the Council and the Secretariat, I express my appreciation to all persons who had been involved one way or another in contributing to the process of charting the path this nation will be taking in the next five years. Appreciation is also extended to the members of the Steering Committee who guided and steered the process throughout.

The process would not have been possible without the technical and financial support provided by our development partners who had also been an integral part of the process. In particular, I would like to acknowledge AusAID and UNAIDS for supporting the government financially and providing technical expertise throughout the entire process. Appreciation is also extended to other UN bodies including WHO, UNDP, UNICEF, UNFPA, World Bank and the European Union who provided much needed technical input in the development of the strategic document.

Finally, I thank the NSP Secretariat support staff who worked tirelessly in providing the backup support to the 7 working groups, the Steering Committee and the NSP Secretariat. (A list of members to the different Committees is attached as Annex II to the document).

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Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
AusAID	Australian Aid for International Development
CBO	Community Based Organisation
CPHL	Central Public Health Laboratory
CSO	Community Service Organisation
EIA	Enzyme Immuno Assay
ELISA	Enzyme-Linked Immuno-Sorbent Assay
FER	Functional Expenditure Review
GDP	Gross Domestic Product
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
MDG	Millennium Development Goals
M & E	Monitoring and Evaluation
MSM	Men who have sex with men
MTCT	Mother to Child Transmission
MTP	Medium Term Plan
NAC	National AIDS Council
NACS	National AIDS Council Secretariat
NDOH	National Department of Health
NGO	Non-government Organisation
NHASP	National HIV/AIDS Support Project
NSP	National Strategic Plan
OI	Opportunistic Infections
PMGH	Port Moresby General Hospital
PMTCT	Prevention of Mother to Child Transmission
PNG	Papua New Guinea
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UN	United Nations
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Treatment
WHO	World Health Organisation

Glossary

Behavioural surveillance

Surveys of behaviour that puts people at risk of HIV transmission. This involves asking a sample of people about their sexual attitudes, drug injecting and other risk behaviours. The sample may be restricted to a certain age group, and to men or women.

Best Practice

Best practice is understood as the continuous process of learning, feedback, reflection and analysis of what works and does not work in the HIV/AIDS response and why. Drawing on practical experiences from countries around the world and within the country itself. Effective approaches, policies, strategies and technologies are identified as "best practice."

ELISA

Acronym for Enzyme-Linked Immuno-Sorbent Assay. It is a type of Enzyme Immunoassay (EIA) to detect the presence of HIV antibodies in the blood or saliva.

Epidemic.

A disease that spreads rapidly through a demographic segment of the human population in a geographic area. Epidemics can be spread from person to person or from a contaminated source such as food or water.

Epidemiology

The branch of medical science that deals with the study of incidence, distribution and control of a disease in a population.

Gender and Sex.

The term 'sex' refers to biologically determined differences, whereas the term 'gender' refers to differences in social roles and relations between men and women. Gender roles are learned through socialisation and vary widely within and between cultures. Gender roles are also affected by age, class, race, ethnicity and religion, as well as by geographical, economic and political environments.

Guiding Principles

Guiding Principles are the cultural, moral and ethical values that form the basis of the National Strategic Plan, including the principles embodied in the National Constitution.

High-risk groups/Groups with high-risk behavior.

These terms should be used with caution as they can increase stigma and discrimination. They may also lull people who don't identify with such groups into a false sense of security. 'High-risk group' also implies that the risk is contained within the group whereas, in fact, all social groups are interrelated. It is often more accurate to refer directly to 'sex without a condom', 'unprotected sex', 'needle-sharing', or 'sharing injecting equipment', rather than to generalise by saying 'high-risk group'.

HIV

Human Immuno-deficiency Virus is the virus that weakens the immune system, ultimately leading to AIDS

HIV Infection.

Entry of HIV into the body and infects susceptible immune cells. This leads to massive reproduction of the virus leading to the progressive destruction of the immune system.

HIV Incidence

HIV incidence (sometimes referred to as cumulative incidence) is the proportion of people who have become newly infected with HIV during a specified period of time. UNAIDS normally refers to the number of people (of all ages) including children (0–14) who have become infected during the past year.

HIV Prevalence.

Cumulative HIV infections within a given period and is usually given as a percentage.

Multisectoral Response

A multisectoral response is a concerted effort by all concerned agencies, organisations and key stakeholders (such as politicians, Non-governmental organisations, churches, private sector organisations, union groups, donor agencies, vulnerable groups, people with HIV and other stakeholders), in the fight against the HIV/AIDS epidemic.

Opportunistic Infections (OI)

Infections that invade the body when the immune system is weakened by the HIV Virus such as TB, pneumonia and cancers like Kaposi Sarcoma.

Orphans

Children/child without parental support. When used in the context of HIV/AIDS, it relates to children whose parents have died of AIDS.

Palliative Care

Palliative care combines active and compassionate therapies to comfort and support patients and their families who are living with the life-threatening illness. Palliative care strives to meet physical needs through pain relief and maintaining quality of life while emphasising the patient's and family's rights to participate in informed discussions and to make choices. This patient and family-centred approach uses the skills of interdisciplinary team members to provide a comprehensive continuum of care including spiritual and emotional needs.

Pandemic

A disease prevalent throughout an entire country, continent, or the whole world.

Peer Education.

Providing factual/vital information to people of a certain age, same sex, has the same interest, of the same organisation or social group, status or position on matters governing their existence. Peer education can motivate peers to achieve behavior change which has to be generated from within the individuals and the whole group.

People Living With HIV/AIDS

Makes reference to people who are infected with HIV. However, in general terms, it also refers to people affected by HIV/AIDS like spouses, children and close relatives.

Prophylaxis.

Preventive therapy given to at-risk individuals to prevent a first infection such as OI, post-exposure prophylaxis such as needle stick injury and rape.

Sentinel Sero-Surveillance

Monitoring system through blood testing to track HIV infection levels in certain populations through certain institutions because they provide access to populations that are either of particular interest in the epidemic or representative of a larger population, for example, antenatal and STI clinics.

Sentinel Surveillance.

This form of surveillance relates to a particular group (such as men who have sex with men) or activity (such as sex work) that acts as an indicator of the presence of a disease.

Sexually Transmitted Infection (STI)

Also called venereal disease (VD), an older public health term, or sexually transmitted diseases (STDs). Sexually Transmitted Infections are spread by the transfer of organisms from person to person during sexual contact.

Sex Worker.

The term 'sex worker' is non-judgemental and recognises the fact that people sell their bodies as a means of survival, or to earn a living. This term is preferable to 'prostitute', 'whore' or 'commercial sex worker', which have negative connotations.

Surveillance

The ongoing and systematic collection, analysis, and interpretation of data about a disease or health condition. Collecting blood samples for the purpose of surveillance is called sero-surveillance.

Syndrome.

A group of signs and symptoms that together are characteristic of a specific condition.

Targeted Interventions

Appropriate strategies, program activities or course of actions aimed to reduce or prevent the spread of HIV amongst certain population groups identified to be at risk.

Youth.

Young people cover both adolescents (10-24 years old). In PNG context, young unmarried adults up to 35 years old also fall into this category, making up more than 50% of the population.

Voluntary counselling and testing (VCT)

A confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS including blood testing for HIV.

Executive Summary

The government's National Strategic Plan (NSP) on HIV/AIDS, 2004 – 2008 is the second National Plan succeeding the Medium Term Plan (1998 – 2002). Over the past fifteen years, the HIV/AIDS epidemic in PNG reached significant heights calling for renewed energies and directions to contain a fast spreading epidemic. PNG has recently been declared the fourth country in the Asia-Pacific region with a generalised epidemic. Previous strategic plans developed to address the epidemic have laid the essential foundations upon which the next five years strategic focus should be built. Furthermore, the changing nature of the epidemic necessitates the need to embark on new initiatives while building on past experiences.

On a global scale, the HIV/AIDS epidemic is devastating economies throughout the developing world, most notably in Sub-Saharan Africa. Eastern Europe is also experiencing explosive rates of infection, largely through the drug injecting population. Infection trends in industrialised countries are on the rise again, largely because of the availability of improved treatment, giving the false impression that risk-taking behaviour is no longer considered an issue. The absence of drugs for HIV/AIDS treatment in PNG necessitates the need for a broadened response to the epidemic, and at the same time to step up efforts to bring in essential drugs to treat the growing number of people infected with the virus.

The socio-economic realities, and behaviors moulded by cultural and sexual practices as well as the gender dimensions of the HIV epidemic in PNG presents ideal conditions for the rapid spread of HIV and other sexually transmitted infections (STIs). This is already evident with the exponential growth of the epidemic over the last fifteen years. All sectors of society need to work together by taking positive steps in addressing the epidemic in the next five to ten years. Experience showed that countries like Botswana, Uganda, Thailand and Brazil have succeeded in their efforts to reverse the rates of infection and in addressing problems arising from the epidemic. Global and regional organisations have developed broad strategic directions for countries to adopt and to apply these to their own country settings. International best practice intended to address the epidemic form an integral part of the NSP while taking into account lessons learnt in-country during the lifetime of the epidemic.

In general, response to the epidemic by various organisations has been slow, but varied, depending on mandated responsibilities. The Department of Health [NDoH] had been instrumental for taking a lead role in addressing the HIV epidemic until the establishment of the NAC and its Secretariat. These two organisations are concurrently in the forefront in pursuing initiatives directly related to the epidemic.

Other organisations actively involved are the private sector (a few private sector organisations), the not-for-profit sector (a notable number of NGOs) and churches.

It was initially thought that the development of the MTP would generate a wide response from various sectors. However, to date the anticipated national response has not been attained. There is an urgent need to look at all possible options to generate the necessary response, if the course of the epidemic is to be reversed.

The strategic directions for the next five years proposed under the NSP continues to build on the fundamental tasks achieved over the fifteen years and more importantly, venture into areas deemed important for a holistic and effective national response. For instance, ARV treatment for infected persons is an essential element for effective prevention strategies. Similarly, the capacity of families and communities must be developed and harnessed to care and support those infected and affected. While public awareness and education was central to the last strategic plan, it is now becoming critical to expand this strategy to include focused behaviour change interventions. In all these, leadership to guide and support a coordinated national response forms the corner-post within which the national response takes place.

The National Strategic Plan places priority on seven (7) focus areas and are not listed in any order of priority. **Prioritisation at the operational stage, however, is essential when deciding on what resources and activities need to be mobilised in the course of scaling up the various elements of the NSP.** The seven focus areas are:

1. Treatment, counselling, care and support;
2. Education & prevention;
3. Epidemiology & surveillance;
4. Social and behavioural change research;
5. Leadership, partnership and coordination;
6. Family & community support; and
7. Monitoring and evaluation

The seven focus areas provide the broad strategic framework for an integrated national response for the next five years, 2004 to 2008. The spread of HIV in a nation is affected by a variety of factors, ranging from individual risk behaviours to wider social, cultural, economic and political situations. Therefore, an integrated response is essential to address the impact of the epidemic at the individual, family, organisational and community levels. The framework is flexible and allows organisations across all sectors of society to adopt strategies and devise appropriate activities to respond within their own settings. It also takes into account the changing nature of the epidemic as well as the political and administrative environment within which the response takes place. Therefore, the framework allows for flexibility to accommodate structural and administrative changes taking place within governments at all levels. Shifts in government policy priorities are also likely to have an impact in implementing the NSP, and may require shifts in the emphasis on priorities.




1. STRATEGIC FRAMEWORK

1.1 The strategic planning process

After the review of the first Medium Term Plan in late 2002, all stakeholders including government agencies, NGOs and donor partners met with the UN agencies to consider the review's recommendations. There was consensus that there was need for a new national plan and a multi-sectoral Steering Committee for this planning process was established. By May 2003, a Secretariat was formed to serve as the technical arm of the Steering Committee. Through a series of meetings by the Secretariat, a situation analysis workshop was organised in June 2003, which led to the identification of the seven priority areas of response to the epidemic. This led to the formation of seven working groups to look at these priority areas. Members of the 7 working groups included a wide representation of all stakeholder including government agencies, private sector representatives, NGOs, development partners, representatives from minority populations, people living with HIV, and others. Each group met on its own timetable and chose its own facilitators but worked to a work plan and a template designed by the NSP Secretariat. The groups continued to meet regularly to consider reports of the situation analysis and develop goals, objectives and strategies for their focal area that would form the basis for a national strategic plan. A second inter-group meeting was convened in November 2003 to discuss the recommendations of each group and combine them into a first draft of the National Strategy. This draft was further refined by the groups at a third inter-group meeting in December. A team of consultants (one international and two national) helped prepare the draft NSP. In mid-December, a smaller technical group met to work on a final technical draft for submission to Council for consideration. At the direction of the Council, the Secretariat and a core group from the Secretariat further revised the document.

1.2 Policy Framework

The basis of policy development in PNG is rooted in the National Constitution, specifically the National Goals and Directive Principles that sets the broad and noble vision for the development of the nation. The five National Goals and directive principles are: 1) Integral Human Development; 2) Equality and participation; 3) National Sovereignty and self-reliance; 4) Natural Resources and Environment; and 5) Papua New Guinea ways. Three of the five National Goals and Directive Principles have direct bearing on HIV/AIDS epidemic in PNG. These are:

-  Integral Human Development;
-  Equality and Participation; and
-  Papua New Guinea ways.

The epidemic touches on every aspect of human life, whether it is social, economic, political or cultural. Individuals, families, communities and organizations are affected in every way from the epidemic. In recognising the diverse socio-economic, political and cultural setting in PNG, the National Constitution lays the foundations by which development can be addressed and measured by.

The Medium Term Development Strategy (MTDS) of government (2003 – 2007) stresses from outset that *“...in considering Papua New Guinea’s development strategy and prospects for growth and development, we must openly confront the terrible reality of HIV/AIDS and its rapid spread throughout the country. Unless we bring this disease under control, there will be devastating consequences for PNG’s development prospects, from both a social and economic perspective...”* The government’s core development strategy for 2003 – 2007 is defined as “export – driven growth, rural development and poverty reduction including good governance and the promotion of agriculture, forestry and fisheries. The focus of governments MTDS are highly vulnerable to HIV and unless the issues of HIV is addressed, progress towards achieving the strategies set out within these areas will prove difficult given the current situation.

Papua New Guinea is faced with many development challenges and the greatest challenge that confronts the nation now is the HIV epidemic. The epidemic has the potential to reverse progress made in developments over the last twenty-five years. The MTDS acknowledges that, “unless the spread of the virus is arrested, the economic and social consequences would prove devastating. In addition to the personal trauma and suffering, the virus has the potential to seriously erode PNG’s base of skilled workers, which would have severe consequences for the country’s growth prospects. The strategy to eliminate the threat posed by HIV/AIDS will need to be multi-sectoral in approach and will need the support of all sectors of society”.

The MTDS identifies seven (7) Development Goals with nineteen (19) associated targets. Goal 6 relates to addressing the issues of HIV/AIDS, malaria and other diseases. Target 13 of this goal specifically relates to HIV/AIDS and that is to *“have controlled and stabilised the spread of HIV/AIDS by 2015”*

In progressing the implementation of the MTDS with regards to the HIV epidemic, the development of this multi-sectoral plan falls in line with the MTDS directives by ensuring that every sector of society takes on the responsibility of addressing issues pertaining to the epidemic. The commitment of government in supporting the efforts of the National AIDS Council is by ensuring that the HIV/AIDS program is accorded a priority programme of government. This will be facilitated by providing funding to the National AIDS Council Secretariat as part of priority expenditure – the primary means by which the government will support the multi-sectoral response.

The National Strategic Plan for HIV/AIDS provides the framework for a national response to the HIV epidemic and falls within the overall policy directives of government. Furthermore, government is also party to a number of international conventions and agreements within which HIV and AIDS has been highlighted as a major issue to be addressed by governments.

These includes the International Conference on Population and Development (ICPD), Women 2000, Gender Equality, Development and Peace for the twenty-first century, World Summit for Social Development and Beyond, Millennium Development Goals (MDG), and the United National Special Session on HIV/AIDS

(UNGASS). In implementing the NSP, government will also honour its international obligations for its citizen population.

1.3 Guiding principles

1. The rights of all PNG citizens, as enshrined in the national Constitution, must be the basis for the delivery of all services relating to HIV and AIDS.
2. Decisions on all aspects of the national response must be based on evidence.
3. Transparency and accountability must be the basis for all aspects of the national response to HIV and AIDS.
4. Respect must be given to the culture of PNG in the implementation of HIV/AIDS related projects and programmes.

1.4 Goals of the National Strategic Plan

The overall goal of the National Strategic Plan for Papua New Guinea is: To reduce the HIV prevalence in the general population to below one percent by 2008, improve care for those infected, and minimize the social and economic impact of the epidemic on individuals, families and communities.

Goals that pertain to each of the focal areas are:

1. **Treatment, counselling, care & support**
To decrease morbidity and mortality from HIV-related illness, improve the quality of lives of people living with HIV, and encourage access to VCT.
2. **Education & prevention**
To facilitate and sustain behaviour change to minimise HIV and STI transmission in specific populations and to increase awareness about prevention in the general population.
3. **Epidemiology & surveillance**
To establish effective and efficient surveillance systems that will provide accurate measurement and understanding of the growth and other characteristics of the HIV epidemic in PNG.
4. **Social and behavioural change research**
To improve social behaviour research in PNG so that it complements epidemiological and other information and informs the development of strategies for behaviour change.
5. **Leadership, Partnership and Coordination**
To encourage politicians and leaders at all levels of society to give a high profile to HIV/AIDS and enhance coordination of development partner's participation and resource mobilisation
6. **Family & community support**
To support and sustain a social and cultural environment that will enable families and communities to care for and support people infected and affected by HIV/AIDS.
7. **Monitoring & evaluation**
To effectively track the progress of the HIV epidemic in PNG through regular monitoring and evaluation mechanisms and measure the impact of the national response.

1.5 Prioritisation

The National Strategic Plan on HIV/AIDS provides the broad framework for every organization within government and non-government sectors to respond to the epidemic within their own capacity and within the resources they have. A multi-sectoral response does not necessarily mean that every organization has a VCT or a clinic or peer education program etc., but what the organization can do in contributing to the overall national response within this framework. This *multisectoral approach* has been the key to successful responses in other countries, such as the Ugandan and Senegalese Governments' partnerships with faith-based organizations and the partnership between health, uniformed services, the entertainment industry, and NGOs in Thailand's 100% condom campaign.

The HIV/AIDS strategic plan for the nation is unlike other sector-specific plans for other sectors. For instance, the National Health Plan was developed specifically to address the major health issues of the country and the plan provides the framework within which the health sector can respond effectively to these issues. The strategic plan for HIV/AIDS is an umbrella plan that is relevant for every sector whether governmental, private sector, faith-based organizations, non-government organizations, donor organizations etc. Ranking the seven focus areas identified in 1.3 would not be helpful to organizations who may want to carry out activities that are more relevant to their settings but are lower down in the priority listing. Therefore, the priorities of one organisation or sector may not be the same as another organisation but all activities implemented by the various organizations should be consistent with the overall strategic framework.

An important point worth noting in light of having to prioritise the focus areas identified in this strategic document is that the HIV epidemic in the country is a **generalised one**. Therefore, many areas of intervention identified in this strategic framework that were not essential in the last MTP now become essential and important elements of the national response.

While it is difficult to rank the seven focus areas identified in the framework, there is a need to clearly identify certain aspects of the response and give prominence and priority to these areas. For instance, **effective leadership and coordination is essential** to expand the national response to the epidemic. Without this, none of the seven focus areas will achieve their objectives. To effectively expand the national response across all sections of the society, the **coordination mechanisms** need to be strengthened to provide coherent technical and financial support to sectors and organizations implementing activities under each of the focus areas. Therefore, the roles and functions of the National AIDS Council and its Secretariat is central in coordinating the overall national response to the epidemic. Furthermore, some focus areas identified within the strategic framework cut across all sectors and will need to be given priority to gain maximum impact. Given the above, emphases on the response should be placed on these focus areas:

- ⓧ **Leadership, Partnership and Coordination** given their importance to gain political support and coordinate an effective response across all sectors of the community.
- ⓧ **Prevention and education** considering that this focus area can be implemented in any setting across all sectors of society, and
- ⓧ **Monitoring and evaluation** in ensuring that progress of activities under all focus areas need to be tracked and results fed back for improvement to future programmes and activities. This is also consistent with the United Nations' recent Three Ones initiative.

Public awareness and advocacy on the HIV epidemic has generated adequate interest within organizations and individuals who are keen to get programs and activities going within their own establishments. There is now a momentum within the national response that needs to be carefully nurtured to ensure that there is consistency and coherence. What is most likely to be lacking is a well established and strengthened coordination mechanism and leadership support at all levels to expand and foster the national response. Given that emphasis is given to the three priorities above, these will provide the needed support for the implementation of other programmes and activities in the other focus areas.

2. HIV/AIDS IN PAPUA NEW GUINEA

2.1 The global context

Over the past two decades, HIV/AIDS has had devastating social and economic impact on some regions of the world. The epidemic shows no sign of abating and families and communities bear its burden. As of November 2003, an estimated 34 to 46 million people worldwide were infected with HIV, including 2.1 to 2.9 million children under the age of 15. Throughout the world in 2003, approximately 4.2 to 5.8 million people became infected with HIV and somewhere between 2.5 and 3.5 million people died of AIDS. Sub-Saharan Africa is currently the most severely affected region of the world but, generally, more than 95 percent of people living with HIV and AIDS live in low- and middle-income countries. The epidemic is now growing quickly in the Asia-Pacific region, and PNG is the fourth country in this region to have a generalised HIV epidemic.

2.2 The epidemic in PNG, 1987-2003

A fast-growing epidemic

There has been an alarming increase of HIV infection along with a high prevalence of other sexually transmitted infections. Effective and early treatment of STI reduces HIV risk. Since the first case of HIV was reported in PNG in 1987, the number of HIV and AIDS cases has risen to 7036 by the end of March 2003 [Figure 1]. From 1995 to 1997 known cases increased by 50% each year. Since 1997, the annual increase in diagnosed cases has been around 30% per year. In 2003, an estimated 150 new cases were reported each month in this population of around 5.4 million people. It is estimated that 10,000 to 15,000 people live with HIV and AIDS in PNG.

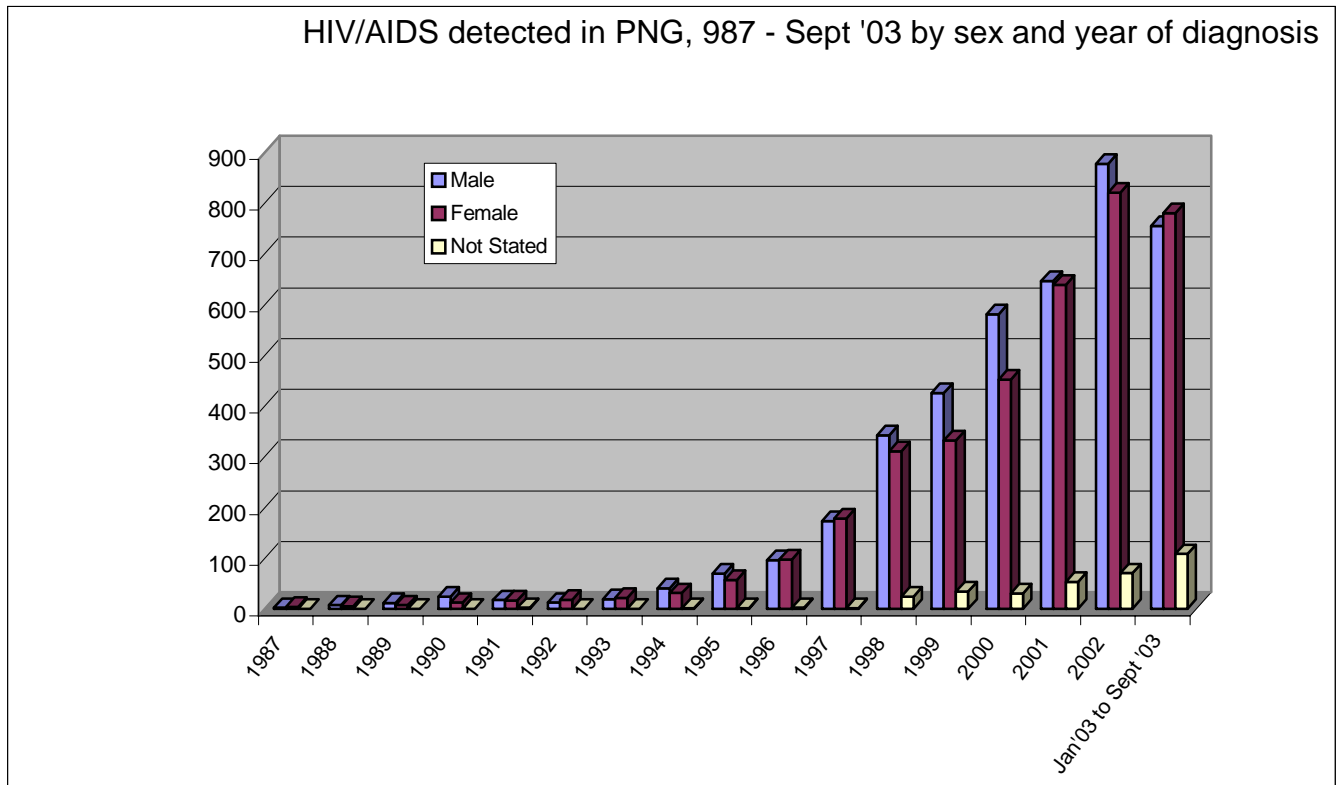
The prevalence of HIV infection in PNG can only be estimated. Surveys so far have been limited to a few locations and a small number of population groups. Outside Port Moresby and a few other towns, HIV prevalence has mostly been measured in blood donors, STI and TB populations. Sentinel surveillance has been conducted in Port Moresby, Lae and Goroka of antenatal women and sex workers, and in all these places the HIV prevalence rate is higher than one per cent.

The epidemic in PNG is driven by high levels of heterosexual risk practices including multiple sex partners. It therefore is fast growing and almost equally affects men and women. The 1:1 sex ratio of known positive cases in PNG is higher than in Thailand and Cambodia. The number of women attending ante-natal clinics in Port Moresby that are HIV positive rose from 0.15% in 1998 to 0.3% in 1999, and to 1.07% for women aged 15-24 in 2003.

The current concentration of known HIV cases in Port Moresby reflects the concentration of testing and access to higher-level health facilities. But other centres are now reporting increasing rates of HIV infection among antenatal women. At the Goroka Hospital, in 2003, antenatal prevalence in all women was measured at 1.5% and in women aged 15-24 years at 0.7%.

Recent sero-surveillance of antenatal mothers in Lae and Daru found HIV prevalence of 2 per cent and 3 per cent respectively. Since mid-2001, AIDS has been the leading cause of death at Port Moresby General Hospital (PMGH) medical wards. Among adults in PMGH, AIDS patients now occupy 60 per cent of the medical wards and 20 per cent of in-patients with TB are HIV positive.

Figure 1



Source: NAC and Dept. Health, September 2003

A generalised distribution

The accurate geographical distribution of HIV in PNG is unknown but concentrations of HIV infection exist in Port Moresby and other towns, along major transport routes, and around rural enterprises such as mines and plantations where there are risk settings, such as active markets for commercial sex. Sexually transmitted infections, which are known cofactors in HIV transmission, are widely prevalent in PNG, even among supposedly 'low-risk' rural populations (Passey et al., 1998).

Poor understanding of HIV transmission contributes to fear and stigmatisation of people living with HIV. It turns, sometimes, to extreme abuse, such as abandonment by the family or community. In the community and workplace, this discrimination threatens human rights and undermines efforts for prevention and care. Given prevailing stigma and discrimination, people living with HIV have been reluctant to identify themselves, but this is slowly changing, and might change faster as treatment becomes available.

2.3 The socio-economic and cultural context

Socio-economic conditions in PNG place its people in a vulnerable state and pose challenges to the government in meeting its commitment to the Millennium Development Goals. On a global scale, PNG ranks in the lowest one-third of all nations, and lowest among its Pacific neighbours, on the Human Development Index (HDI) [UNDP, 1999]. The country has a high fertility rate (4.8%) and a young population, with 42 per cent under the age of 15. The infant mortality rate (82/1000 live births) and maternal mortality rate are amongst the highest in the world. Literacy is also very low, with only around 25 per cent of the population being functionally literate [UNDP, 1999]. Around 85 per cent of the population live in rural areas. The generally low status of women and the special health risk they face as well as sexual violence places them at a higher risk of HIV infection.

PNG is a diverse nation with many different cultures, languages, traditions and practices of sexuality and marriage that exposes people to the risk of HIV infection. Common to the many cultural groups is gender inequality that is expressed through the dominance of men in family, clan and community decision-making. Women's representation at all levels of the economy and government is very limited. The expansion of education and employment opportunities since the 1960s has done little to alter the dominance of the subsistence economy and traditional political systems that provide little or no voice for youth. The churches have played a significant role in social change in Papua New Guinea, reaching the remotest rural areas and providing almost 50 per cent of health and educational services, but have been unable to change entrenched gender relations [Brouwer, et al, 1998].

Economic growth in PNG has been unsteady. GDP growth rates averaged only about 2.2 percent between 1975 and 2000. The mineral boom of the 1980s improved the economy, but mainly created enclave economies [Baxter, 2002]. In the 1990s, decline in this sector produced negative economic growth and contributed to rising poverty levels. Over 30 per cent of the population now live in poverty and government capacity to provide basic services is under great strain. Economic and social infrastructure is in disrepair, particularly for rural residents, denying them access to basic social and economic services [CIE, 2002; National Department of Health, 2002]. The national and provincial governments cannot meet the requirements of primary health care and other services as defined by the Organic Law, and the provincial system is being reformed to address this problem of service delivery. This has left the burden of rural health service provision largely to the churches, with limited but regular funding from government. Increasing unemployment and stark absence of economic opportunities contribute to urban migration, squatter communities and high levels of crime.

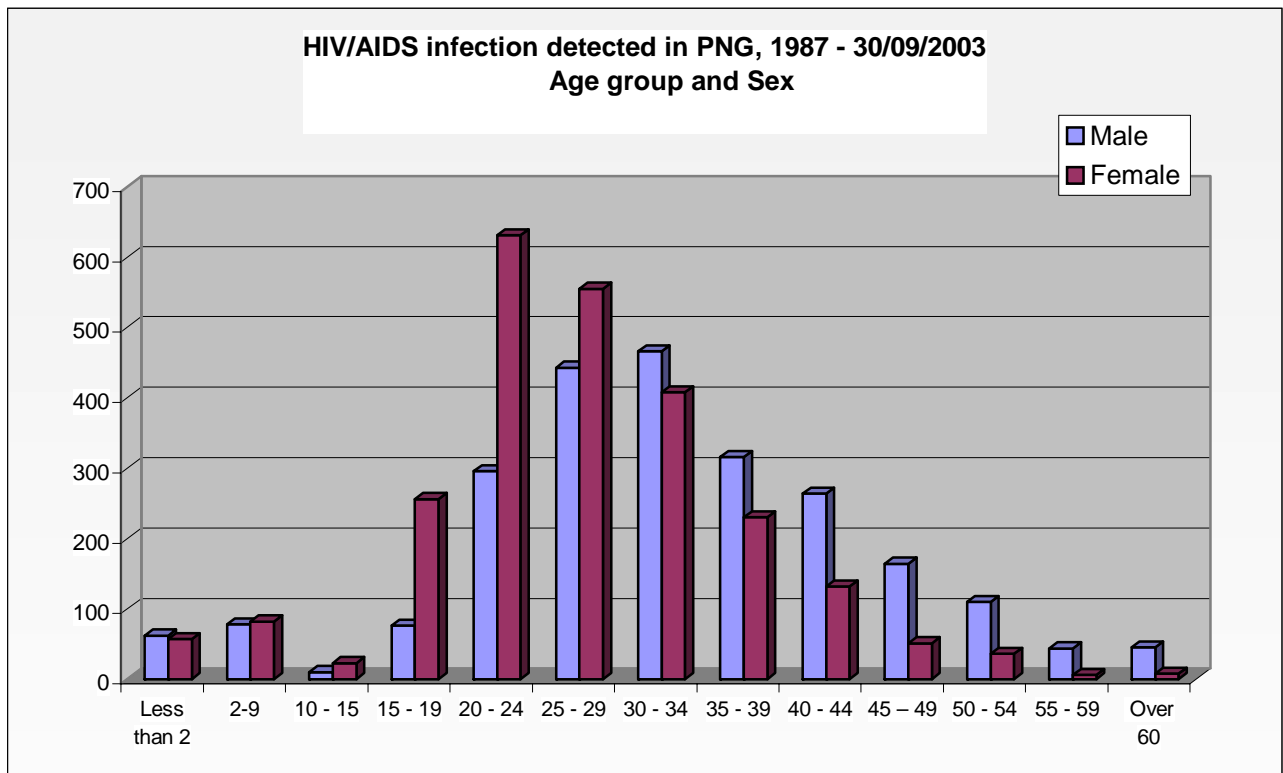
2.4 National Vulnerability to HIV

The determinants of vulnerability to the epidemic in PNG include:

- Limited employment opportunities, illiteracy and urban migration, which contribute to growing poverty in PNG;
- Rapid social change, especially as it affects gender relations, increases the vulnerability of women, weakens social structures, and particularly exposes young people to HIV infection;
- Lack of availability and poor access to health services and the poor health status of the population which increases their susceptibility to HIV infection, including the prevalence of malaria and poor antenatal care (only 43% of births are supervised);
- Exceptionally high and rising prevalence of STI and the still low acceptance of condoms.
- Patterns of male sexual behaviour including a high incidence of rape, line-ups or pack rape, sexual assault, and weak law enforcement.

There are particular gender aspects of this national vulnerability. Women in PNG have low life expectancy largely because of the health risks posed by childbirth, malnutrition and malaria. Women also have a literacy rate about 10 per cent lower than men. While almost equal numbers of men and women are reported to have HIV, women are generally infected at a younger age [*see Figure 2*]. Women are particularly disadvantaged by limited employment opportunities and may lack information about medical services, counselling or support services. Because of the difficulties of economic survival, many women trade sex for money or other goods. In some circumstances, sexual transactions are brokered by male relatives [*Hammar, 1998*]. Men often exercise violent aggression towards women to maintain their authority, making women the victims of coerced sex, family or sexual violence thus exposing them to the HIV infection.

Figure 2
 HIV infection detected in Papua New Guinea, 1987 – Sept 2003 age group and sex



Source: NAC and Dept. Health, September 2003

2.5 Achievements to date

Acknowledging the risk of HIV/AIDS to the country, the Government established the National AIDS Council (NAC) and its Secretariat by Act of Parliament in December 1997. The NAC is a multisectoral committee that comprises of representatives from government departments, the Council of Churches, the National Council of Women, the Chamber of Commerce, NGOs and people living with HIV. The NAC is mandated to facilitate and coordinate a comprehensive multisectoral national response to the HIV epidemic. Five working advisory committees (behaviour change, medical expert advice, legal and ethical advice, research and sectoral response) operate at the national level. Twenty Provincial AIDS Committees have been established, although these vary in their capacity to function, and in some provinces lack community representation and support from local government.

The NAC and the NDoH are responsible for the response to the HIV epidemic. With extensive technical and financial assistance from its development partners and through the participation of a wide range of organisations, this has created an enabling environment for an effective HIV response that is now stronger than at any time since the first case of HIV was recognised.

Key achievements in establishing a strong foundation for the HIV response with wide-reaching impact on all sectors of society are indicated below:

Improvements to the policy and legislative environment

Existing policies approved and in place included the NAC approved 100% condom use policy in 2000. Another policy currently under enforcement is the 100% safe blood supply. In July 2003 the PNG HIV Management and Prevention Bill was unanimously passed into legislation as the HIV Prevention and Management Act 2003. This established legal grounds to redress discrimination and stigma and defines conditions for mandatory screening. The Bill supports the recognition of human rights entrenched in the PNG Constitution and International Guidelines on HIV/AIDS and Human Rights.

Workplace policy and sectoral interventions have also been made possible through the collaborative efforts of donors and NACS by working closely with industry groups and Union organisations. This has influenced the capacity of PNG to implement a multi-sectoral response and resulted in the development of program responses in key public sector agencies including the Correctional Services, Ministry of Education, Ministry of Social Welfare and Development, private industry including the mining sector and the Trade Union Congress.

Increased awareness and understanding of HIV transmission and prevention

Three major social marketing campaigns were undertaken between 2001 and 2003 adopting the ABC approach. (Abstinence, Be faithful to one uninfected partner and Condom promotion). Of these, condom promotion has been regarded as the most important and condoms have continuously been promoted and distributed widely. Evaluations of phase one and two of the social marketing and awareness campaigns have demonstrated an increased understanding of HIV in the community. This is a necessary first step towards behaviour change. The campaigns have stimulated discussion of AIDS and the 'sensitive issues of sex and condom use' as well as challenging the acceptance of gender roles and gender related violence. These campaigns have also encouraged debate and challenged attitudes relating to stigma and discrimination towards people living with HIV.

The national campaign has also been supported with the development and distribution of IEC materials, the establishment of a National Resource Centre, condom distribution and grant support for community initiatives including theatre.

Young people's vulnerability and their key role in HIV prevention has been recognised through specific initiatives identified and supported by young people themselves. These include the Special Youth Project, strengthened youth organisational networks, awareness raising and youth engagement in community education, condom distribution and small-scale micro-enterprise development. Leadership in the area of peer education programs is supported through the EU Sexual Health Project. Further support is provided by UNDP focusing on leadership aspects, policy and gender issues.

The high prevalence of STIs in PNG increases the risk of HIV transmission. Control of STIs and HIV are closely linked. It is well established that effective and early treatment of STI reduces HIV risk (Hammer & Lupiwi 2004). Much work has been done in the health sector in collaboration with NHASP addressing skills of health workers to diagnose and treat STIs including the provisions of antibiotics for the treatment of STIs. The establishment of the National Centre for Sexual Health and the strengthening of STI clinics in other major centres look at strengthening links with counselling services, improves laboratory testing and reporting of HIV, provision of specialist clinical sessions for people living with HIV and stigma reduction amongst health workers.

Clinical management of opportunistic infections as well as the need for antiretroviral therapies (ART) is vital for an effective national response. Treatment protocols and guidelines for ARV treatment have been developed by the NDoH and training for prescribers in the use of ARVs has been conducted. Currently, a pilot project for the introduction of ARVs into the PNG public health care system is underway. This has enabled other programme partners, including WHO, UNICEF and other multi-lateral organisations, to respond by, for example, providing drugs.

Epidemiological surveillance is a critical tool for generating awareness and action and has been a key plank of effective HIV responses globally. Although in its infancy, surveillance capacity in PNG has been significantly improved over the last three years resulting in the collection of surveillance data from a number of STI, TB and antenatal clinics. Efforts in this area intends to improve reporting and feedback mechanisms for both HIV and STI data to provinces to enhance clinical care and increase PNG specific knowledge of HIV transmission through research (epidemiological and behavioural) funded through the grants programme.

Extended counselling and care services

Technical interventions in STI management described above, are both 'interconnected and complementary' to Voluntary Counselling and Testing (VCT) and home-based care. PNG's capacity to respond to the need for expanded testing (linked to counselling) and to provide care and support for people living with HIV has been considerably enhanced in the last three years. Through the collaborative effort of government and donors, support has been provided to NACS in developing the curriculum for counselling training and training a cadre of counsellors who are in turn scaling-up counselling training in all provinces.

In reducing the burden in the health care system, home and Community-based care facilities including the development of appropriate technology home-based care kits are funded through the grants programme. NACS has also been supported to facilitate the greater involvement of people living with HIV in the national response through advocacy training for people living with HIV and the establishment of a network of people living with HIV to be involved in care and support work. Provisions of grant funds are provided to support people living with HIV in awareness and care initiatives. People living with HIV are supported further through international and national conference attendance and have been an integral part of planning for the national response including counselling.

Increased capacity to manage an effective response

In expanding the response to provinces, the NAC has established twenty Provincial AIDS committees (PACS) and Secretariats to support the response at provincial level. With funding and technical support from AusAID, PAC offices have been established and equipped in all provinces and training and capacity building undertaken with provincial staff and partner organisations. Provinces are now better positioned to respond to the epidemic through the support provided from NACS and its development partners.

Even in the context of severe resource constraints in PNG (both human and financial), and in a relatively short timeframe, the partnership between NACs, the NDoH and donor partners, response to the epidemic to date has provided a major contribution to the creation of an enabling environment and the foundation for an accelerated response.

2.6 The challenge now

Papua New Guinea now faces a devastating HIV epidemic. If effective action is not taken, HIV will soon take a terrible toll on the people and the economy. It has been estimated that prevalence levels could reach about 18 per cent by the year 2010 with over 50,000 adult deaths. By 2020, adult deaths could increase to about 98,000 with a devastating 13 per cent reduction in the size of the working age population and 34 per cent decrease in the size of the work force [*CIE, 2002*]. The PNG Government has itself estimated that, "If the epidemic is left to run at the present rate of increase, 70 per cent of the hospital beds in the country could be occupied by AIDS patients in 2010. For every 5 per cent increase in HIV prevalence in PNG, the total national spending on health will need to increase by 40 per cent. At a 10 per cent HIV prevalence rate, tuberculosis will rise 50-fold to affect 30 per cent of the population" [*National Health Plan, 2001–2010: pp 123–124*].

Long-term donor assistance to the national HIV response will continue to be required in PNG if it is to address the unique challenges of the epidemic and bring about the social change needed to minimise its impact. Effective responses required sustained and integrated support across the continuum of care from prevention to treatment and care combined with a high-level of bipartisan political commitment. However, with much of the groundwork now in place, PNG is in a strong position to build on its achievements and to scale up its national response to address key challenges.

The government, the churches and the private sector are showing renewed commitment to addressing the epidemic. This Strategic Plan for 2004-2008 is designed to reposition efforts to counter and slow down the epidemic, by taking action to:

- Provide people with the capacity for self protection through information and by making voluntary testing available to all;
- Improve treatment, care and support for people living with HIV and effectively reduce stigma and discrimination;
- Better monitor the characteristics of the epidemic, track its course, and factor this knowledge into plans and strategies for all sectors;

- Strengthen the capacity of the NAC in coordinating the national response through the implementation of the NSP;
- Conduct intervention programmes for groups at special risk of HIV infection;
- Involve all sectors of PNG society – government, private sector, church, civil society organisations, traditional leadership – in taking practical action to reduce the spread of HIV and provide care for people affected by it; and
- Intensify advocacy on HIV/AIDS and political leadership to articulate the PNG situation and mobilise Papua New Guineans towards a collaborative action.

Based on a comprehensive review of the situation in Papua New Guinea and extensive consultation with all agencies, NGOs, donor partners and specialists, seven priority programme areas have been identified to form the pillars of the strategic direction for the next five years. These are:

1. Treatment, counselling, care and support;
2. Education & prevention;
3. Epidemiology & surveillance;
4. Social and behavioural change research;
5. Leadership, partnership and Coordination
6. Family and community support, and
7. Monitoring & evaluation.

3. FOCUS AREAS

3.1 Treatment, counselling, care and support

Situation analysis

There is an urgent need to improve treatment and care for people living with HIV. AIDS is now the leading cause of mortality and a prominent cause of morbidity at the Port Moresby General Hospital (PMGH). Tuberculosis is a serious national health problem and 20 per cent of TB in-patients at the PMGH have HIV. ARV drugs are not widely available, other than at high cost to a few people treated by private practitioners. All hospitals throughout the country have basic antibiotics and other drugs for treatment and have been treating opportunistic infections. Laboratory and diagnosis support for opportunistic infections is very limited. Therefore, while some drugs are available to treat opportunistic infections most people do not seek medical assistance due to the unavailability of HIV treatment. The adult standard treatment book covers these treatment protocols.

Management and treatment of sexually transmitted infections needs to be intensified and scaled up throughout the country. Prevalence rates of STIs remain extremely high in PNG providing an increased opportunity for the rapid spread of HIV. Recent studies by IMR carried out in the Pogera Valley and Daru confirm increased HIV infections associated with high STI prevalence.

Over the past two years, efforts have been made to address mother-to-child transmission (MTCT). Guidelines and protocols are in place, however, the biggest problem is the availability of adequate space for private and confidential counselling and also availability of counsellors at the PMGH antenatal clinic. There is no treatment or prophylaxis available for children, nor is post-exposure prophylaxis available for health-care workers and rape victims. Capacity to manage HIV including opportunistic infection is very limited. Recently, 410 doctors both from the public and the private sector were trained to become ART prescribers.

Universal infection control measures are poorly applied throughout the health-care system. Blood donors are screened for HIV antibody but not for HIV antigen, leaving a window open for HIV infection through blood products. The ongoing issues relating to medical supplies such as drugs, disposal syringes, gloves etc., is a major concern.

Voluntary counselling and testing (VCT) is only available in clinical settings, mainly in STI clinics. Many health workers have been trained including non-health people in VCT and are contributing to the increasing numbers of testing being done in the country. Development of non-clinical sites is being investigated currently. The National Advisory Group for Care and Counselling has developed guidelines and protocols for pre- and post-test information. The NAC Secretariat, CSOs and faith-based organisations have developed a national network of counsellors and trainers. The HIV Management Bill mandated pre- and post-test counselling for HIV testing. These developments have legitimised the counselling process and will increase demand for it. Further training in voluntary counselling and testing will need to be undertaken to meet this need. There are few professional counsellors working in PNG let alone in the HIV field. In many parts of the country, people cannot readily find out about their HIV status or make the most of the few facilities

that exist for prevention and care. Opportunities for VCT urgently need to be scaled up, particularly at the provincial and district levels.

Since care for HIV patients is very limited in hospital settings, some NGOs and faith-based organisations are setting up community care facilities. The coordination between these services varies from province to province. In provinces with well-established services and good provincial coordination, the relationship between the health system and community based care services are strong. Where this does not exist, there is poor coordination between the clinical and non-clinical settings. In general, referrals in the health system remain poor with provincial hospitals not referring to each other or to the district hospitals or health centres. While the country already has a comprehensive referral system in place, the NDoH needs to strengthen this system and make it function. The involvement of people living with HIV in care is very limited. This is partly a consequence of the prevailing discrimination and stigmatisation, with people living with HIV sometimes being abandoned by their families or rejected from their homes.

Along side increasing participation of churches and CSOs in HIV activities, there is also growing commitment by major industry groups to provide care and treatment. Current standards of care and treatment, however, are not known and facilities need to be scaled up and coordinated by Ministry of Health in collaboration with caregivers.

Goal

To decrease morbidity and mortality from AIDS and related causes, to improve the quality of lives of people living with HIV, and to encourage access to VCT.

Objective 1

To make ARV treatment available and accessible to at least 10 per cent of people currently infected with HIV and AIDS throughout PNG by 2005 and 25 per cent by 2008

Strategies:

1. Introduce HIV/AIDS treatment and care by increasing the capacity of public and private hospitals, developing simplified and easily deliverable training, and improving laboratory diagnostic capacity.
2. Build public-private partnerships to expand access to treatment and care facilities, and improve the coordination of public, private, CSO and other organisations working on HIV/AIDS/STI issues, including people living with HIV.
3. Build capacity of health-care workers to manage HIV-AIDS patients effectively.
4. Secure adequate level of funding for the purchase and distribution of ARVs.

Objective 2

To develop and implement risk management procedures to minimise exposure to HIV infection in health and non-health care settings by 2006.

Strategies:

1. Promote healthy workplace practices to reduce the risk of HIV infection through:
 - Development and enforcement of occupational health and safety standards
 - Encouraging workers, unions and employers to jointly develop and implement workplace policies on HIV/AIDS in all workplaces
 - Develop post exposure management of health care providers.
2. Improve the selection of blood donors to ensure the safety of blood supplies

Objective 3

To establish at least two sites for VCT services in each province that are easily accessible to people by 2008.

Strategies:

1. Expand and promote VCT services throughout PNG.
2. Improve the quality and expand the availability of counselling services
3. Build the capacity of Health Workers in counseling and optimal obstetric care
4. Provide adequate HIV rapid test kits for all antenatal and family planning clinics in the country.

Objective 4

To reduce bed occupancy rates of AIDS related patients by 50% by 2008 by strengthening of family and community care support groups.

Strategies:

1. Build capacity for families, communities and people living with HIV to be involved in care and treatment
2. Conduct research into types of community and home based care.

Objective 5

To reduce incidence and rate of STIs in risk populations to 5% and the general population to 3% by 2008.

Strategies

1. To expand the district level training of health workers in the syndromic management of STIs to every district.
2. Ensure that all provincial and district hospitals have STI clinics that are easily accessible and unlabelled and provide free, gender specific, private, confidential sexual health services.
3. To enhance and strengthen the capacity of all health workers through ongoing training to effectively manage and treat clients with STIs.
4. To ensure the constant supply of antibiotics and other medications to effectively treat STIs.

Monitoring and evaluation

1. Monitor the progress and impact of ART programmes, including surveillance of drug adherence and resistance, to evaluate the impact of the treatment programmes
2. Regular collection and analysis of data on service coverage, delivery and quality using standard indicators as well as assessment of the quality of this data.
3. Provide basic training for health-care workers in data collection and management.

3.2 Education and prevention

Situation analysis

Education and prevention are key strategies in reducing the spread of HIV in PNG. In order to effectively change the behaviours that drive the epidemic, education programmes must raise awareness and be followed with targeted interventions with vulnerable groups. Since 2001, three comprehensive social marketing campaigns have been conducted nationally. The campaigns, conducted through television, radio and the press, included the development of print media for distribution in the communities to support interpersonal strategies. The impact evaluations conducted on the campaigns indicated increased awareness about HIV and AIDS and some behavioural change, particularly in the use of condoms (NHASP, 2003). Since lack of information was identified as a barrier to knowledge and behaviour change, accessibility and accuracy of information has been the focus of materials development resulting in the publication of pamphlets and posters that were distributed widely throughout the nation during the MTP period. While prevention activities under the last MTP largely aimed to raise awareness in the general population, activities that were generated and supported included behavioural change programmes or targeted interventions for youth, high risk settings like nightclubs, the Defence Force, Police and the CIS.

Prevention and education strategies that create dialogue and generate response have begun to make a mark in the country. Theatre and music have been supported through training and funding and is fast becoming a popular means of reaching the public. NGOs and CBOs have been supported to conduct education activities that employ a range of strategies.

Now that the epidemic in PNG is generalised, everyone is vulnerable. Groups at particular risk, include people who trade sex for materials or favours and men who have sex with men. Cultural practices, such as polygamy, and gender relations make women generally vulnerable. Men often exercise violent aggression towards women to maintain their authority, making women the victims of coerced sex, family or sexual violence, and exposing them to HIV and other STIs. Prevention and education services must address both the high-risk groups and the general population in culturally appropriate ways.

Peer education projects, such as the TransSex Project and the Tertiary Students Peer Education Project, have demonstrated ways to encourage at-risk groups to adopt HIV prevention behaviour. It is evident that if these programmes are to be effective, they need to be sustained, be client specific and involve personal empowerment, knowledge of human rights, access to services, and skilled peer educators.

School programmes for youth recognise the need to integrate education about HIV and STI in their curricula and are integrating age appropriate materials. The schools, however, lack resources, teachers are untrained, and parental attitudes are often negative. Education programmes for out-of school youth need to be expanded further to reach a greater proportion of young people outside of the formal education system including the general community.

Resources are needed to implement newly developed work-place programmes. The media need to become more involved and better informed to help overcome denial and prejudice.

Goal

To facilitate and sustain behaviour change to minimise HIV and STI transmission in specific populations and increase awareness about prevention in the general population.

Objective 1

To provide 80 per cent of the country's population with relevant, accurate and comprehensive messages about prevention of HIV transmission by 2008.

Strategies

1. Build and strengthen capacity at all levels to effectively implement HIV education and prevention programmes, with particular focus on culturally appropriate means of communication.
2. Expand STI/HIV prevention and education activities through all avenues, including mass media, school programmes, peer education, community drama groups, and other reproductive and sexual health education programmes.
3. Develop standards for quality control, including the inclusion of research findings and involvement of stakeholders in all stages of programme design, from planning and implementation to monitoring and evaluation.
- 4.
5. Incorporate life-skill education into all HIV prevention, care and support programmes especially among young people in school and out of school.

Objective 2

To target interventions to groups at particular risk, using culturally acceptable methods, to keep HIV prevalence in these groups below 5 per cent by 2008.

Strategies

1. Implement special advocacy and education programmes targeted to particular groups (youth, sex workers, parents, women, men, political and traditional leaders, men who have sex with men, people living with HIV, etc).
2. Reach all at-risk groups with relevant preventative services.

Objective 3

To increase safer sexual practices amongst the sexually active population, in particular the youth population.

Strategies

1. Make condoms widely available and accessible to people and promote appropriate use
2. Develop and enforce condom marketing strategies

Monitoring and evaluation

1. Quarterly reports on ongoing education programmes;
2. Assessment of school curriculum content on HIV;
3. Documentation on new ways to conduct preventative education;
4. Demonstrated links with behavioural research;
5. Assess the impact of prevention and education programmes through both quantitative and qualitative methods.

3.3 Epidemiology and surveillance

Situation analysis

The official record of HIV/AIDS cases in PNG certainly under-represents the extent of HIV infection. One indication of this, is the high ratio of known AIDS to HIV cases. HIV and AIDS are under-reported because the surveillance system is only recently developed, rural medical services face considerable constraints, and testing is very limited and mostly confined to high risk groups in urban areas. There are no formal AIDS cases or related deaths notification systems. Some known HIV-positive people are not included in the official count, including some who were diagnosed overseas or treated by private doctors.

Sentinel surveillance sites have been established at the PMGH antenatal clinic, STI and TB clinics, in Lae (ANC and TB clinics) in Goroka (ANC, STI & TB clinics), Mt Hagen (STI clinic the ANC clinics in Daru, Buka and Vanimo. Results of recent surveillance were indicated earlier. Plans are now underway to expand surveillance into other sites that had been identified by NACS and NDoH.

The epidemiological data available is limited due to the under reporting as well as the lack of notification of confirmed HIV positive individuals. Progress has been made over the last few years to improve reporting by CPHL through a computerised system and trainings have been conducted in the provinces to improve HIV notification. Of reported HIV cases, around 4 per cent are of unknown sex, 40 per cent of unknown age, 71 per cent of unrecorded means of transmission, and 76 per cent of unrecorded province of origin and of occupation.¹ The data is also biased in that around 70 per cent of new HIV cases are diagnosed in Port Moresby General Hospital (PMGH), possibly because testing is very limited elsewhere.

The Central Public Health Laboratory (CPHL) in Port Moresby is the reference laboratory for HIV confirmatory tests. Since Western Blot is not available in PNG because of its high cost, the reference laboratory is using WHO approved algorithm that involves a battery of EIA rapid or simple assays. All blood donors are screened for HIV antibodies. Other than blood donors, tests come from STI and other clinical samples and 10 active sentinel surveillance sites, which include 6 antenatal clinics, all in urban areas.

CPHL sends results of all HIV tests, both positive and negative, back to the source laboratories, which pass them on to the referring physicians. A copy of all positive results, with other epidemiological information and laboratory testing statistics, is sent to the National AIDS Council, which is currently the national reporting centre. The quality of the data now reported is poor because many reporting forms are incomplete due to inadequate reporting and issues surrounding confidentiality. There is insufficient capacity in the NAC to collate and report this data in a timely way.

CPHL processed 18,427 tests in 2002, with a turn-around time of 3 to 7 days. Delays in returning test results to patients in the provinces, sometimes of six months or longer, were due to problems in shipping specimens from small and remote hospitals, especially the cost of transporting the specimen.

Currently, most testing kits are procured and distributed by donors and sustainability is a concern. Only two technicians are allocated to CPHL for

¹ HIV/AIDS Quarterly Report, September 2003

confirmatory testing but if the sentinel surveillance system is expanded and ARV and PMTC treatment become available, the human resource capacity of CPHL will need to be strengthened. The sentinel surveillance system has just been established in the last two years and will need to be strengthened to assist the tracking of the epidemic in the country.

Goal

To establish effective and efficient surveillance systems that will provide accurate measurement and understanding of the growth and other characteristics of the HIV epidemic in PNG.

Objective 1

To strengthen and maintain a comprehensive, efficient and a well resourced national surveillance system by establishing at least one surveillance site in all provinces by 2008.

Strategies

1. Establish a coordinating body for HIV/AIDS and STI surveillance at both national and provincial levels under the leadership of the Ministry of Health.
2. Strengthen the capacity of CPHL Laboratory and introduce ELISA and other techniques for HIV screening and confirmation to at least 50 per cent of laboratories.
3. Introduce rapid testing techniques to complement the expanding need for surveillance and also for VCT throughout the country.

Objective 2

To increase the availability of accurate data about the risk of HIV infection for particular groups and how best to reduce these risks by expanding sentinel surveillance sites to five district hospitals by 2006 and ten by 2008.

Strategies

1. Strengthen and expand the sentinel surveillance system to cover rural and urban areas throughout PNG, including the collection and management of data.
2. Improve capacity to conduct surveillance at both provincial and national levels
3. Strengthen the central national body to manage all the surveillance, clinical and research data on HIV and STI.

Objective 3

To enhance the information system by establishing a well-resourced information centre by 2005 and link this up with other information systems.

Strategies

1. Link HIV data with other information collection systems, including social and behavioural research.
2. Establish an accurate notification system for AIDS cases and deaths.
3. Facilitate a consensus meeting every 2-3 years to assess the epidemic trend as well as estimate and make future projections.

Monitoring and evaluation

1. Production of quarterly information reports on HIV and STI indicators (including UNGASS and MDG target indicators).
2. Annual report on the availability, timeliness and quality of the information produced.
3. Annual report on the resources directed towards epidemiology and surveillance, and on information dissemination and use.
4. Use of surveillance information for developing policies and strategies.

3.4 Social and behavioural change research

Situation Analysis

A key aspect of HIV Prevention is change in sexual and harm inducing behaviour that put people at risk of infection. In every community, socio-economic and cultural factors that shape people's behaviour, how they perceive gender roles, and sexual relations puts people at risk of HIV infection. Social and cultural behaviour also underscores people's perceptions of risks and attitudes towards and willingness to support people with HIV. For these reasons, research into social, cultural and economic factors that underpin and influence behaviour is important to the broad spectrum of the national response. Of relevance also, and in need of investigation through social behaviour research are the complex combinations of traditional and modern values that provide the overarching context of life in many developing countries. These complex contextual factors have been shown to create "moments" of confusion, conflict and sometimes despair leading to unnecessary risk taking (Plange, 2000; Spooner et al 2001).

'Traditional' social and cultural systems in Papua New Guinea have been documented by a number of anthropologists, starting at the beginning of the twentieth century. Without mentioning any by name, these studies provide a valuable base for the understanding of varieties in cultures and social systems in the nation. More recent studies on sexual behaviour and gender relations (by for example Annette Weiner, Laura Zimmerman) give valuable information on traditional ideals and changes that have taken place.

Behaviour change interventions in general do not pay enough attention to the context in which high risk behaviour occurs. The shortage of reliable data on how sexual attitudes and behaviour are shaped has restricted the effectiveness of HIV prevention programmes. Recent studies on sexual behaviour and gender relations (eg; Zimmerman 1993, 1998)² give valuable information about changing sexual behaviour. Nonetheless, they give little guidance for effective HIV interventions because these studies usually lack the required quality and types of data. The lack of such data negatively affected national reporting of UNGASS in 2003 and will also affect the reporting of MDG goals in 2007.

Social behaviour research has the ability to explore factors that shape people's behaviour, and local social and cultural dynamics that could be used to achieve positive changes in behaviours that constitute a risk to HIV infection. Social Behaviour Research is a highly effective tool for short-term applied research that can be used as a basis for designing intervention materials and strategies, and assessing the impact of awareness and prevention programmes and services. To assist the national response, social research capacity needs to be developed and strengthened.

Against this demonstrably pervasive importance of social behaviour research, it must remain a relevant aspect of the National Response in order to continuously yield relevant data information that can be used as the basis for developing effective strategies and programmes for the national response.

² A.Weiner, 1976; Zimmer-Tamakoshi, 1993, 1998.

Goal

To improve social behaviour research in PNG so that it complements epidemiological and other information and informs the development of strategies for behaviour change.

Objective 1

To build capacity to strengthen social behaviour research and undertake at least two behaviour and social research work annually in collaboration with other research institutions.

Strategies

1. Create and resource a Social Behaviour Research Group within NACS.
2. Build research capacity in provinces through research initiatives.

Objective 2

By 2005, undertake collaborative research with national and international research institutions into social, cultural, economic and gender factors that shape sexual behaviour in PNG.

Strategies

1. Network and collaborate with national and international research institutions, universities and other relevant organisations.
2. Conduct short-term applied research on factors that shape risk behaviour and serve as barriers to behaviour change:
 - Among selected communities in provinces.
 - Among target groups.
 - In attitudes to people living with HIV and their families.
 - In condom use.
3. Conduct research into the socio-economic impact of the epidemic on society including modelling

Objective 3

To produce evidence-based information that can be used to design strategies for sustainable change in risk behaviour, by 2008.

Strategies

1. Collaborate with institutions and organizations throughout PNG to collect and consolidate social behaviour data.
2. Collaborate with organizations involved in prevention and education to strengthen behaviour change interventions.
3. Design evidence-based interventions for behaviour change and distribute to relevant organisations for implementation.
4. Disseminate results and strategies to relevant organisations, institutions, government departments, planners and other stakeholders through collaboration, workshops and discussions.
5. Compile a database on HIV and AIDS-related research.

Monitoring and evaluation

1. Annual report on the availability and development of research projects, reports and strategies.
2. Annual report on the resources available for behavioural change research.
3. Annual report on the development of behaviour change strategies and implementation.
4. Quarterly summaries and analyses of ongoing research and preliminary results.

3.5 Leadership, Partnership and Coordination

Situation analysis

There has been insufficient political leadership in the national response to HIV. Therefore, there has been no political drive to encourage and mobilise the population to take seriously the threat posed by this epidemic. HIV has been mainly seen as a health issue and other sectors have not been fully involved in addressing the epidemic. Various sectors of the society have been responding but not in a coordinated way.

There is good evidence that an HIV epidemic can be contained with strong political will, a pragmatic approach, and the effective mobilisation of resources. The success achieved in countering the epidemic in countries such as Botswana, Uganda, Brazil and Thailand, are good examples. Political commitment in PNG to date includes the passing of the National AIDS Council Act in December 1997; establishment of the National AIDS Council and Secretariat in June 1998; approval of the National HIV/AIDS Medium Term Plan (1998 – 2002); and the passing of the HIV Prevention and Management Act of 2003.

Despite the political support to legislate and pass policies in Parliament and Cabinet, sustained political support to implement legislations and policies are not forthcoming. While the NAC was given considerable powers under the legislation, its resources are limited and depend largely on other partners. It is now under the Ministry of Health and does not properly reflect the multi-sectoral nature of the epidemic and the need for a wider response. A recent review of the NAC raised concerns about the way it functions and the commitment of some of its members (Functional Expenditure Review, 2003). Because of its large size (representing 22 agencies), the NAC often fails to achieve a quorum and cannot put pressure on government departments to improve this performance. The FER Review identified a need to make the NAC more representative and effective.

A national response of such magnitude will require the NAC and its Secretariat to be strengthened enormously to take on a more proactive role in coordinating national response. This would mean realigning or restructuring the NAC to ensure that it is effective and responsive to the changing nature of the epidemic.

Leaders at all levels need to be encouraged to keep HIV high on the national agenda and share information about the epidemic with their constituencies. The capacity of Provincial AIDS Committees needs to be built to manage HIV programmes, and resources need to be distributed equitably across the country.

Many agencies and organisations are making valuable contributions to HIV prevention and control but their work is not well coordinated. NGOS are particularly active in HIV education. Church organisations have initiated most care and support services. The PNG Trade Union Congress and other unions are working on peer education programmes. Private sector organisations in the Mining and Petroleum industry are developing workplace policies and programmes including prevention, care and treatment.

International development partners are providing invaluable technical and financial resources to the national response. Dynamic partnerships need to be built between the many agencies – government, donor agencies, NGO, CBO, faith-based organisations, private sector organisations – with a mutual commitment to consultation and joint decision-making.

The National AIDS Council and in particular the Secretariat needs to be strengthened considerably to coordinate the overall national response to the epidemic. This would require beefing up its current capacity and increased national resources to enable it to coordinate and support the various organizations including the provinces in the response.

Goal

To encourage politicians and leaders at all levels of society to give a high profile to HIV and enhance coordination of development partners, participation and resource mobilisation

Objective 1

To ensure annual increase in financial commitment and political involvement to the national response by fostering political and leadership commitment at all levels of society.

Strategies

1. Support strategic advocacy at all levels of leadership, including local, traditional leaders and women.
2. Promote the inclusion of appropriate HIV advocacy in all codes of ethics and leadership.
3. Encourage leadership in the private sector to develop and implement workplace policies on HIV at industry-level and workplace level.
4. Advocate for increased resources to be allocated to HIV, in line with the progress of the epidemic.

Objective 2

To strengthen existing partnerships and establish new partners on the basis of equality and mutual respect at all levels.

Strategies

1. From 2004, organise an annual National HIV/AIDS Partnership Forum, to keep HIV high on the national agenda.
2. Ensure that development and implementation of HIV workplace policies is one of the contractual obligations of departmental heads (in the public sector).
3. Industrial agreements and awards (in the private and public sectors) should include clauses relating to core elements of workplace policy on HIV/AIDS including prevention and non-discrimination
4. Ensure that national planning at all levels fully incorporates issues relating to HIV and AIDS.

Objective 3

To strengthen the capacity of NAC and its Secretariat to effectively coordinate the national response to HIV through the implementation of the NSP, including effective provincial coordination.

Strategies

1. Streamline and/or reorganise the current NAC and provincial structures to be responsive and effective in performing their functional responsibilities.
2. Strengthen the capacity to NAC to coordinate the implementation of the NSP and the national response.
3. Develop NACS capacity to coordinate with its development partners and partner organization.
4. Ensure that sufficient resources are mobilised to support the national response.
5. The implementation of the NSP is monitored and evaluated on a regular basis.

Monitoring and evaluation

1. Compile profiles on leaders regarding their support for and messages about HIV prevention.
2. Audit the inclusion of HIV in the programmes of different sectors.
3. Monitor effectiveness of coordination by NAC.
4. Monitor the allocation of resources to HIV at all sectors and levels.

3.6 Family & community support

Situation analysis

Traditional cultural values and practices emphasise the role of the family and community in providing care and support. Unfortunately, the extent of fear in the community about HIV has had an opposite effect and contributes to serious neglect and abuse of people living with HIV in some instances (NHASP, 2003). Although discrimination may be subsiding in Port Moresby, stigma and discrimination remain strong elsewhere. Families and communities often cannot talk openly about sex. Economic and other strains on households are eroding the capacity of families to care for relatives and other community members. Discrimination affects both the people infected by HIV and other members of their families and communities. For example, the number of children orphaned by AIDS is growing and children are also particularly vulnerable to discrimination and abuse.

Care for people with HIV is almost non-existent, except where church health services are building programmes of community-based care. Many people in PNG have difficulty accessing appropriate information and services because they do not know where to go for help. Services are limited, poorly coordinated and some health-workers have negative attitudes. There is little voluntary counselling and testing available. Health system resources are very limited. In order to address the growing needs, family and community care and support systems must be strengthened. These systems need to address not only the needs of people living with HIV, but the whole community, including medical and psychological support. These problems must be addressed through community education programmes, the training of caregivers and counsellors, and the enforcement of relevant laws against discrimination. Community and family leaders need to be assisted in providing care and support to children orphaned by AIDS and to better communicate with their members in breaking down discrimination and reinforcing prevention messages. Well-qualified counsellors need to be available at the district and community level, to provide support to people living with HIV and their families and improve coordination between health and social services. Caregivers need to have good access to information and skills, as well as necessary drugs and supplies. Youth-friendly and community-friendly information, care and support facilities need to be established. Partnerships between government, churches and NGOs need to be strengthened, in order to improve coordination between services and better use of available resources.

Goal

To support and sustain a social and cultural environment that will enable families and communities to care for and support people infected and affected by HIV.

Objective 1

To increase access for people living with HIV throughout PNG to access STI/HIV community based care and support services.

Strategies

1. Increase family and community capacity to care for people living with HIV by training and certifying counsellors, and providing necessary training and support for caregivers.
2. Involve people living with HIV as advocates in community education programmes.
3. Improve collaboration between various providers of care and support, such as government, NGOs, CBOs, faith-based and private sector organisations, in order to build effective and complementary networks and strengthen referral systems.
4. Apply the outcomes of national and international research to improve care and support for people living with HIV, including orphans, such as by piloting innovative workplace and community-based prevention, care and support programmes.
5. Support all efforts to enable families to meet their needs through basic education, health and well-being.

Objective 2

To develop a supportive environment for people living with HIV and their families through the establishment and/or training support and care groups in all provinces by 2008 and reduce discrimination and violence against them.

Strategies

1. Conduct communication training for community and family leaders to help them to talk about HIV and sexuality, address discrimination, and reinforce prevention messages.
2. Build capacity of community groups to support and care for people living with HIV especially pregnant and lactating mothers.

Objective 3

To ensure proper full recognition of human rights, including children's rights, in addressing the HIV epidemic, including respect for confidentiality, reduction of discrimination, and increased access to care and support.

Strategies

1. Conduct community education programmes and enforce laws against discrimination, in order to encourage a more supportive environment and reduce stigmatisation or violence against people living with HIV and their families, including ensuring that children are not discriminated against because of the sero-status of their parents or other family members.

Objective 4

To build capacity for community based organisations and groups to identify and provide support for orphans and vulnerable children.

Strategies

1. Construct criteria for identifying orphans and vulnerable children (OVC).
2. Enable CBOs to compile information on orphans and vulnerable children and to monitor their status on regular basis.
3. Build capacity of school teachers to identify and register OVC in their communities.
4. Build into the traditional safety nets for the care and support for OVC.
5. Ensure that all orphans and vulnerable children have access to schooling and health care services through the establishment of a community-based Trust Fund for orphans and vulnerable children.

Monitoring and evaluation

1. Develop a national network of agencies providing or promoting care and support at the community level, and share information on successful interventions and remaining gaps.
2. NAC to collate reports from this network into an annual analytical report.

3.7 Monitoring and evaluation

Situation analysis

There is currently insufficient capacity in PNG to monitor and evaluate the effectiveness of the national response. A principal weakness of the earlier National Mid-Term Plan was its lack of a monitoring and evaluation system. The quality of services and the impact of activities were not measured. There are, therefore, very little data by which to ascertain the effective use of resources. This weakens the national response, restricts political will within PNG to address the epidemic, and discourages donors from continuing to support the national response.

This absence of monitoring and evaluation stems in part, from an underlying lack of understanding of its importance as an instrumental aspect of the National Response. Some organisations understand it more as a form of fault-finding, or an unwelcome challenge to their mode of operation, rather than a tool to improve the effectiveness of their activities. Systems for monitoring and evaluation are weak in PNG because insufficient resources have been allocated to this activity. There is a particular shortage of skills.

These weaknesses must be addressed. Capacity needs to be built in order to be able to identify whether the right things are being done to counter HIV in PNG, and whether effective ways are being used. It is also necessary to be able to calculate whether these activities are being done on a large enough scale to make a difference, and whether resources are being appropriately and effectively channeled. Building this capacity will require that sufficient resources be allocated to monitoring and evaluation. An international rule of thumb is that this requires around 10% of the national budget for HIV/AIDS/STI activities. Links need to be established with all partners, including NGOs, private sector and faith-based organisations, donors, and research institutions.

Goal

To effectively track the progress of the HIV epidemic in PNG through regular monitoring and evaluation mechanisms and measure the impact of the national response.

Objective 1

To develop a Monitoring and Evaluation framework to produce, collate, analyse and disseminate information on the national response to HIV, by 2004.

Strategies

1. To create a well-resourced national Monitoring and Evaluation Unit that has formalised links with national research institutions and leading agencies.
2. Establish indicators for the different levels of M&E, and national and provincial data collection and analysis systems.
3. Involve all stakeholders in the design, implementation and analysis of monitoring and evaluation activities.
4. Ensure that all activities have an evaluation plan to assess how they have progressed towards their objectives, and conduct regular monitoring of the implementation progress in regard to inputs and outputs.

Objective 2

To accumulate and disseminate data from all sources including provinces through the use of relevant indicators that will assist in the reporting on respective international milestones for example, UNGASS and the MDG by 2005.

Strategies

1. Through the Monitoring and Evaluation Unit, provide feedback and guidance to provinces and districts for M&E, for linking with other sectors, and coordinating needs.

Objective 3

To measure the effectiveness and efficacy of the national response by undertaking a review of the NSP by 2008

Strategies

1. Develop and apply evaluation tools to measure the effectiveness and efficacy of the national response, and build capacity through training.
2. Undertake an evaluation of the National Strategic Plan.

Monitoring and evaluation

1. Regular reports on the status and progress of the national HIV/AIDS programme.
2. Regular reports on national capacity to monitor and evaluate the HIV/AIDS response, including financial and manpower resources, the existence and use of guidelines, and the transparency of this process, measured by the regular dissemination of information to all stakeholders including the general public.

REFERENCES

- Aeno H, Blanchard D, Sibille J, Yoifa S. Survey of knowledge and attitudes relating to STDs, including HIV/AIDS, among high school teachers in Eastern Highlands Province. Abstract in Programme and Abstracts of the Thirty-fourth Annual Medical Symposium of the Medical Society of Papua New Guinea, Port Moresby, 7-11 Sep 1998:61.
- Anang J. HIV/AIDS prevention project for sex workers, policemen, security men, dockside workers and sailors. 1997 Abstract A41 in Program and Abstracts of the Thirty-third Annual Symposium of the Medical Society of Papua New Guinea, Goroka, 2-5 Sep 1997: 48.
- Anang.J., & Jenkins.C, 1998, Transex Project reports presented at the Medical symposium in Lae.
- Anang J, Jenkins C. 1998, Encouraging safer sex among police, security men and sex workers in Port Moresby. Abstract in Programme and Abstracts of the Thirty-fourth Annual Medical Symposium of the Medical Society of Papua New Guinea, Port Moresby, 7-11 Sep 1998:63.
- Bisai N, Peter W, Sommi SS. 1999, HIV/AIDS awareness through theatre dramatization in Morobe South Coast - Waria District. Abstract in Program and Abstracts of the Thirty-fifth Annual Symposium of the Medical Society of Papua New Guinea, Rabaul, 6- 10 Sep 1999:22-23.
- Centre for International Economics, 2002, Potential Economic Impacts of an HIV/AIDS Epidemic in Papua New Guinea, AusAID, Canberra.
- Decock Ana Maria. 1997 Talking Health. The Wisdom of the Village. Adults/Youth. National Department of Health, Papua New Guinea.
- Hammar. L, 1999 Caught Between Structure and Agency: The Gender of Violence and Prostitution in Papua New Guinea, Transforming Anthropology, Vol.8, N0.1&2 :77-96.
- Jenkins C, Alpers M. 1994. Knowledge vs behaviour changes: preventing AIDS transmission in Papua New Guinea. Abstract in Programme and Abstracts of the Thirtieth Annual Symposium of the Medical Society of Papua New Guinea, Mount Hagen, 7-10 Sep 1994: 31.
- Jenkins, C. 2002, [Situation review??]
- Lepani .C, 2002 (unpublished)/ Gustafsson B, Traditions and Modernities in Gender Roles. Transformations in Kinship and Marriage among the M'buke from Manus Province. NRI Monograph 35, NRI, Port Moresby. 1999.
- Lemeki et al. 2003. Culture and gender factor influence attitude and sexual behavior among urban youth in the Eastern Highlands. PNG Annual Medical Society Symposium 2003. Abstract and proceeding 11.
- Lupiwa S, Suve N, Horton K, and Passey M. 1996. Knowledge about sexually transmitted diseases in rural and periurban communities of Asaro Valley of Eastern Highlands Province: the health education component of an STD study. PMG Med J39:243-247.
- McGrath Janet W., Rwabukwali Charles B. 1994. Anthropology and AIDS. The Cultural Context of Sexual Risk Behaviour among Urban Baganda Women in Kampala, Uganda. Chapter 15 pp. 208-228 in *The Family and HIV*. Robert Bor and Jonathan Elford (eds). London N.Y Cassel.

Ministry of Health [dates? Publ/ unpubl statistics??]

Ministry of Health, 2003, National Health Plan, 2001–2010: PP 123–124].

National AIDS Council Secretariat, various dates,

O'Reilly Keven R., Msiska Roland, Mouli Chandra V. and Islam Monir. Behavioural Interventions in Developing Nations. 1999. Chapter 7 pp. 137-154 in *Preventing HIV in Developing Countries. Biomedical and Behavioural Approaches*. Laura Gibrey, Ralph J. DiClemente, Sten H. Vermund (eds.). New York. Kluwer Academic/Plenum Publishers.

Oyang G, et al. 1997 Encouraging safe sex among highway drivers and sex workers along the Lae-Highlands Highway in Papua New Guinea. Abstract B18 in Program and Abstracts of the Thirty-third Annual Symposium of the Medical Society of Papua New Guinea, Goroka, 2-5 Sep 1997:77.

Passey, M., C. Magone, S. Lupiwa, M. Suve, S. Tiwara, A. Clegg and M. Alpers, 1998. 'Community-based study of sexually transmitted diseases in rural women in the highlands of Papua New Guinea: prevalence and risk factors,' Sexually Transmitted Infections 74:2; pp. 120-7.

Public Sector Reform and Monitoring Unit 2002, Functions and Expenditure Review of the National AIDS Council, Prime Ministers Department, Port Moresby. Mimeo.

The Humanity Foundation, 2003, Summary Report on the National Capital District Provincial AIDS Committee Street Kids Survey, July – August 2003, NCD Provincial AIDS Committee Secretariat, Port Moresby.

UNAIDS, 2003 The Media and HIV/AIDS. p5

UNDP, 1999 Human Development Report

UN, 2001, [Situation review]

UN/USAID 2002 [Review of Medium Term Plan]

Weiner, Anette 1976, *Women of Value, Men of Renown: New Perspectives in Trobriand Exchange*. Austin and London: University of Texas Press.

Wingood Gina W. & DiClemente Ralph J. 1999. The use of Psychosocial Models for Guiding the Design and Implementation of HIV Prevention Interventions. Translating Theory into Practice. Chapter 9 pp 187-204 in *Preventing HIV in Developing Countries. Biomedical and Behavioural Approaches*. Laura Gibrey, Ralph J. DiClemente, Sten H. Vermund (eds.) New York. Kluwer Academic/Plenum Publishers.

Zimmer-Tamakoshi L. 1993, Nationalism and Sexuality in Papua New Guinea. *Pacific Studies Volume 16, No. 4 pp. 61-99*.

Zimmer-Tamakoshi L. 1998, *Modern Papua New Guinea*. Thomas Jefferson University Press

ANNEX I: TERMS OF REFERENCES

Terms of Reference – Steering Committee

Specific Terms of Reference:

1. Direct and coordinate the overall process of developing the National Strategic Plan (NSP);
2. Approve proposed work plan for the development of the NSP document;
3. Approve TOR for Working groups
4. Determine membership of Working Groups;
5. Provide guidance and advice to Working Groups;
6. Identify priorities and targets to be addressed in the NSP;
7. Define sectoral roles and responsibilities in implementing strategic objective including those of national, provincial and local-level governments, NGOs, churches and donor agencies;
8. Liaise with existing Provincial AIDS Committees in developing the NSP;
9. Develop guidelines for the establishment of committees and/or working groups as components of the NSP;
10. Review and comment on Working Groups' draft documents;
11. Identify cross-cutting issues and integrate Working Groups' strategies into a comprehensive plan
12. Determine document outline and form
13. Review draft sections of the document as required;
14. Review and comment on draft NSP;
15. Plan and convene a national NSP conference to present the draft NSP for revisions and amendments;
16. Approve final document before submission to the NAC and NEC;

Terms of Reference – NSP Secretariat

Specific Terms of Reference:

1. Coordinate and organize logistics for:
 - the Steering Committee;
 - the Facilitators Group meetings; and
 - the seven Working Groups.
2. Compile minutes of meetings for the Steering Committee, the Facilitators Group and the Working groups;
3. Compile all documentation for Steering Committee and Working groups prior to consultations and meetings;
4. Compile and put together reports of the Working Groups in consultation with the Group Facilitators;
5. Organize workshops or conferences for each of the working groups and the Steering Committee;
6. Manage the budget of the NSP planning process
7. Prepare financial reports and acquittals on use of funds
8. Organize all logistics associated with the NSP process.

Terms of Reference: Working Group 1: Treatment, Counselling, Care and Support

Specific Terms of Reference are as follows:

1. INTRODUCTION

TOR

- a. Draft sections of the Laboratory, Treatment, Counseling, Care and Support sections for NSP documentation;
- b. Participate in all national and provincial workshops, and seminars relating the development of the NSP.

2. GENERAL

TOR

- a. Review and assess achievements to date in the areas of diagnostic procedures, treatment, counselling and care with a view to reinforcing and building on existing program activities;
- b. Review the findings and recommendations of the Functional Expenditure Review (FER) of the National AIDS Council of 2002, the National AIDS Support Project Internal Review and the UN review of the Medium Term Plan on HIV/AIDS and STI – 1998 – 2002 with a view of incorporating them into the National Strategic Plan as specific objectives;
- c. In light of the passage of the HIV/AIDS Management Law, address the issue of confidentiality, including partner notification, and contact tracing, and develop appropriate guidelines as related to counseling and referral services;

3. COUNSELLING

TOR

- a. Assess needs in the area of counseling, referral and Care services and identify strategies to address these needs;
- b. Assess the need of counsellor support and relief and identify strategies to address these needs;
- c. Define appropriate structures for coordinating, supervising, monitoring and evaluating counseling and care services;
- d. Define appropriate mechanisms for establishing and maintaining register of counselors at national and provincial level and recommend for a board to be established with clearly defined roles and responsibilities;
- e. Establish different categories of Counsellors (basic and advanced counseling);
- f. Identify and review guidelines on the training of Counselors and how they are integrated into government, NGO and private sector training programs;
- g. Propose and recommend guidelines for telephone counseling and referrals, including policy guidelines for volunteer workers;
- h. Identify existing care and counseling services for people living with HIV/AIDS and propose the development of guidelines on how to strengthen these services;

- i. Establish mechanisms and recommend the establishment of positions in all Provincial hospitals, Rural Hospitals and major health centers with duty statements clearly defined
- j. Identify mechanism for the establishment of youth-friendly counselling services;
- k. Identify mechanisms for the establishment of counselling services for marginalized groups; and
- l. Identify needs for protocols for medical staff in all hospitals, clinics, health centers and private practice regarding pre- and post test counseling referral to counselors following confirmation of positive HIV tests and integration of care services for people living with HIV/AIDS (simple protocol manual)

4. DIAGNOSTIC PROCEDURES & TREATMENT

TOR

- a. Review the current diagnostic procedures and treatment;
- b. Review and identify medical facilities already treating HIV patients and identify what treatments are already available in country;
- c. Assess the viability of making HIV/AIDS drugs available and accessible in the country;
- d. Identify the processes necessary to include ARVs in the approved drug list of the Pharmaceutical Board;
- e. Define appropriate mechanisms for developing treatment protocols for HIV/AIDS infected persons;
- f. Mechanisms of providing diagnostic procedures for counselling and care for all pregnant mothers;
- g. Review mechanisms in place for procedures for all blood and blood products usage and testing; and
- h. Area of Traditional Healers, Alternative medicine

5. CONCLUSIONS

- a. Review draft sections of the other Working Groups and clearly identify the links with other components to this component; and
- b. Review complete draft of the NSP and provide comments and suggestions;

Terms of Reference – Working Group 2: Education and Prevention

Specific Terms of Reference:

- 1 Review and assess achievements to date in the areas of Education and Prevention with the view to reinforcing and building on existing program activities;
- 2 Review recommendations of the Functional Expenditure Review (FEW) of the National AIDS Council of 2003, the NHASP internal review and the UN review of the Medium Term Plan on HIV/AIDS and STI – 1998 –2002 with a view of incorporating them into the Strategic Plan as specific objectives;
- 3 Define appropriate structures and channels, including social and community networks for coordinating education and prevention and disseminating information;
- 4 Identify gender-based strategies for reaching high risk populations and marginalized groups, including out-of-school youth, settlements and commercial sex workers, people living with HIV, men who have sex with men; *including sensitive issues on culture, social, economic and politics.*
- 5 Assess needs in the areas of teacher training and health worker training and identify strategies to address those needs.
- 6 Assess needs in the area of curriculum development with a particular focus on the primary school, high school, and vocational schools, *and colleges and universities*, and identify strategies to address those needs.
- 7 Review and suggest innovative ways of dealing with the content for the following program areas:
 - 7.1 Information materials;
 - 7.2 Curriculum development;
 - 7.3 Peer Education;
 - 7.4 Parent Education;
 - 7.5 Teacher Training
 - 7.6 Health worker education;
 - 7.7 Non-formal community education, and *best practices.*
- 8 In collaboration with Group 4, review guidelines for social marketing of condoms and condom distribution and recommend guidelines where absent and suggest refinements with existing ones;
- 9 Review guidelines and identify inputs for an advocacy program on HIV/AIDS awareness and prevention at the national, provincial and LLG levels;
- 10 Address the issue of responsible media coverage of HIV/AIDS and recommend the development of guidelines and consider inputs for nation-wide media campaign on HIV/AIDS awareness and prevention, including messages appropriate to PNG cultures, values and resources,
- 11 Draft section on education and Prevention for the National Strategic Plan document
- 12 Review draft sections of other Working Groups
- 13 Review first full NSP draft and provide comments and suggestions
- 14 Identify and recommend key performance indicators for monitoring and evaluation for the group.
- 15 Participate in conferences, workshops as and when they are organized relating to the National Strategic development.

Terms of Reference Working Group 3: Epidemiology and Surveillance

Specific Terms of Reference are as follows:

1. Review and assess achievements to date in the areas of epidemiology and surveillance with a view to reinforcing and building on existing policy guidelines and program activities;
2. Review recommendations of the Financial Expenditure Review (FER) of the National AIDS Council of 2003, the NHASP internal review and the UN review of the Medium Term Plan on HIV/AIDS and STI – 1998 – 2002 with a view of incorporating recommendations relating to epidemiology and surveillance into the NSP as specific objectives;
3. In regards to epidemiology;
 - a. Review current HIV/AIDS and STI reporting systems and recommend guidelines to for improved data collection, analysis and reporting; and
 - b. Define appropriate structures and channels including existing networks for coordinating data collection, analysis and reporting
 - c. Identify appropriate information technology software for use in data collection, analysis including HIV/AIDS modeling.
4. In relation to surveillance;
 - a. Review current HIV/AIDS and STI surveillance systems in relating to:
 - i. Sero-surveillance; and
 - ii. Behavioural surveillance
 - b. Recommend guidelines and policies with a view to improving, expanding and linking sero-surveillance and behavioural surveillance information;
5. Identify and recommend best practice options for expanding surveillance and epidemiological work beyond the current scope covered;
6. In collaboration with other Working Group 5, identify and recommend institutions (government, private sector, NGOs, Churches) and individuals with capabilities of undertaking behavioural surveillance activities
7. In collaboration with Working Group 4, identify and recommend research priorities and guidelines to monitor trends in sexually transmitted diseases including HIV and AIDS;
8. In collaboration with other working groups, identify cross-cutting issues and ensure that these are addressed collaboratively;
9. Identify training needs for strengthening surveillance and epidemiological work.
10. Draft section on Epidemiology and Surveillance for the NSP;
11. Review draft sections of other Working Groups;
12. Review, comment and make suggestions on the full NSP draft document; and
13. Participate in all national and provincial workshops, and seminars relating the development of the NSP; and
14. Recommend key performance indicators to be used in monitoring and evaluating strategies for this response area.
15. The committee can amend the TOR as work progresses in the area as and when the need arises.

Terms of Reference – Working Group 4: Behaviour Change Research

Specific Terms of Reference:

1. Review existing Policy Guidelines on behavioral change research relating to HIV/AIDS.
2. Review existing work on behavioral change in PNG in relation to HIV/AIDS, identify gaps, and make recommendations for further research complementary to National Strategic Plan.
3. Evaluate the MTP review in relation to behavioral change and recommend strategies to be incorporated into the NSP.
4. Identify and prioritize social and behavioral research in relation to the prevention of HIV. For example:
 - Safe Sex practices including condom use;
 - Knowledge on HIV/AIDS and STIs;
 - Access and utilization of services including counseling, care, clinical service etc.;
 - Religion and sexuality issues;
 - Gender relations and HIV/AIDS;
 - Community values, beliefs and HIV/AIDS;
 - Youth;
 - Human rights;
 - Stigma and Discrimination
 - Sexual violence
 - Family/community structural changes in relation to HIV/AIDS
5. Identify and recommend research into cultural practices that put people at risk of infection.
6. Participate in conferences and workshops if and when required for the National Strategic Plan.
7. Consider and recommend to the NAC to act as a registry for any research and reports related to HIV/AIDS and STIs.
8. Identify and recommend key performance indicators for monitoring and evaluation for the Behaviour Change Research Group.
9. Draft the Behavioral Change Research component of the National Strategic Plan.
- 10 Collaborate with other organizations that undertake socio-cultural, economic, medical and any other research related to HIV/AIDS.

Terms of Reference – Working Group 5: Leadership, Partnership & Coordination

Specific Terms of Reference:

1. In view of reinforcing and building on the national response, review and assess:
Current leadership commitments, directions, strengths and weaknesses from all sections of society in addressing issues pertaining to the HIV/AIDS epidemic;
 - 1.1 Partners, current and potential in collaborating for a national response and to identify weaknesses and strengths to further strengthen these partnerships; and
 - 1.2 Coordination roles of organizations from all sections of society including government, private sector, NGOs, youth, women's organizations, churches donor organizations etc.
2. Review recommendations of the Functional Expenditure Review (FER) of the National AIDS Council of 2002, the NHASP internal review and the UN review of the Medium Term Plan on HIV/AIDS and STI – 1998 – 2002, and the NAC Act with a view of incorporating recommendations relating to leadership, partnership and coordination into the National Strategic Plan as specific objectives;
3. Review national and international best practice documents relating to leadership, partnership and coordination and recommend options for adopting some practices;
4. Critically review and examine the NACS structure, roles and responsibilities of the NAC/NACS as a central coordinating body;
5. Critically review the PAC structure and its linkages with the Provincial Administration and other stakeholders;
6. Recommend advocacy strategies that will strengthen leadership roles from all sectors of society
7. Identify and recommend options for establishing high level commitment at national level for HIV/AIDS and the option of replication at provincial levels;
8. Review and recommend guidelines for strengthening leadership, partnerships and coordination for overall national response to the HIV/AIDS epidemic;
9. Identify and recommend policy options in all government sectors that will facilitate strengthening coordination, partnerships and leadership in all sectors;
10. Identify framework for sectoral responsibilities in implementing the National Strategic Plan objectives, including those of national provincial and local-level government, NGOs, churches and donor agencies;
11. Ensure that cross-cutting issues are addressed and fully considered to be fully integrated into the National Strategic Plan;
12. Draft sections of Leadership, Partnership and Coordination for the NSP document;
13. Review draft sections of other Working Groups and make any inputs on cross-cutting issues;
14. Review the full NSP draft and provide comments and suggestions; and

15. Participate in conferences, workshops as and when they are organized relating to the National Strategic Plan development.
16. Identify appropriate indicators to monitor the implementation of strategies.

Terms of Reference – Working Group 6: Family and Community Support

Specific Terms of Reference:

1. Review, and assess:
 - Achievements to date in the areas of homecare and community support with the view to reinforcing and building on family and community support systems within PNG families and communities;
 - Family and community support and safety networks within families and communities in PNG; and
 - Existing protocols and guidelines for home and community – based care for use by families and communities in caring for people living with HIV/AIDS;
2. Review findings and recommendations of these documents with a view of incorporating recommendations relating to homecare and community support into the NSP as specific objectives:
 - Functional Expenditure Review (FER) of the National AIDS Council of 2002;
 - National HIV AIDS Support Project internal review; and (requires clearance from AusAID)
 - UN review of the Medium Term Plan on HIV/AIDS and STI – 1998 – 2002
3. Identify existing community and family support services for people living with HIV/AIDS and recommend guidelines on how to strengthen and enhance cultural and social resources in meeting the needs of people infected and affected by HIV/AIDS;
4. Assess needs in the area of family/community care and support, referral and homecare services including the needs of counselor support and relief and identify strategies to address those needs;
5. Work closely with relevant Working Groups to ensure that duplication does not occur and that strategies compliment each other;
6. Draft sections of Family and Community Support for the National Strategic Plan document;
7. Review draft sections of relevant working groups;
8. Review first full NSP draft and provide comments and suggestions;
9. Participate in conferences, workshops and seminars when they are organized relating to the National Strategic Plan development; and
10. Identify appropriate indicators to monitor the implementation of strategies.

Terms of Reference – Working Group 7: Monitoring and Evaluation

Specific Terms of Reference are as follows:

1. Review and assess achievements to date in the areas of monitoring and evaluation with a view to reinforcing and building on existing policy guidelines and program activities;
2. Review recommendations of the NHASP internal review and the UN review of the Medium Term Plan on HIV/AIDS and STI – 1998 – 2002 with a view of incorporating them into the National Strategic Plan as specific objectives;
3. Assess needs in the areas of monitoring and evaluation and identify strategies to address those needs;
4. Develop M & E strategies in the context of the national epidemic to respond to the requirements of the international conventions including:
 - a. International Conference on Population and Development relevant to HIV/AIDS;
 - b. Women 2000: Gender Equality, Development and Peace for the 21st Century
 - c. World Summit for Social Development and Beyond – Achieving Social Development for all in a Globalizing World;
 - d. Millennium Development Goals;
 - e. UNGASS Declaration of Commitment
5. Identify and recommend a draft Monitoring and evaluation framework that will guide the government in monitoring and evaluating the implementation of this National Strategic Plan and its impact;
6. Draft section on Monitoring and Evaluation for the NSP document;
7. Review draft sections of other Working Groups in relation to M & E and make any input on cross-cutting issues;
8. Participate in conferences, workshops as and when they are organized relating the development of the National Strategic Plan

ANNEX II LIST OF PARTICIPANTS

National Strategic Plan List of Members

NO	NAME	ORGANIZATION
Working Group 1: Treatment, Counselling, Care and Support		
1.	Ms PRISCILA AGELAVU	POM GENERAL HOSPITAL
2.	Ms ALEXIA DEKENE	DEPARTMENT OF DEFENCE
3.	DR SALIK GOVIND	WHO
4.	Fr. JUDE RONAYNE FORDE	SIMON OF CYRENE
5.	Mr PETER SINE	HOPE WORLD WIDE
6.	Dr PAISON DAKULALA	ANGAU MEMORIAL HOSPITAL
7.	Ms HELEN BEREM	PLWHA - NHASP
8.	Mr DAVID PASSIREM	NACS
9.	Dr CATHY RETO	PORGERA JOINT VENTURE
10.	Dr DIRO BABONA	CPHL - PMGH
11.	Dr GRACE KARIWIGA	MTC - PMGH
12.	Mr JOE ANANG	UNICEF
13.	Dr M. KIROMAT	PMGH
14.	Mr BOMAL GONAPA	NACS
15.	Ms SHARON WALKER	NHASP
16.	Ms KAY McCOL	STOP AIDS (PNG)
17.	MAJOR MARLENE JONES	SALVATION ARMY
18.	Mr PETER MOMO	PLWHA
19.	Dr GOA TAU (FACILITATOR)	PMGH
20.	Sr HUNHOFF TARCISIA (Facilitator)	CATHOLIC SECRETARY
Working Group 2: Prevention and Education		
21.	Dr UTE SCHUMANN (Facilitator)	EUSHP
22.	Professor Glen Mola	Pt Moresby General Hospital
23.	Ms ILI MOVONO	NHASP
24.	Ms CHRISTI MORF	UNDP
25.	Mr BOMAL GONAPA	NACS
26.	Ms MIRIAM MIDIRE	UNFPA
27.	Mr MEDLEY KOITO	DEPT. OF EDUCATION
28.	Mr JOHN REI	MEDIA COUNCIL
29.	Mr JUDAH IPARAM	DEPARTMENT OF HEALTH
30.	Ms JELILAH UNIA	NHASP
31.	Mr KAL INDISTANGE	NACS
32.	Mr MAX MEA	PLWHA
33.	Mrs MAURA MEA	PLWHA
34.	Mrs JESICA LESLEY	HOPE WORLD WIDE
35.	Ms JUDITH ELLY POSENU	SAVE THE CHILDREN
36.	Mr BILLY STRANGE (Facilitator)	EU

37.	Ms HOLLY B. ARUWAFU	SPECIAL YOUTH PROJECT
38.	Mrs THERESA TABEL	YOUTH COMMISSION
39.	Ms JEANETTE SOUTHWELL	STOP AIDS (PNG)
40.	Mr GARY RAI	YOUTH - NHASP
41.	Mr WILLIE WARI	YOUTH - NHASP
42.	Dr CHRIS HUDSON	IMR
43.	Dr GREG LAW	NHASP
44.	Mr JOE LARI	3 ANGELS
Working Group 3: Epidemiology and Surveillance		
45.	Dr GILBERT HIAWALYER	DEPARTMENT OF HEALTH
46.	Dr DIRO BABONA	CPHL - PMGH
47.	Mr BOMAL GONAPA	NACS
48.	Professor SIM	MEDICAL FACULTY
49.	Dr JOHN MILLAN	NHASP/ NACS
50.	Dr ESOROM DAONI	DEPARTMENT OF HEALTH
51.	Dr AENO	PNG RED CROSS
52.	Dr JOACHIM PANTUMARI (Facilitator)	NACS
Working Group 4: Social and Behaviour Research		
53.	Ms ROSA AU	UPNG
54.	Mr WILFRED PETERS	NACS
55.	Dr NII-K PLANGE	UNAIDS
56.	Dr LAWRENCE HAMMAR	IMR
57.	Dr JOHN MUKE	UPNG
58.	Ms JUDITH MICHAEL	PLWHA – MADANG PAC
59.	Dr BERIT GUSTAFSSON	NHASP
60.	Dr ANNE WAIKO	UPNG
61.	Mr BOMAL GONAPA	NACS
62.	Mr JOSEPH SILL	STOP AIDS (PNG)
63.	Mr THOMAS KAUAGE	PEER EDUCATOR
64.	Ms MARY ANDREW	SAVE THE CHILDREN
65.	Mr MOSES TAU	Men who have sex with men
66.	Ms GERALDINE MAIBANI (Facilitator)	IMR
Working Group 5: Leadership, Partnership and Coordination		
67.	Ms BARBARA SMITH	NHASP
68.	Mr PETER WALIAWI	NACS
69.	Dr Paulo Proto	NHASP
70.	Ms JUDITH ASCROFT	NHASP
71.	Mr JARRY ANUK	PSRAG
72.	Dr MOALE KARIKO (Facilitator)	TUC
73.	Dr NINKAMA MOIYA (Facilitator)	NACS
74.	Mr RORY SITAPAI	SPECIAL YOUTH PROJECT
75.	Mr BILL NIXON RANGEL	UNDP
76.	Mr BOMAL GONAPA	NACS
77.	Dr ISIYE NDOMBI	UNICEF
78.	Mr LESLEY BOLA	NHASP

79.	Mr VINCENT GODUON	DSWD
80.	Ms OLIVE AVEI	CPA
81.	Ms ROSE APINI	PNG AIDS FEDERATION
82.	HELEN SAMILO	PLWHA – STOP AIDS
83.	Ms MOLLY WILLIE (Facilitator)	DSWD
Working Group 6: Family and Community Support		
84.	Ms MARGARET MARABE	PLWHA – STOP AIDS
85.	Mr ISIDORE WINKUARU	PMGH
86.	Mr DAVID PASSIREM	NACS
87.	Mr STEVEN YOIFA (Facilitator)	SAVE THE CHILDREN
88.	Sr ROSE BERNARD	CATHOLIC – BANZ /WHP
89.	Mr BOMAL GONAPA	NACS
90.	Mr VAGI ONEVAGI	NATIONAL CULTURAL COMMISSION
91.	Ms GWEN TULO	PNG COUNCIL OF CHURCHES
92.	Ms RUBBIE KENNY	SPECIAL YOUTH PROJECT
93.	Mr DAVID EPHRAIM	SPECIAL YOUTH PROJECT
94.	Sir PAULIAS MATANE	NEWTON PACIFIC & ASSOCIATES
95.	Ms KONIO DOKO	DSWD
Working Group 7: Monitoring and Evaluation		
96.	Mr BILL NIXON RANGEL	UNDP
97.	Dr NINKAMA MOIYA (Facilitator)	NACS
98.	Mrs AGNES GEGE	NACS
99.	Mr BOMAL GONAPA	NACS
100.	Dr GILBERT HIAWALYER	Department of Health
101.	Dr Raj Pereira	NHASP

NSP – STEERING COMMITTEE MEMBERS

No.	NAME	ORGANIZATION
1.	Dr NINKAMA MOIYA	NACS
2.	Mr JARRY ANUK	PSRAG
3.	Mr JOHN RAY	MEDIA COUNCIL
4.	Dr SAM LAHIS	DEPT OF AGRICULTURE
5.	Dr SALIK GOVIND	WHO
6.	Ms MOLLIE WILLIE	DSWD
7.	Dr Nii K. Plange	UNAIDS
8.	Mr HAROLD URE	DEPT OF EDUCATION
9.	Mr PETER LOCKEY	AUS AID
10.	Mr MAHESH SHARMA	WORLD BANK
11.	MEMBER	ADB
12.	JEANETTE SOUTHWELL	STOP AIDS (PNG)
13.	Sr TARCISIA HUNHOFF	CATHOLIC SECRETARY
14.	MAX MEA	PLWHA
15.	MAURA MEA	PLWHA
16.	HELEN BEREM	PLWHA – NHASP
17.	Dr ILA TEMU	PLACER NIUGINI LTD
18.	Dr JAMES CHIN	CHAMBER OF COMMERCE
19.	Dr JAMES WANGI/ Dr DAONI	DOH
20.	Sir PAULIAS MATANE	NEWTON PACIFIC ASSOCIATES
21.	Ms MARIANA ELLINGSON	DNPRD
22.	Mr THOMAS LISENIA	NHASP
23.	Mr ALBERT BUNAT	DNPRD

NSP – SECRETARIAT MEMBERS

No	NAME	ORGANIZATION
1.	Dr NINKAMA MOIYA	NACS
2.	Dr SALIK GOVIND	WHO
3.	Dr NII-K PLANGE	UNAIDS
4.	Ms CHRISTI MORF/ Mr BILL NIXON	UNDP
5.	Dr ESOROM DAONI	DOH
6.	Dr PAULO PROTO	NHASP
7.	Ms BARBARA SMITH	NHASP
8.	Mr JOE ANANG	FOCAL POINT/HIV AIDS
9	Mr ALBERT BUNAT	DNPRD
10	Dr GOA TAU	PMGH
11.	Dr UTE SCHUMANN	EUSHP
12.	Mr THOMAS LISENIA	NHASP
Secretariat Support Staff		
13	Janet Ame	NACS
14	Bera Reuben	NHASP
15	Marieta Kavora	NACS
16	Amuk Peters	NACS
17	Lydia Tundimi	NACS