

TECHNICAL SUPPORT FOR HIV/AIDS PREVENTION, CARE AND TREATMENT PROJECT

*Summary of achievements and lessons learned from
a five-year experience in a multi-country and regional
project in the Asia Pacific*

PAPUA NEW GUINEA End of Project Report

Prepared and
submitted by:

FHI 360
**Asia Pacific Regional
Office**

19th floor, Tower 3,
Sinhorn Building
130-132, Wireless Rd.
Lumpini, Phatumwan
Bangkok 10330.
Thailand

Telephone:
662.263.2300

FHI 360
Papua New Guinea

Unit 3, Allotment 33,
Section 38
(P.O. Box 477)
Steamships Compound,
Waigani, NCD
Papua New Guinea

Telephone:
675.323.0966

This report is made possible with support from the American People through the United States Agency for International Development (USAID) under the terms of the Technical Assistance and Support Contract 3, Task Order 2 (GHS-I-02-07-00007-00). The contents of the report are the sole responsibility of FHI 360 and do not necessarily reflect the views of USAID or the United States Government.

The publication may be freely reviewed, quoted, reproduced, or translated, in full or in part, provided the source is acknowledged. The mention of specific organizations or products does not imply endorsement and does not suggest that they are recommended by FHI 360 or USAID over others of a similar nature that are not mentioned.



December 2012

CONTENTS |

Acknowledgements
Executive Summary
Country context and epidemiology

USAID/FHI 360 program strategy	1
Strategic objectives	
Working with local partners	
Building capacity through technical assistance	
Tools development	
Strategic Objectives	
1. Strategic information made more available and useful	5
2. Access to comprehensive prevention interventions for MARPs increased	9
3. Access to care, support and treatment for PLHIV and their families increased	20
4. Enabling environment strengthened	28
5. Effectiveness of USG-supported programs enhanced by leveraging other donor resources	32
Lessons learned, continued challenges & conclusion	36
Appendices	42
Appendix 1: Works Cited	
Appendix 2: Project Partners	
Appendix 3: Decision Tree	

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
AusAID	Australian Agency for International Development
BSS	Behavioral surveillance survey
CHBC	Community and home-based care
CMT	Case management team
COGS	Clinic Operational Guidelines and Standards
CoPCT	Continuum of Prevention to Care and Treatment
CoPCT-CC	CoPCT Coordinating Committee
CPHL	Central Public Health Laboratory
CPP	Comprehensive Prevention Package
FBO	Faith-based organization
FSW	Female sex worker
FY	Fiscal year
GBV	Gender-based violence
GoPNG	Government of Papua New Guinea
HBYP	Helvim Bilong Yumi (“Our Help”) Project
HCT	HIV counseling and testing
HIV	Human Immunodeficiency Virus
HRM	High-risk man / high-risk men
HRW	High-risk woman / high-risk women
HWW	Hope Worldwide
IA	Implementing agency
IBBS	Integrated behavioral and biological survey
IEC	Information, education and communication
KBW	Kirap Bung Wantaim
MARP	Most-at-risk population
M&E	Monitoring and evaluation
MSM	Man who has sex with men / men who have sex with men
NACS	National AIDS Council Secretariat
NCD	National Capital District
NDoH	National Department of Health
NGO	Non-governmental organization
OI	Opportunistic infection
OV	Outreach volunteer
PAC	Provincial AIDS Council
PE	Peer educator
PHO	Provincial Health Office
PLHIV	Person living with HIV/AIDS / People living with HIV/AIDS
PLWHA	People Living With Higher Aims
PNG	Papua New Guinea
PPTCT	Prevention of parent to child transmission
ProMEST	Provincial Monitoring and Evaluation Surveillance Team
PSRC	Peer Support Resource Centre
PY	Person-years
QA/QI	Quality assurance/quality improvement
RDMA	Regional Development Mission Asia (USAID)
SBC	Strategic behavioral communications
S&D	Stigma and discrimination
SNF	Sirus Naraq Foundation
SOP	Standard operating procedure
STI	Sexually transmitted infection
TA	Technical assistance
TG	Transgender
TRENDS	Tracking Exposure Knowledge and Behavior
TWG	Technical working group
USAID	United States Agency for International Development

ACKNOWLEDGEMENTS

We would like to extend our deepest thanks to the Government of Papua New Guinea (GoPNG), in particular the National Department of Health and the National HIV/AIDS Council – Secretariat, for their continued leadership since the beginning of this project in 2007. The commitment and dedication of our local partners, their staff and the volunteers have led to the success in providing quality HIV/AIDS prevention, care and treatment services and linkages to the populations in need. Their invaluable guidance has been critical to shaping the program over the life of the project to make the interventions more effective. The development and scale up of the Continuum of Prevention to Care and Treatment model would not have been possible without the vision and support from the USAID Regional Development Mission Asia and from the USAID/Pacific Islands mission.

EXECUTIVE SUMMARY

As of 2011, an estimated 0.8% of the adult population of Papua New Guinea (PNG) was infected with HIV. Prevalence was markedly higher among men who have sex with men (MSM) and female sex workers (FSWs), estimated at 4.3% and 5.9% nationally, respectively, though this varies by region. The epidemic is driven primarily through unprotected heterosexual sex, and surveys have shown that relatively high proportions of both men and women in PNG maintain multiple and concurrent sexual partnerships and that consistent condom use is low. HIV risk in PNG is also significantly influenced by contextual factors including widespread gender-based violence towards women and MSM.

The Technical Support for HIV/AIDS Prevention, Care and Treatment Project was a five-year, (2007–2012) USAID-funded project implemented by the FHI 360 Asia-Pacific Regional Office in the region and four countries: China (Yunnan and Guangxi Provinces), Laos PDR, Thailand, and Papua New Guinea. In PNG, the specific goals of the project were to:

- » provide technical leadership and mentorship to improve the planning, collection, analysis, and use of strategic information related to the HIV epidemic;
- » increase access to comprehensive prevention interventions for most-at-risk populations (MARPs);
- » increase access to care, support and treatment for most at risk populations for HIV (MARPs), including PLHIV and their families;
- » support coordination of local stakeholders to promote the enabling environment;
- » leverage and harmonize additional donor resources to support the scale up of US government-supported projects

FHI 360 worked in PNG to develop a Comprehensive Package of Services (CPS)¹ and a Continuum of Prevention to Care and Treatment (CoPCT) model designed to increase access by MARPs to comprehensive prevention interventions which are linked to care, support and treatment services. Under the CPP model, FHI 360 partnered with government and non-governmental organizations in the National Capital District (NCD) and in Madang Province to provide a comprehensive service package including education and behavior change on HIV and risk reduction, condom distribution, and sexual health services including diagnosis and treatment for sexually transmitted infections (STIs) and HIV counseling and testing (HCT). Intervention activities targeted MSM and FSWs in designated “hotspots” including bars and clubs, as well as men and women at high risk for HIV in community settlements.

¹The CPS model is one component of the Comprehensive Prevention Package (CPP) model, which has been developed with USAID/RDMA support in each country implementing the project. Implementation in PNG focused on the CPS component specifically.

FHI 360 also piloted a CoPCT model that paired the Comprehensive Prevention Package (CPP) with the delivery of HIV treatment, care and support services in NCD and Madang. This model aimed to strengthen the provision of high-quality clinical services, including antiretroviral therapy (ART), and to establish an effective system for coordination and referral between different service providers. In addition, FHI 360 leveraged significant support from the Australian Agency for International Development (AusAID) to link treatment services with community and home-based care (CHBC). People living with HIV/AIDS (PLHIV) played a major role in service delivery under the CoPCT model.

While CPP and CoPCT interventions were launched independent of one another, these two models became much more closely linked over the life of the project, with prevention services integrated into many aspects of the CoPCT.

FHI 360 also supported the Government of PNG (GoPNG) to strengthen the collection and use of strategic information on the HIV epidemic for planning and implementing the national response, and served on numerous national-level technical working groups (TWGs) to offer technical assistance in areas including surveillance and monitoring and evaluation (M&E), decriminalization of sodomy, care and treatment, and gender-based violence (GBV). As a result of GBV information gathered through strategic information exercises, FHI 360 also integrated GBV messages and activities into numerous components of the project, including prevention education and provision of clinical services.

Throughout the project, FHI 360 placed particular emphasis on enhancing intervention quality and sustainability and on documentation and dissemination of lessons learned in order to enhance replication of USAID-supported models. This has included leveraging UNICEF funding to complete the first national curriculum on prevention of parent-to-child transmission (PPTCT) of HIV, to conduct a process evaluation of the CoPCT model and to document the CoPCT to assist in rolling out this model.

This project also supported limited technical assistance to the national integrated behavioral and biological survey, supported by the GoPNG, multilateral and bilateral partners.

There have been clear successes under the project as implemented by FHI 360, including a reduction in both AIDS-related mortality and improvements in follow-up of ART patients at the Lawes Road clinic funded under the CoPCT model. FHI 360 has assisted in the systematic collection of better information to guide the epidemic response, and has piloted a tool for better identifying high-risk individuals for prevention interventions. However, additional work remains to effectively prevent the spread of the HIV epidemic in PNG, and to better care for those who are infected. Provision of ART must be further strengthened, and prevention interventions need to expand better-targeted coverage of high-risk individuals with effective behavior change messages and activities. Stigma and discrimination toward not only MARPs but also PLHIV remain significant challenges as well. FHI 360 and local partners under the program made significant contributions to the national HIV response, and it is hoped that this report offers sufficient evidence for continued support of the USAID model in PNG, so that further progress will be possible.

COUNTRY CONTEXT AND EPIDEMIOLOGY



As of 2011, there were an estimated 34,100 people living with HIV/AIDS in Papua New Guinea, with approximately 0.8% of the population infected.¹ Most-at-risk populations have a higher prevalence ranging between an estimated national average of 4.3% among MSM and 5.9% among FSW,² though this varies considerably by region. In fact, one of the continuing gaps in the country is regular and high-quality HIV, STI, and behavioral surveillance among FSWs and MSMs in key geographic areas. However measured, HIV prevalence in PNG remains the highest in the South Pacific region.

HIV in PNG appears to be driven primarily through unprotected heterosexual sex, which as of 2010 accounted for roughly 47% of all reported cases of infection.² However, in more than half of all reported cases, no possible transmission route was reported, making it difficult to know exactly how people become infected.² A 2010 behavioral surveillance survey (BSS) among FSWs and MSM in the national capital district of Port Moresby (hereafter referred to as 'NCD') indicated that multiple and concurrent sexual partnerships are common among these populations. MSM reported having 2.5 male partners and 2.1 female partners in the past month, and women, an average of 7.5 male partners, of which 4.5 were clients.³

Consistent condom use is low in PNG – 13%-20% among MSM, 30% among FSWs with regular clients, as measured in the above-mentioned NCD BSS – and condom breakages are frequently reported. Anal sex is also common in heterosexual encounters, and is likely a significant driver of the epidemic, given the low rates of condom use.³

Contextual factors in PNG additionally impact vulnerability to infection. Notably, MSM and FSWs drink large quantities of alcohol on a regular basis, and many also smoke marijuana regularly, behaviors which are anecdotally linked to improper condom use.³ Gender-based violence is also widespread – in the 2010 BSS, 63% of FSWs and more than half of MSM reported having been raped in the previous month, often more than once or by more than one person.³

Given high rates of unprotected sex and of sexual violence, it is not surprising that in the 2010 BSS, 40% of MSM and 33% of FSWs reported STI symptoms in the past year. Despite this, 36% of women with symptoms did not seek healthcare services. MSM usually did seek services, but most did not acknowledge their male-to-male sexual behaviors.³ While further investigation is necessary in PNG, research and clinical experience in other settings has demonstrated a link between failure to disclose sexual practices and inappropriate or incomplete provision of clinical services.⁴⁻⁶ Additionally, only 26% of MSM and 33% of FSWs had been tested for HIV within the last year and received their test results.³ Numerous surveys have documented the existence of clinic-based stigma and discrimination toward MARPs – including verbal and physical abuse and denial of services – which is a major barrier to encouraging health service uptake among these populations.^{3, 7-9}

Papua New Guinea's national AIDS response has been overseen and coordinated by the National AIDS Council Secretariat (NACS) since 1997. Annual operational plans are guided by the National Strategic Plan for HIV/AIDS (2011-2015), which has resulted in increased uptake of HCT and access to antiretroviral therapy.⁷ The government also established a provincial-level coordinating mechanism known as ProMEST (Provincial Monitoring and Evaluation Surveillance Team) to enhance reporting of HIV/AIDS programming data. However, HIV prevention continues to be a major challenge; while HIV awareness has increased, the epidemic response has been criticized for failing to address the structural and social factors that affect HIV transmission.⁷

USAID/ FHI 360 PROGRAM STRATEGY

The Technical Support for HIV/AIDS Prevention, Care and Treatment Project was a five-year, (2007–2012) USAID-funded project managed by the FHI 360 Asia-Pacific Regional Office in the region and four countries: China (Yunnan and Guangxi Provinces), Laos PDR, Thailand, and Papua New Guinea. In PNG, FHI 360 has worked to develop a Comprehensive Prevention Package and a Continuum of Prevention to Care and Treatment model designed to increase access by MARPs to comprehensive prevention interventions which are linked to care, support and treatment services. The principal audience for these interventions has been MSM, FSWs and PLHIV, though secondary targets have include high-risk men and women whose behaviors (i.e. multiple and concurrent sexual partnerships) put them at increased risk for HIV infection.

Throughout implementation of the USAID Regional Development Mission Asia (RDMA) project, FHI 360 placed particular emphasis on enhancing intervention quality and sustainability and on documentation and dissemination of lessons learned in order to enhance replication of USAID-supported models.

Strategic objectives

The overall objective of the project was to provide technical support to the USAID HIV/AIDS prevention, care and treatment program focused on MARPs in South East Asia. The specific objectives of the project in Papua New Guinea were to:

- » provide technical leadership and mentorship to improve the planning, collection, analysis, and use of strategic information;
- » increase access to comprehensive prevention interventions for MARPs, including PLHIV and their families, through the CPP model;
- » increase access to care, support and treatment for MARPs, including PLHIV and their families, through the CoPCT model;
- » support coordination of local stakeholders to promote the enabling environment;
- » leverage and harmonize additional donor resources to support the scale up of USG-supported projects

In line with these objectives, the project developed, implemented, monitored, evaluated and replicated innovative models for HIV/AIDS prevention, care and treatment for MARPs and PLHIV in the Port Moresby National Capital District and in Madang Province.

Working with local partners

FHI 360 recognizes that long-term sustainability is contingent upon the buy-in and ownership by local governments, implementing agencies (IAs) and other stakeholders of models and processes developed and supported under the project. Over the life of the project, FHI 360 partnered with those listed below (see Appendix 2 for the Partners List):

Implementing agencies funded through the USAID/FHI 360 Project.

<i>HOPE Worldwide</i>	Through the Helvim Bilong Yumi (“Our Help”) Project (HBYP) in Port Moresby, HWW provided HIV and STI clinical services and MARP-oriented HIV prevention work in communities and hotspots. HWW operated the two CoPCT clinics, 9 Mile and Lawes Road, where referrals for MARPs are made through the CoPCT
<i>National Capital District Provincial AIDS Committee (NCD PAC)</i>	The NCD PAC led province-wide CoPCT coordination and chaired the CoPCT Coordination Committee
<i>Madang Provincial AIDS Committee (Madang PAC)</i>	The Madang PAC led province-wide CoPCT coordination and chaired the CoPCT Coordination Committee
<i>People Living with Higher Aims (PLWHA)</i>	This community based organization convened the PLHIV support group in Madang and conducted prevention activities with MARPs for the CoPCT component in Madang
<i>Papua New Guinea Red Cross Society, NCD/Central</i>	The Red Cross Society conducted prevention outreach for MARPs with self-care training for PLHIV in NCD and Central provinces in FY08
<i>National Spiritual Assembly of Bahai’s</i>	Through the Sirius Naraq Project, this partner conducted prevention outreach for adults, youth and PLHIV in NCD and Central provinces in FY08

FHI 360 worked with a wide range of local partners under non-USAID cooperative agreements which effectively leveraged funding to strengthen and expand services available under the CoPCT model.

Building capacity through technical assistance

Throughout the project, FHI 360 worked to strengthen the capacity of local implementing agencies to deliver high-quality, effective HIV prevention, care and support services. Technical assistance (TA) delivered by FHI 360 included:

- » formal trainings using empowerment-based, participatory adult education methodologies,
- » exposure visits,
- » sub-grant provision,
- » on-going mentorship and supervision
- » standard operating procedures (SOPs), guidelines, and information, education and communication tools

FHI 360 has taken a “cascading” approach to the provision of TA, so that over the course of the project, local partners have transitioned from recipients of support to recognized technical experts capable of providing TA to other local organizations in their own right. For instance, an STI nurse with the HBYP clinic at Lawes Road in Port Moresby helped provide training and sensitization on sexual health issues for MARPs to staff and outreach volunteers at the Sirius Naraq Foundation. The ART nurse at the Lawes Road clinic conducted an in-service training on basic HIV/AIDS care for the medical unit staff at Port Moresby General Hospital. The ART prescriber at the 9 Mile Clinic also provided in-service training for the same staff on STI, and assisted with a workshop for HIV counselors and ART prescribers organized by NCD Health Services. Complementing technical capacity is the building of organizational capacity to develop, monitor and manage programs independently, which positions them to be strong candidates for other sources of funding. In Madang, the Provincial Health Office provided additional funding to PLWHA to continue their work and expand their reach. These examples are capacity building of local staff and organizations to both provide expertise locally and to continue programs.

Tools development

Over the course of the project, FHI 360 supported the development and/or adaptation, in collaboration with local partners, of numerous tools, checklists and SOPs. A “decision tree” tool (see Appendix 3) helped outreach volunteers to make culturally sensitive judgments regarding who was (or was not) a member of a high-risk group, and FHI 360 supported development of some of the first MARPs-targeted IEC materials in PNG. HIV service information booklets and tracking logs helped increase successful referral to clinical service providers, and quality assurance/quality improvement checklists helped ensure provision of high-quality, appropriate services when clients arrived.

Tools were developed in support of the institutionalization, dissemination and replication of HIV prevention, care and treatment approaches piloted under the project. As such, tools developed under the project were shared within PNG at the request of government partners and/or other funding agencies.

1 | STRATEGIC
INFORMATION
MADE MORE
AVAILABLE AND
USEFUL

STRATEGIC INFORMATION MADE MORE AVAILABLE AND USEFUL

A great deal of effort has been put into strengthening the national surveillance and M&E systems in PNG; however, there is currently no combined biological and behavioral surveillance in place for monitoring the epidemic among most-at-risk populations. Without this systematic surveillance in place^A it has been challenging for the government and its partners to know epidemic and behavioral trends and whether interventions have been efficiently targeted enough in key MARP groups.

Additionally, where data are available, there is limited capacity at the implementation level to use this data to drive program planning and service delivery.

Strategic information is therefore needed to improve the evidence base for decision making, and systems must be strengthened to collect, analyze, utilize, and disseminate that data. Over the course of the project, FHI 360 has worked to build a robust evidence base for data-driven intervention planning and management, and to strengthen M&E systems at the national and program levels to guide policies and resource allocation.

Strengthening the Evidence-base for the Epidemic Response

Planning for HIV interventions among MARPs in PNG has been complicated by a relative lack of information regarding key risk behaviors among most-at-risk populations, including FSWs and MSM. FHI 360 addressed this situation through implementation of a Behavioral Surveillance Survey using respondent driven sampling in 2010 among 302 MSM and 283 FSWs in NCD. Key findings from this survey included:

- » high levels of heterosexual anal sex,
- » high rates of condom breakage,
- » high rates of discrimination and gender-based violence, and
- » a lack of awareness among women of condom use as an HIV prevention strategy.

FHI 360 has widely disseminated the results of the 2010 BSS, and used the results to refine intervention strategies for MARPs by, for instance, ensuring that effective condom use is demonstrated and practiced during outreach education, redoubling condom promotion efforts among women, and

^A FHI 360 currently plans to provide technical assistance for the systematic collection of surveillance data under the USAID-supported follow-on MARPs project awarded in 2012



BEHAVIORS KNOWLEDGE EXPOSURE TO INTERVENTIONS

Behavioral Surveillance Survey
Port Moresby, Papua New Guinea
MAY 2011

SUMMARY

In November and December 2010, USAID funded FHI to conduct a behavioral surveillance survey (BSS) among men who have sex with men (MSM) and women engaged in transactional sex in Port Moresby, Papua New Guinea. The survey aimed to provide information in order to better understand how HIV is transmitted in the country, how transactional sex contributes to the HIV epidemic, and to help assess the outcomes of HIV outreach and prevention efforts.

The results of this BSS are noteworthy in that they support evidence of high-risk behaviors collected during previous studies and surveys. As reported elsewhere, for example, this BSS found a high degree of violence towards MSM and women, particularly by family members or people known to the participant; a lack of fixed venues for sex work; greater awareness of HIV transmission from mother to child than through unprotected sex; and low levels of condom use with both partners and clients.

Equally important for future programs, however, are high risk behaviors and new trends such as high levels of anal sex among both sexes; the purchase of anal sex by women; a significant population that had never used latex condoms; the refusal of care providers to deliver services to women that sell sex; and a high prevalence of penile modifications.

METHODOLOGY

The BSS targeted two distinct risk populations: MSM and women engaged in transactional sex. Respondent-driven sampling (RDS) was used to survey 285 MSM and 288 women. Selection criteria included being between 15 and 49 years old, having lived in Port Moresby for at least 12 months, not being under the influence of alcohol or drugs at the time of the interview, and having a valid permanent address for MSM eligible participants had to have had anal sex with at least one man in the past 3 months; the women they had to have conducted sex for money or goods with at least 2 men in the past 7 days.

This report and the findings described herein were funded by USAID Regional Development Mission and are consistent with USAID's technical assistance and support provided to PNG under the October 2009 AID 007 00001 001. The data were collected by the Behavioral Surveillance Survey team at FHI 360, supported by the United States Agency for International Development, the United States Government, and the Papua New Guinea Government. The findings are those of the authors and do not necessarily reflect the views of the USAID or the United States Government.

facts@a glance

ANAL SEX WITH HETEROSEXUAL SEX

- 71% of MSM had anal sex with their female partners in the past month
- 51% of women had anal sex with their male partners in the past month

SEXUAL VIOLENCE

- 81% of MSM were sexually abused in the previous year
- 81% of MSM had been cut or scratched in the previous month
- 81% of MSM had been cut or scratched in the previous year
- 81% of women were sexually abused in the previous year
- 81% of women were sexually abused in the previous month

STI

- 81% of MSM had STI symptoms in the previous year
- 81% of women had symptoms of STI in the previous year
- 81% of women had symptoms of STI in the previous month

USE OF ANAL LATEX CONDOMS

- 81% of MSM used 100% latex condoms in the previous month
- 81% of MSM used 100% latex condoms in the previous year
- 81% of women used 100% latex condoms in the previous month
- 81% of women used 100% latex condoms in the previous year

DISCRIMINATION AND STIGMA

- 81% of MSM were discriminated against by their family, friends, or community
- 81% of women were discriminated against by their family, friends, or community

including trauma counseling in the project for gender-based violence (GBV) survivors. Based on BSS results, FHI 360 and USAID have also begun to re-conceptualize sex work in the context of PNG, where the majority of so-called “FSWs” engage in periodic, opportunistic transactional sex rather than engaging in sex work as a long-term economic strategy.

At the time of this report, a separately-funded national IBBS was in process, also managed by FHI 360 with financial support from multiple partners including the World Bank, Asian Development Bank, AusAID, the New Zealand Agency for International Development and USAID RDMA. This large-scale survey will substantially contribute to a fuller understanding of the HIV epidemic and its correlates.

Recognizing the need to identify and reach high-risk populations in those locations where they seek sexual partners and may be open to receiving HIV prevention information and services, FHI 360 also provided technical assistance for local partners in NCD and Madang to conduct mapping of MARPs hotspots. Information on where and at what times MARPs can most effectively and efficiently be reached helped to improve the target of intervention activities when the project’s prevention strategy was redesigned in 2010.

Enhanced Monitoring and Evaluation

Most-at-risk populations in PNG are poorly codified and do not congregate in segregated and easily identifiable venues (brothels, gay bars, bath houses etc.) as is the case in many Southeast and East Asian settings. Thus a key difficulty for interventions targeting MARPs has been accurately identifying and reaching out to the right individuals, which resulted in skewed monitoring and evaluation data. In addition to mapping “hotspots,” FHI 360 convened local stakeholders, including representatives from GoPNG and UNAIDS, to standardize operational definitions for MARPs, which were used to develop a “decision tree” flowchart that accurately classifies project clients into the appropriate target population. Successful implementation of this tool helped staff to deliver properly targeted interventions and rationalized reporting of project data. The outcome was that the total number of persons reached by FHI 360 implementing agencies (IAs) declined; however, the persons reached were of higher risk and thus a more efficient intervention target.

BEHAVIORS KNOWLEDGE EXPOSURE TO INTERVENTIONS



Report from
A BEHAVIORAL SURVEILLANCE SURVEY
PORT MORESBY, PAPUA NEW GUINEA
MAY 2011



FHI 360 also supported implementation of TRENDS (Tracking Exposure Knowledge and Behavior) modules on HIV, malaria, tuberculosis, reproductive health and GBV monitoring in community settings and hotspots. The goal is to monitor trends in intervention exposure, knowledge, behaviors, and service utilization among project beneficiaries. This information can be used to evaluate project effectiveness and to inform intervention design and targeting.

Finally, FHI 360 provided technical assistance on M&E principles, data use and data analysis for improved programming for the National AIDS Council Secretariat (NACS) and PACs, IAs, and the Provincial Monitoring and Evaluation Surveillance Team (ProMEST) in Madang and NCD. FHI 360 staff participated in the national surveillance and M&E technical working group (TWGs) and the Research Advisory Committee, and shared data regularly with the GoPNG, AusAID, other donors and implementing partners.

Strategic Information for Clinical Service Strengthening

FHI 360 provided technical assistance to clinical service providers under the CoPCT model to collect, analyze and use data to improve service quality and increase successful service referrals. This included supporting data quality assessments and clinical quality assurance/quality improvement assessments at Lawes Road and 9 Mile clinics in NCD and the Id Inad clinic in Madang. Regular data quality assessments helped improve the quality of clinical data and manual records were converted into retrospective electronic data basis covering data from 2009 to 2012 to make analysis simpler giving concurrent feedback into improving programs.

An HIV service information booklet, the first of its kind in PNG, was developed with FHI 360 support to assist service providers in NCD and Madang in informing clients of the range of available services. The booklets helped to strengthen referral linkages, and have been described as invaluable by many key stakeholders, including government organizations.

2

ACCESS TO
COMPREHENSIVE
PREVENTION
INTERVENTIONS
FOR MARPS
INCREASED

ACCESS TO COMPREHENSIVE PREVENTION INTERVENTIONS FOR MARPs INCREASED

The USAID RDMA project established a comprehensive prevention package (CPP) model to provide key HIV prevention services to those populations most at risk of becoming infected with HIV or of spreading their infection to others so as to avert the maximum number of new infections. In Papua New Guinea, the CPP included behavior change communication delivered by teams of trained peer educators and outreach volunteers, distribution of condoms and lubricant, HIV counseling and testing and diagnosis and treatment of STIs. These interventions were linked to treatment, care and support for PLHIV through HCT and STI services.

Under the project, FHI 360 provided technical support and mentorship to deliver HIV prevention interventions under the CPP model to Hope Worldwide for the HBYP Project in NCD, the PLWHA group in Madang, and the NCD and Madang PACs. In developing the CPP, FHI 360 worked closely with the GoPNG, AusAID, the Asian Development Bank and other donors to implement key HIV prevention activities.

Behavior Change Communications

FHI 360 supported local partners in NCD and Madang to deliver targeted BCC messages for MSM and FSW through trained peer educators (PEs) and outreach volunteers (OVs). Activities included provision of prevention services for MSM and FSW in so-called “hotspots” (bars, nightclubs) where MARPs go to meet sexual partners. FHI 360 additionally provided services for high-risk men and women (HRM and HRW) in community settings (settlements) who report unprotected vaginal and anal sex with multiple and concurrent partners but who do not fall under the MARPs framework as traditionally defined. This innovation was necessary because the key behaviors driving HIV risk in PNG are not necessarily linked to self-reported identity as is the case in other settings in Southeast and East Asia.



HBYP outreach volunteer working in the communities

Key technical support from FHI 360 for implementation of BCC activities included assistance in designing a “decision tree” tool used by PEs and OVs to accurately identify members of target populations. FHI 360 staff helped to design and pre-test the tool, revised it to fit the local cultural context, and trained project staff in its use.

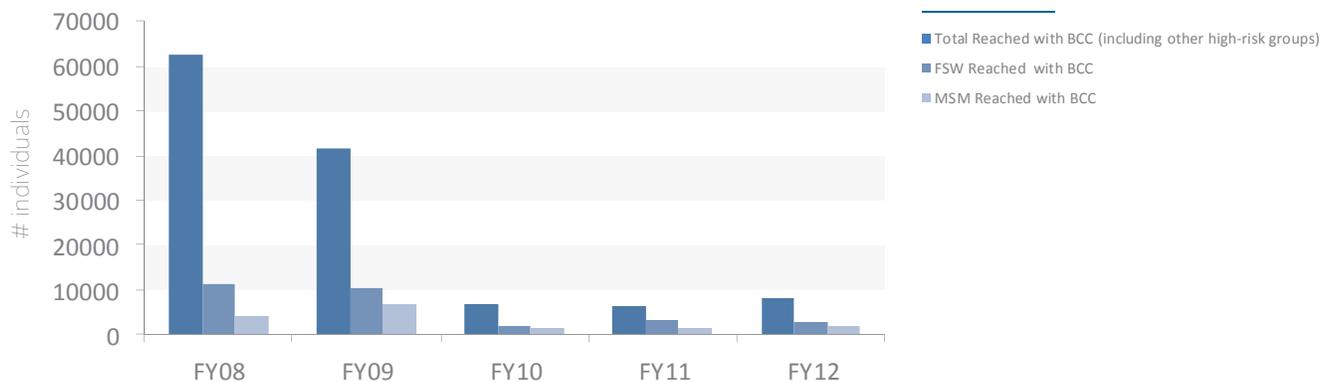
FHI 360 also assisted local partners to conduct mapping of MARPs hotspots in NCD and Madang, and in designing outreach strategies and “edutainment” activities appropriate for these venues. Following the mapping exercise, project activities were split between hotspot-based activities conducted by MSM and FSW peer educators, and regular outreach to HRM and HRW in community settlements conducted by outreach volunteers.

To better guide BCC activities, FHI 360 staff worked with local partners and community representatives to design a strategic behavioral communications (SBC) plan, which included audience segmentation, communication objectives, channels of communication, and key monitoring indicators. Messages aimed at increasing consistent condom use and access to HIV testing were developed and pre-tested, and communication materials such as posters, coasters, tote bags, and t-shirts were developed to promote consistent condom use and HIV testing. As part of the plan, FHI 360 staff facilitated monthly refresher trainings for PEs and OVs in response to their demand for more extensive knowledge about HIV and related health issues.



HBYP volunteer demonstrating female condom at ATS settlement (Port Moresby)

Chart 1 – Individuals reached with BCC interventions, FY08-FY12



settlement-based OVs, and has negotiated with venue owners/ managers to ensure that the dispensers remain stocked.

Over the life of the project, FHI 360-supported implementing agencies worked with more than 160 targeted and non-targeted condom outlets, and distributed more than 1.6 million male latex condoms (branded and non-branded). The project additionally distributed approximately 84,364 female condoms. Because the BSS conducted by FHI 360 in NCD showed unexpectedly high levels of reports of condom breakage, peer educators and outreach volunteers were also trained and monitored to ensure that they conducted accurate and effective condom demonstrations as part of the regular outreach education activities.



Doing condom demonstration to MARPS

Integrating Prevention into Care and Support Services

FHI 360 also worked to integrate prevention services into existing treatment, care and support interventions, both as part of the CoPCT model and also in partnership with other organizations conducting care and support work with non-USAID funding. In Madang, FHI 360 worked with PLWHA to set up condom outlets and condom dispensers in five CHBC sites. In NCD, FHI 360 facilitated a joint mapping project in seven communities where the Sirius Naraq Foundation (SNF) received AusAID funding to conduct community and home-based care activities; as a result, FHI 360 placed condom dispensers in 10 CHBC sites, conducted sensitization meetings on prevention programming with community leaders in those sites, and worked with HBYP to place 10 outreach volunteers with SNF CHBC teams to better reach high-risk men and women in community settings.

Diagnosis and Treatment of Sexually Transmitted Infections

Over the life of the project, FHI 360 provided technical assistance through training and ongoing mentorship in STI management for healthcare staff from the Lawes Road and 9 Mile clinics in NCD, the Id Inad clinic in Madang, and other clinics linked with the CHBC program.

Trainings focused on providing MARPs-specific sexual health services and strengthening linkages between STI and other health care services including HIV treatment, care and support. Training methodology included classroom instruction as well as in-service

As can be seen in Chart 1 above, implementing agencies reached a large number of unique individuals with BCC interventions in FY08-FY09; but, with the introduction of the decision tree tool in FY10, program coverage declined significantly. However, new monitoring and evaluation data collected using the decision tree is considered to be a more accurate reflection of the true profile of high-risk behaviors in the community. This is appropriate given the focus of the project on reaching most-at-risk populations. From FY10-FY12, when M&E data were better rationalized, total number of BCC encounters increased 23% (from 6,344 to 7,827) while the number of FSWs and MSM encounters also increased, by 66% and 45% respectively. Following introduction of the decision tree, MSM and FSW also accounted for a greater proportion of all BCC encounters (from 24% in FY08 to 56% in FY12).

Peer Support and Resource Centre

In FY12, FHI 360 worked in partnership with PLWHA in Madang to establish a Peer Support and Resource Centre (PSRC). The PSRC is an important “safe space” for MARPs interventions, because of the higher levels of stigma and subsequent invisibility of MARPs in Madang. The venue functions as a platform for delivering health education messages through one-on-one and small-group interventions, hosting peer support meetings, and facilitating referral to health care services.

FHI 360 supported PLWHA to create a detailed work plan for the PSRC, develop key messages for MARPs, and prepare a fact sheet to sensitize service providers and the local population to the services at the PSRC and the importance of MARPs-specific work.



1taim U condoms available at the FHI 360 World AIDS Day stand, 2012

Condom Promotion

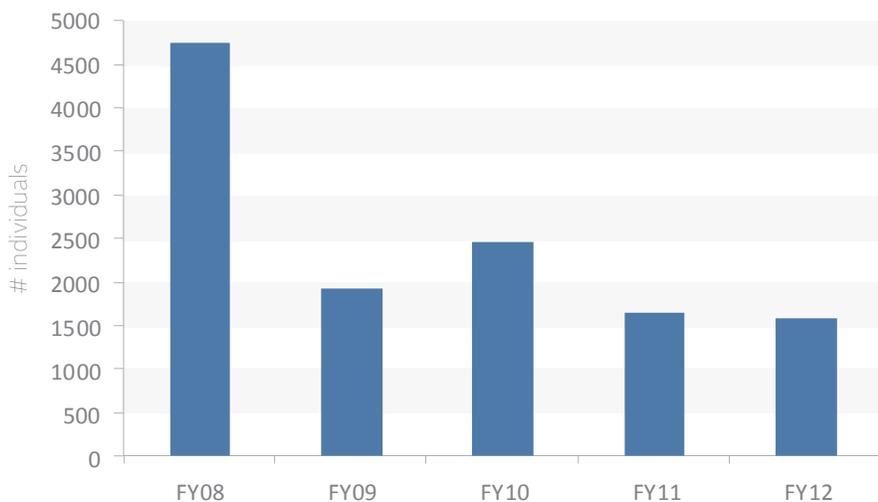
Based on the results of the 2010 BSS in NCD, which showed low levels of consistent condom use, FHI 360 developed a new brand of men's condom, called *1 taim U: blotrupla man* (*With you: for real man*) using condoms donated by USAID. The package contains four latex condoms and two sachets of water-based lubricant. Branded condoms have been distributed through partner clinics and during outreach exercises in hotspots and community settlements. The project has also installed free condom dispensers, donated by NACS and branded with *1 taim U* stickers, in bars, nightclubs, small shops, and hotels and has established condom outlets in the homes of

training and engaged mentoring on performing male and female genital examination, including proctoscopy/anoscopy, speculum examination, and bimanual examination for diagnosing bacterial and viral STIs including Pelvic Inflammatory Disease. Syphilis testing was promoted using rapid tests and on-site serology monitoring.

Labs were also strengthened for delivering an expanded STI syndrome management approach for MARPs. Internal and external quality assurance was implemented with linkages with the Central Public Health Laboratory (CPHL).

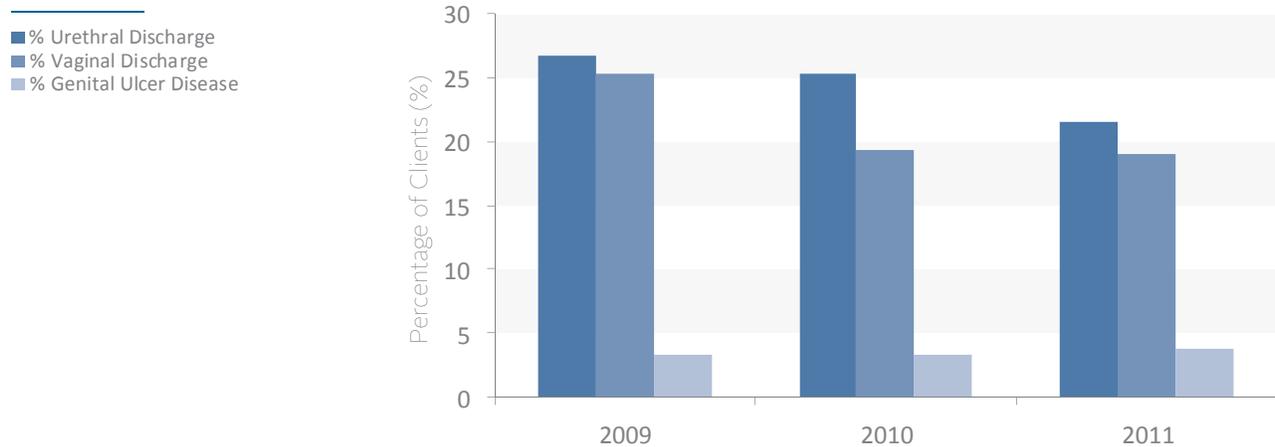
Under the project, FHI 360 supported provision of STI diagnosis and management services to an average of 2,465 clients per year (see Chart 2, below). This average is skewed by the high number of clients served in FY08 – the subsequent decline in service uptake may be attributed in part to the reduced number of individuals (both MARPs and high-risk general population) reached which BCC interventions following introduction of the decision tree tool. In addition, security concerns in the communities where clinical services were located resulted in repeated clinic closures in 2010 and 2011. Finally, it should be noted that clinics reported only those individuals screened AND treated for STIs – numbers below therefore do not reflect individuals without STI symptoms who received a check-up but did not require treatment. In order to assure that quality assurance/quality improvement

Chart 2 – Individuals provided with STI diagnosis and treatment, FY08-FY12



(QA/QI) are integral parts of STI service provision, a performance standards tool was piloted in the two NCD clinics in FY12. The tool focused on STI management for MSM and FSW and included management of asymptomatic STIs, presumptive treatment for gonococci and chlamydia, conducting internal examination and promoting regular health checkups once a quarter to align with the Clinical Operating Guidelines (COGs). STI syndromic management amongst MARPs including one-time presumptive treatment was also rolled out. A retrospective analysis of some trends for specific STI syndromes was carried out showing that, while there was no decline in genital ulcer disease, there was some decline amongst Lawes Road clinic attendees in vaginal and urethral discharge (see Chart 3, below).

Chart 3 – Percent of clients with STI syndromes, Lawes Rd. Clinic 2009-2011



FHI 360 also played a proactive role in the establishment of the STI TWG which met for the first time in April 2011, and assisted HBYP to establish a syphilis case management team at the two NCD clinics, which resulted in a reduction in loss to follow-up from 80% to 33%.



9 Mile Clinic, Port Moresby

HIV Counseling and Testing

HCT is a key entry point into treatment, care and support services for PLHIV and thus the linchpin of “test and treat” prevention strategies. Under the RDMA project, FHI 360 conducted training on HIV counseling for MSM and transgender (TG) people for 36 counselors from government and non government HCT centers in NCD and Madang. Many of the HCT counselors from the nonUSAID/FHI 360- funded HCT sites had never been trained on counseling for MSM and TG people before this training. This training was followed by a MSM sensitivity and awareness workshop for clinicians.

The National Department of Health (NDoH) evaluated the content of the FHI 360 trainings and agreed to modify it to fit the PNG content and include it in the national HCT training manual. FHI 360 also developed tools to support provision of high-quality HCT services, including pre- and post-test risk assessment forms which were piloted at four clinical sites in FY12.

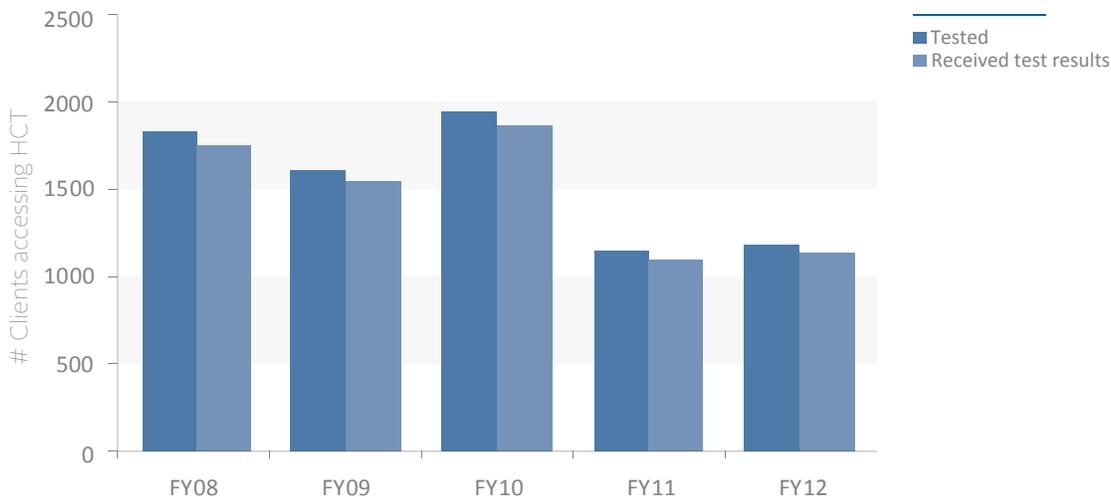
FHI 360 also worked with NCD health services to streamline HCT quality assurance and quality improvement measures in NCD by conducting routine quality monitoring of 16 HCT services centers in the province.

Also in FY12, and in close collaboration with NDoH and the PHOs, FHI provided technical assistance in the roll out of a new HIV testing algorithm which enables on-the-spot delivery of a confirmed test result using the Clearview® HIV 1/2 STAT-PAK® assay manufactured by Alere. The algorithm, which reduces what was formerly a two- to three-week wait for a confirmatory test result to within 30 minutes was piloted tested in the HBYP clinics at Lawes Road and 9 Mile before being rolled out nationwide. Following training, FHI 360 also supported the Madang PHO to roll out of this algorithm to various testing sites in Madang province, in collaboration with Laboratory manager from the Modilon Hospital and an officer from the Disease Control section of the PHO. The new algorithm was rolled out in five HIV/AIDS testing sites in Madang during this time: Topo Health Centre (Gusap), Ena Clinic (Bogia), Malala VCT centre (Sumkar), Gaubin Hospital, Miak Health Centre (Sumkar).

In order to improve coordination and collaboration between HCT services, in FY10 FHI 360 worked with the NCD PAC to establish a VCT Counselors Network. The network included staff of the FHI 360-supported sites at Lawes Road and 9 Mile, as well as other government-supported VCT centers. Meetings were held quarterly, and served as a forum to discuss issues including patient management, referral between sites, and creation of a standardized referral card. The network also provided a platform to conduct an assessment of all VCT service sites in NCD, for which FHI 360 provided technical assistance. This network has now been formalized under the NCD PAC, which continues to chair regular meetings.

While improved provision of HCT services has been a key focus of technical assistance under the project, FHI 360 also worked with local partners to strengthen service demand. This included convening a meeting with clinicians in FY11 to identify perceived barriers to testing, and strengthening VCT promotional efforts. The re-designed SBC strategy included a major component on VCT promotion, and FHI 360 also worked with higher levels of government to produce a billboard featuring the NCD governor encouraging people to know their HIV status. The billboard was installed in a high-visibility spot in NCD and the key message was disseminated through numerous media outlets including through distribution of branded IEC such as tote bags and t-shirts.

Chart 4 – Clients provided with HCT services, FY08-FY12



From FY08 to FY12, FHI 360-supported HCT service sites provided counseling and testing for an average of 1,536 clients per year (see Chart 4, above). Loss to follow-up never exceeded 4%. In 2010 at the Lawes Road clinic in NCD a total of 47 positive cases (7.58%) were detected among women, while 34 cases were detected among men (7.91%). These numbers are consistent with low-end estimates of HIV prevalence among MARPs in NCD calculated as part of the 2010 BSS, which based on participant self-report estimated HIV prevalence among MSM to be between 9-40% and among women engaging in transaction sex to be between 8-27%. At the Id Inad clinic in Madang, an average of 11.9% of men (5.0%-18.4%) and 29.6% of women (9.2%-27.0%) were tested positive for HIV each calendar year between 2007 and 2010.

While HCT services have been successful at identifying HIV-positive cases, a key shortcoming under the project was that specific MARPs populations remained a minority among HCT clients, and in fact declined from accounting for 42% of all HCT clients in FY08 to 10% of all clients in FY12. Further investigation is necessary to determine effective methods of increasing service uptake among FSWs and MSM.

SUCCESS STORY

COMPREHENSIVE HBYP SERVICES ARE “SECOND TO NONE.”

Star Gabari (not her real name) is one of the longest-serving outreach volunteers at the Helvim Bilong Yumi (“Our Help”) Project (HBYP) supported by FHI 360 under the USAID RDMA project. She is one of the more vocal members of the outreach team, and is passionate about her job helping women who engage to transactional sex to stay healthy and prevent HIV. But she wasn’t always this way - Ms. Gabari remembers a time when she didn’t want to hear anything the HBYP workers had to say.

Ms. Gabari first came to live with relatives in Port Moresby after her husband, a policeman, died. She found life in the capital to be difficult, so she began selling goods at the market during the day and engaging in risky behaviors like heavy drinking and unprotected sex in the evenings, sometimes with as many as five or six different partners in a week. It was during one of these nights out that Ms. Gabari first met members of the HBYP outreach team.

“I ignored their advice the first time they contacted me,” Ms. Gabari remembers. “It took some time for them to convince

me to go to Lawes Road for a health check.”

Having eventually agreed to receive services at the Lawes Road clinic, supported by the project, Ms. Gabari is well-suited to promote those services to other women in Port Moresby. She has learned a lot about HIV and STIs, and as a member of the HBYP outreach team she has referred thousands of her peers for HIV testing and STI diagnosis/screening.

The HBYP outreach team works in communities and it so-called “hotspots” like bars and night clubs to conduct behavior change communications with people at high risk of becoming infected with HIV. Outreach team members include volunteers and peer educators, who reach out to their peers to promote consistent condom use and uptake of clinical services for STIs, HCT and OI/ART. Target populations include men who have sex with men, transgender people, women engaging in transactional sex and other high-risk men and women including clients of sex workers and women whose husbands have other partners. As a member of the HBYP team,

Ms. Gabari received training from FHI 360 on HIV/AIDS and other STIs, communication skills and behavior change techniques, and the use of communication tools such as the decision tree and HIV risk cards. “The HBYP project has really changed my life, my personality,” she explains. “The language I use, the way I dress – it has all changed. People respect me more nowadays.”

Ms. Gabari speaks very highly of the USAID-funded services, noting especially that under the project, HBYP is providing a comprehensive package of coordinated services: “We do prevention, care and support, treatment and even tracking of clients for follow-up.”

“The beneficiaries are very happy with the quality of HIV/STI service provided by our clinics,” she says. “The clients have only to pay for the bus fare, everything else including laboratory tests are free of charge ... My clients believe that HBYP services are second to none.”

3

ACCESS TO
CARE, SUPPORT
AND TREATMENT
FOR PLHIV AND
THEIR FAMILIES
INCREASED

ACCESS TO CARE, SUPPORT AND TREATMENT FOR PLHIV AND THEIR FAMILIES INCREASED

FHI 360 recognizes the intrinsic link between HIV prevention and services for PLHIV, who require life-long, comprehensive care, support and treatment services. Under the USAID project in PNG, FHI 360 supported the development of a Continuum of Prevention to Care and Treatment model that links and consolidates prevention, care and support, and treatment services to ensure a strong continuum of care for those at risk for, living with or affected by HIV. In order to establish the CoPCT, the NDoH and FHI 360 worked with local authorities in NCD and Madang to identify service gaps and areas that needed to be strengthened, and the strengthened the capacity of selected health facilities, PLHIV support groups, NGOs, and faith based organizations (FBOs) to provide comprehensive, quality HIV/AIDS prevention, care, support and treatment services and referrals.

Services included under the CoPCT model include diagnosis and treatment of tuberculosis (TB) and opportunistic infections (OI), ART, family planning, reproductive health, antenatal care services, PPTCT, in-patient, laboratory, pharmacy, nutrition, family violence, income generation, and community and home-based care. FHI 360's role in this model was to:

- » provide technical support for establishing the CoPCT at national and provincial levels;
- » establish a referral mechanism and strengthen linkages between services;
- » strengthen capacity of partner organizations to use provincial M&E data for project planning and improvement;
- » ensure appropriate PLHIV input into CoPCT services; and,
- » develop an SBC plan and support the development of IEC materials.

Assessing care needs

In collaboration with the other members of a joint NDoH/US Government stakeholder team^B, FHI 360 in FYO8 conducted a site assessment in the Eastern Highlands and Madang province. The goals of this survey were to map existing services and identify service gaps, determine local implementation partners responsible for filling those gaps, and review existing services, and design strategies for ensuring effective linkages between different service providers. The assessment included a desk review, meetings with key government and community partners,

^BThe team comprised representatives from the US Government (USAID and US CDC), Government of Papua New Guinea (NAC Secretariat and PAC Secretariat), international organizations (FHI 360, WHO, Clinton Foundation, and UNAIDS), PLHIV support groups (PLWHA and Ikat Hope) and AusAID.

interviews with PLHIV, their families, and service providers, and a review of existing coordination mechanisms.

Following this assessment, a report on assessment findings and recommendations for establishing the CoPCT model was presented to the Government of PNG and key stakeholders.

CoPCT coordination and linkages

In order to build support and buy-in for the CoPCT model, FHI 360 sponsored a study tour to Cambodia to learn from the nationwide Continuum of Care model in that country. FHI 360 also hosted orientation workshops to inform and sensitize all partners at national, provincial and district levels, and to plan CoPCT activities.

Continued consultations with PACs and provincial health offices (PHOs) and key stakeholders culminated in the establishment of the provincial CoPCT-Coordination Committees (CoPCT-CC) by PAC/ PHO and FHI 360 in NCD and Madang. These committees were responsible for improving coordination and referrals across services, conducting annual joint planning, and providing a discussion forum through monthly meetings. The CoPCT-CCs had a diverse membership of public and private sector bodies (PACs, PHOs) and private companies (including fisheries, transport companies, and hotels), health workers, PLHIV partners, NGOs, FBOs and CBOs. The CoPCT-CCs also employed local coordinators; who, with technical support from FHI 360, provided guidance in strengthening the CoPCT partnership and coordination with the key stakeholders.

FHI 360 also worked with the CoPCT-CC to conduct a mapping exercise to enumerate existing services in the CoPCT sites, and helped to design a service information booklet, the first of its kind in PNG, to assist service providers in making successful referrals. The booklets have been widely adopted and described as invaluable by many key stakeholders, including government organizations.

Ensuring quality of clinical service provision

Under the CoPCT model, FHI 360 supported the strengthening of clinical care services in NCD (Lawes Road and 9 Mile clinics) and Madang (ART clinic at Modilon Hospital). FHI 360, in collaboration with the NDoH, has conducted in-service training and providing mentoring support for health workers in a number of areas,



Outreach and CHBC - KarKar Island



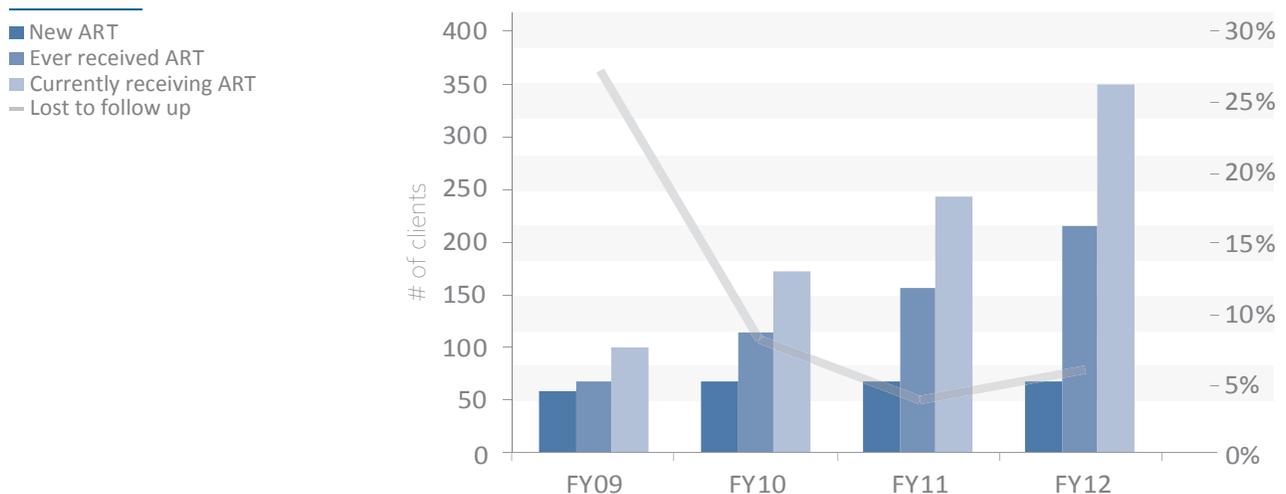
Client flowcharts for ART and OI-ART

including family planning, vital signs collection training, standard precautions, infection control, occupational health and safety, blood borne pathogens, pulmonary tuberculosis, and HIV post-exposure prophylaxis. FHI 360 staff also conducted mentoring and coaching through one-to-one direct observation with all health care providers (physician, STI nurse, lab technician, case management team, and receptionist) focused on process improvements, physical examination techniques, differential diagnosis formulation and treatment algorithms.

In addition, FHI 360 supported facilities in developing clear client flow diagrams and Standard Operation Procedures at the HIV clinics, and provided direction on the use of medical forms. FHI 360 also helped establish a system at the three clinics to streamline patient flow, to organize filing of medical records and to create a coding system.

From FY09-FY12, FHI 360 supported the provision of non-ART clinical services (including OI treatment and prophylaxis and TB/HIV services) for an average of 258 PLHIV patients per year. Under the CoPCT model, FHI 360 also supported 267 new PLHIV to initiate ART between FY09 and FY12 and the number of clients currently receiving ART increased 211% from 71 in FY09 to 221 in FY12 (see Chart 5, below). In July 2012, FHI 360 conducted QA/QI as part of the CoPCT process evaluation and reviewed electronic data base and clinical records of 184 ART clients. Mortality rates decreased from 56.5 per 100 person years (PY) in 2008 to 20.5 per 100 PY in 2009, 13.6 per 100 PY in 2010, and 6.8 per 100 PY in 2011 (Hazard Rate= 0.1, $p < 0.001$).

Chart 5: Provision of ART services, FY09-FY12



In order to facilitate sharing of experiences and lessons learned, NDoH and FHI 360 also established an HIV clinician network in NCD that meets quarterly for case discussion, and in 2009, the Momase Regional STI/HIV medical officer and FHI 360 established an HIV clinical response committee at Modilon General Hospital in Madang province. This committee comprises key staff in each hospital unit/ward and acts as a forum for staff to discuss problems and ideas and to provide feedback to hospital management staff.

Reduction in loss to follow-up is a key indicator for the CoPCT model, and the broad collaborative nature of the CoPCT has resulted in a number of improvements in retention in care. Key among these improvements had been the introduction of Case Management Teams (CMTs) comprised of doctors, nurses and HIV-positive case managers to deliver care, treatment, and support to PLHIV. CMTs are critical to CoPCT implementation in the context of a weak health system and complicated mobility patterns. These teams provide crisis support, adherence counseling, positive prevention and tracking of patients lost to follow-up and spread the roles and responsibilities among a wider group of providers.

FHI 360 provided technical assistance for the training of CMTs through the HBYP project in NCD and Modilon Hospital in Madang. Upon HIV diagnosis, PLHIV are linked to CMTs who lead them through pre-ART counseling, baseline tests, and opportunistic infection treatment and prophylaxis. CMTs ensure that PLHIV patients are followed-up at regular intervals through home and clinic visits, and - among those on ART - monitored and provided with adherence counseling. Adherence support within the CoPCT model involves trained counselors, adherence plans, and a treatment assistant who is someone living in the household of the PLHIV patient. Every PLHIV patient is encouraged to form a special bond with their case manager, some of whom are also PLHIV.

FHI 360 also provided support for the successful implementation of monitoring tools to support adherence counseling, the use of tracking logs to monitor client appointments, the use of HBYP patient trackers, and guidelines on managing loss to follow-up. CMT staff additionally built referral linkages with community and home-based care services supported by FHI 360 in CoPCT sites but fully funded under the Australian Agency for International Development (AusAID).



Community mobilization

As a result of technical assistance from FHI 360, the loss to follow-up rate for patients on OI medication and/or ART at the two NCD clinics decreased from 38% in 2008 to 5% in 2011. The loss to follow-up rate at the Id Inad Clinic declined from 14% to 1% between 2008 and 2011. Additionally, among the 122 PLHIV clients who initiated ART during the project period 95% adherence to ART increased from 58.8% to 75.1% (p=0.027). The UNAIDS Global AIDS Response 2012 report for Papua New Guinea included the contribution of CMT model in reducing mortality as a best practice example and USAID also reported this best practice in their newsletter.

Responding to drug stock-outs

FHI 360 assisted the NDOH during the national stock out of ARV in the beginning of May 2012 by carrying out close supervision and capacity building of clinicians in the three CoPCT ART clinics. Capacity building focused on supporting clinical staff to change the first line ART drugs regimes, look at immediate side effects, and implement the needed emphasis on adherence counseling while changing treatment regimens. In June 2012, FHI 360 trained and built capacity of HBYP clinicians to address issues related to a change in regimes including opportunistic infections, ART management, and monitoring of complications as a result of switches in primary regimens.

Enhancing involvement of PLHIV

Strengthening involvement of PLHIV in the provision of care and support services for HIV-positive patients is a key goal of the CoPCT model. FHI 360 has supported PLHIV to play major roles in the areas of HIV prevention education and HIV-related care, support and treatment. They conduct awareness raising and facilitate service referral through outreach and peer education activities. They serve as members of the case management team at the HIV out-patient clinics to provide health education on self-care, pre-ART and adherence counseling. They are also active members of the community home-based care teams that visit PLHIV within their homes or in the community to provide a wide range of prevention, care and support services. Aside from these activities, PLHIV also participate in CoPCT-CCs.



CHBC provision by People Living with Higher Aims, Madang



Preparing clean foods for cooking



Counseling of family Health & Care

Under the project, FHI 360 and HBYP leveraged resources from AusAID to collaborate with the Sirius Naraq Foundation CHBC project in NCD to establish a PLHIV support group known as Kirap Bung Wantaim (KBW) (translated as “Rise and Get Together”). The KBW support group brings together PLHIV who are registered for OI/ART services at the Lawes Road and 9 Mile clinics as well as PLHIV clients receiving CHBC through SNF to meet and address issues concerning them. Support group meetings have focused on topics such as nutrition, fundraising issues and sports and members have now opened a bank account. In addition, in FY10 HBYP and SNF worked together to strengthen the referral pathways from the community to health facilities and back.

FHI 360 has provided technical and operational support for the KBW network, which in NCD has evolved into a formal PLHIV network with elections and various committees. KBW also holds monthly meetings in Madang, which continue to function as informal meetings between PLHIV and service providers. Also in Madang, a PLHIV group called the Karkar Friends Network was formed in Karkar Island, where it supports the ART management program which launched on the island in November 2010.

Finally, FHI 360 also provided support and training for the inclusion of PLHIV case managers in the CMT teams under the CoPCT. Using PLHIV as case managers enhances the ability of CMT to support and understand the issues faced by PLHIV. It also helps address stigma and discrimination amongst health care providers within the health system.

SUCCESS STORY

BUILDING PLHA CAPACITY AS CARE AND SERVICE PROVIDERS UNDER THE COPCT

Jane Tropu, one of the original outreach volunteers under the USAID/FHI 360-supported Helvim Bilong Yumi (“Our Help”) Project (HBYP), was working to provide HIV prevention and health promotion information in her home community of the Burns Peak settlement in Port Moresby when she tested positive for HIV. People living with HIV/AIDS (PLHA) face serious stigma in Papua New Guinea, as in many other parts of the world, but rather than giving up, this 38-year-old wife and mother took control of her health and life, and helped to demonstrate the key role PLHA can play in the HIV epidemic response.

Ms. Tropu tested positive for HIV at the 9 Mile Clinic, supported by FHI 360 under the USAID project. She received timely counseling support, and found the courage to disclose her status to senior clinic staff. With support from HBYP, Ms. Tropu attended an FHI 360 training of trainers course on PLHA self-care and became a self-care trainer. As HBYP staff recognized her skills and dedication, she was also offered a job as an HIV testing counselor.

When Ms. Tropu became ill, she was visited regularly by HBYP staff at the hospital. “Some of my own relatives did not come and visit me in hospital but my workmates from the project visited me regularly,” she said. “I was very happy.” Upon discharge from the hospital, she started ART at the FHI 360-supported Lawes Road Clinic.

Ms. Tropu’s experience is an excellent example of the successful functioning of the Continuum of Prevention to Care and Treatment (CoPCT) model of HIV services being piloted by FHI 360 in PNG. Through strengthened coordination and referral, she was seamlessly transitioned from community-based prevention into an HIV testing clinic, and then on to clinical care and ART services. More importantly, Ms. Tropu is an example of how FHI 360 is strengthening the GIPA principle (Greater Involvement of People living with HIV/AIDS) by building the capacity of PLHA to give back to their communities, improve service provision and support one another.

FHI 360 has supported PLHA in PNG to play major roles in

the areas of HIV prevention education and HIV-related care, support and treatment. They conduct awareness raising and facilitate service referral through outreach and peer education activities. They serve as members of the case management team at the HIV out-patient clinics to provide health education on self-care, pre-ART and adherence counseling. They are also active members of the community home-based care teams that visit PLHIV within their homes or in the community to provide a wide range of prevention, care and support services. Aside from these activities, PLHIV also participate in the coordinating committees for the CoPCT in Madang and in the National Capital District.

Ms. Tropu now enjoys her counselor role working with her peers. She feels this has boosted her confidence and helped her to live positively. She has now regained her health by gaining optimum weight and living healthy, and is a role model to other HIV-positive clients accessing the services at both the Lawes Road and 9 Mile clinics.

4 | *ENABLING
ENVIRONMENT
STRENGTHENED*

ENABLING ENVIRONMENT STRENGTHENED

FHI 360 recognizes that the ability of HIV prevention, treatment, care and support interventions to make a real and lasting impact on the spread of HIV will be determined in part by the broader social and policy environments in which these interventions are implemented. Under the project, FHI 360 has therefore provided technical support for a range of enabling environment interventions to address the social, economic and legal determinants that facilitate the behavior change process and encourage MARPs and PLHIV to participate in all levels of the epidemic response. In PNG, enabling environment work was integrated within the CoPCT model. The project focused on modeling the greater involvement of PLHIV and on the mobilization of MARPs communities; reduction of S&D through clinical and community-based activities; provision of technical assistance to partners and key stakeholders on strengthening the evidence base for HIV programming and improving capacity and outcomes; and support to the coordination, collaboration and referral networks of partners and key stakeholders.

Table 1: Number of organizations provided with capacity

	Strategic Information	HIV-related Policy Development	Institutional Capacity Building
FY08	6	0	6
FY09	5	3	8
FY10	6	3	10
FY11	5	2	7
FY12	9	2	11



People Living With Higher Aims (PLWHA), Madang

Supporting community mobilization

FHI 360 was the first international organization to conduct MARPs-specific activities in PNG, under the previous USAID-funded project.^c In part as a result of this work, MARPs were included for the first time in the 2011-2015 National HIV and AIDS Strategy, a significant achievement given continued resistance in PNG to recognizing the needs of these marginalized groups. Under the project, FHI 360 conducted training in community mobilization for 227 individuals and at the beginning in FY10 supported the establishment of MSM and TG networks which held monthly meetings in NCD. Consultation with the members of these networks assisted FHI 360 in designing communication tools for MSM/TG; members of the network's Leadership Development Group additionally worked with the Ministry of Community Development on (thus far, unsuccessful) efforts to decriminalize homosexuality and sex work in PNG.

The project also initiated a support group for women, with over 50 members, aimed at empowering FSWs to access health care services. This group was established in response to FHI 360 BSS data showing that 49% of FSWs reported they had been denied health services when they disclosed they sold sex which resulted in 36% not seeking health care in the previous year when they had STI symptoms.

Finally, FHI 360 provides direct support and funding to PLWHA, the major PLHIV network in Madang, as well as indirect support to PLHIV groups in NCD through HBYP and the NCD PAC. PLHIV are involved in provision of clinical and community services and in the design, implementation and evaluation of project activities in both sites.

Reducing stigma and discrimination in the healthcare system

As noted above, there is significant stigma and discrimination within PNG healthcare services toward MARPs, which has resulted in reluctance among members of these populations to access services even when they have a clear health-related complaint. To reduce stigma and discrimination in healthcare settings, FHI 360 conducted clinician trainings on MSM awareness and sensitivity, which covered topics including an introduction to gender, sexuality and sexual orientation; a description of how service providers' attitudes can affect service provision for MSM and TG patients, and

^cUSAID Cooperative Agreement HRN-A-00-97-00017-00

interventions needed to reduce MSM/TG vulnerability to HIV and other STIs. Sensitivity in meeting the needs of MSM and FSW has also been emphasized in STI trainings and ongoing supervision and mentorship by FHI 360.

Through these initiatives, FHI 360 has developed a cadre of health care professionals who promote issues related to MSM and FSW health care needs and who deliver friendly, nonjudgmental services.

Working with case management teams under the CoPCT model, FHI 360 and clinical partners in NCD and Madang demonstrated the importance and effectiveness of training PLHIV in health care service provisions especially on ART client management, positive prevention and ART counseling. Besides building confidence among members of the PLHIV population in PNG, this model also demonstrated a reduction in the number of clients lost to follow up and reduction of stigma and discrimination in three clinics in NCD and Madang. NACS also invited FHI PNG to be part of the GoPNG delegation to present the approved abstract on “Efforts to reduce stigma in health care settings in two provinces in PNG” at the XVIII International AIDS Conference held in Vienna, Austria from 18-23 July 2010.

Advocacy and capacity building for an enhanced epidemic response

FHI 360 has worked with governmental and non-governmental organizations at all levels to reduce community-based S&D toward MARPs and to advocate for a supportive policy environment. This has included support to the NCD PAC to conduct sensitization workshops with local level government and faith-based leaders in order to increase their support for HIV programming and PLHIV. FHI 360 staff also participated in several national-level TWGs to inform policy, develop SOPs, and share best practices and lessons learned, including technical working groups on GBV and decriminalization of sodomy.

FHI 360 has also collaborated with multilateral agencies including WHO, UNICEF and UNAIDS on development and review of technical approaches and guidance. Under the TASC3 project, FHI 360 strengthened the national response by supporting the development of curricula for the prevention of parent-to-child transmission, and through involvement with the NACS and the Global Fund Country Coordinating Mechanism. Assistance with service mapping, development of counselor networks, and support to PACS, PHOs and civil society organizations also assisted in capacity building for local epidemic responses.



Kirap Bung Wantaim PLHIV support group meeting, Madang

5

*EFFECTIVENESS
OF USG-
SUPPORTED
PROGRAMS
ENHANCED BY
LEVERAGING
OTHER DONOR
RESOURCES*

EFFECTIVENESS OF USG- SUPPORTED PROGRAMS ENHANCED BY LEVERAGING OTHER DONOR RESOURCES

With support from USAID/RDMA, FHI 360 has provided technical assistance and financial support for the implementation of comprehensive HIV prevention interventions as well as care and support services to MARPs in PNG. However, FHI 360 recognized the enormous needs for the services that USAID funding alone can't provide. Therefore, FHI 360 leveraged funding and resources to complement and expand the scope, scale and sustainability of the USAID project.

Since the commencement of the current contract, FHI 360 has leveraged approximately US\$11 million of additional funding from non-USAID sources in order to strengthen strategic information about the HIV epidemic in PNG, expand the scope of the CoPCT model to include CHBC, build capacity for provision of PPTCT services, and conduct numerous activities investigating and addressing gender-based violence.

Linking CoPCT with community and home-based care

FHI 360 successfully expanded the scope of services provided under the CoPCT model to include home-based care and support for PLHIV patients and their families through CHBC teams in Madang and NCD funded by AusAID. Staff and beneficiaries from the USAID-supported HBYP in NCD are closely linked with the AusAID-supported Lukautim Hauslain project implemented by SNF. This linkage resulted in the establishment of the PLHIV support group KBW with membership mostly made up of PLHIV associated with these two projects. Similar links were established between the USAID-funded Peer Support Resource Centre in Madang and the RIPA CHBC project funded by AusAID, both of which are implemented by the PLWHA group.

One result of this linkage is that prevention interventions supported under USAID were also integrated into CHBC programs funded by AusAID, enhancing “prevention for positives” strategies. HBYP volunteers worked closely with SNF at the community level to provide key HIV prevention messaging to beneficiaries of community and home-based care and high-risk men and women in communities. Similarly, the RIPA CHBC team in Madang actively promoted condoms and IEC materials developed by FHI 360 and USAID.

Capacity building for prevention of parent-to-child transmission

USAID funding contributed to a UNICEF award for the development of the first PPTCT guidelines and training package. With USAID and AusAID funding contributions, FHI 360 developed the PPTCT and pediatric AIDS curriculum for NDoH through a contracted with UNICEF. The curriculum has four modules targeting different populations: PPTCT, pediatric AIDS, PPTCT for health managers and PPTCT for community workers. Key partners including UNICEF, NDoH, Clinton Foundation and Susu Mamas made their contributions, comments and feedback through consultation meetings/workshops organized by FHI 360 and NDOH. The curriculum was field-tested, and a final version completed by the end of FY11. The NDoH will be using this tool as the national curriculum.

Addressing gender-based violence and empowering women

The design of the USAID RDMA project in PNG did not explicitly address issues of gender or gender-based violence; however, reduction of GBV and strengthening of gender-based equality are among the U.S. Government's high-priority areas. Prevention of GBV is additionally a key principle of the Global Health Initiative, the framework for USG-supported health efforts. FHI 360 leveraged additional sources of support to further these goals in PNG:

- » Exxon Mobil funding for Violence Against Women assessments in Sandaun and Western Highlands, and
- » FHI 360 corporate funding to conduct qualitative research on the extent of GBV in two health FHI 360-supported health facilities as part of a multi-country study on gender-based violence among MSM, MSW and TG.

The results of these studies were used to inform HIV prevention and care programming under the project. In light of the preliminary results from the GBV study, FHI 360 integrated GBV components into project activities in NCD and Madang, including trauma counseling and clinical standard operating procedures for victims of GBV and inclusion of GBV prevention messages in one-on-one interactions, group sessions and community awareness events conducted by outreach teams. A GBV module was also included in the TRENDS tool to help monitor and evaluate prevention programming and guide future intervention planning.

FHI 360 also leveraged AusAID funding to implement the Powerful Voices of Woman Project (PVWP), which was piloted successfully by women in two CHBC sites in NCD in 2010. PVWP supported women from two urban settlements in Port Moresby to use photography and speak out on development issues affecting their daily lives. The project was a success as it brought ordinary women from the community to the spotlight and attracted the attention of those in authority; photos from this project were also highlighted during the November 2010 visit from U.S. Secretary of State Hilary Clinton.

Integrated Behavioral and Biological Surveillance

FHI 360 has secured funding from the World Bank and other sources for a general population integrated behavioral and biological surveillance survey to be conducted among households in every province of PNG. FHI 360 is leveraging multiple sources of funding, including from USAID, to carry out this survey, which will provide valuable information to guide future planning and decision-making for the epidemic response, including resource allocation, intervention design and accurate identification of most-at-risk populations. The IBBS survey is currently on-going.

LESSONS
LEARNED,
CONTINUED
CHALLENGES &
CONCLUSION

LESSONS LEARNED, CONTINUED CHALLENGES AND CONCLUSION

The USAID-funded project in Papua New Guinea was built on a foundation established through previous collaborative projects and evolved over five years supported by the inputs of numerous local and international agencies and technical experts. A full accounting of all the factors which contributed to the success of this project is beyond the scope of this report. Nonetheless, for the benefit of other agencies which may be interested in replicating this project, in whole or in part, in their own communities, below are a list of key lessons learned over the course of project implementation:

Health staff commitment to providing services to PLHIV is attainable.

In Modilon Hospital, the turnaround in health providers' attitudes toward PLHIV and their commitment to providing them with services is significant. Members of KBW have reported that there are positive changes in health care providers' attitudes towards them.

PLHIV have a key part to play in service delivery for HIV-positive patients.

PLHIV played an active role in shaping the CoPCT, service delivery and monitoring services. Involvement of PLHIV in service delivery included working as case managers at the HIV clinic and as CHBC team leaders and members. PLHIV now openly utilize the government health services in the two satellite sites of Lawes Road and 9 Mile Clinic and Modilon General Hospital.

Data-driven approaches can effectively inform program planning and implementation.

FHI 360 introduced monitoring and evaluation tools to drive quality improvements in delivery of clinical services, patient data tracking to reduce loss to follow-up among ART/OI patients, and collected data through a behavioral surveillance survey, Violence Against Women assessment, and GBV study which have informed the design of prevention messaging and services.

Community-based groups can take leadership with proper support.

There is little evidence that a strong sense of community unites members of marginalized populations in PNG. However, initial steps have been taken with support for new organizations like the MSM Kapul Champions group, PLWHA and KarKar Friends, and the FSW support group, which have already become active in supporting effective service delivery and advocating with the government for greater resources and a supportive policy environment for MARPs interventions. Further measures should be taken to develop the leadership of this and other groups in order to foster a truly community-driven epidemic response.

BCC approaches should target specific audiences and move beyond awareness-raising.

One-size-fits-all approaches may raise awareness of the threat of HIV infection, but they are insufficient to promote adoption of prevention behaviors. For behavior change communication to be effective, prevention strategies, messages and materials must be targeted to the specific knowledge, beliefs, values and attitudes which drive behaviors in those populations at risk of becoming infected with HIV or spreading their infection to others. BCC approaches must also be regularly refreshed in order to avoid message fatigue on the part of audiences and the peer educators and outreach volunteers responsible for message delivery.

Continuing Challenges

While the project in PNG achieved definite successes, as enumerated above, FHI 360 and local implementing agencies also faced a number of implementation challenges, which continued across the life of the project. These challenges included:

Lack of consensus on operational definitions for MARPs

There are unique challenges in PNG to creating operational definitions for most-at-risk populations including men who have sex with men and female sex workers. Research conducted by FHI 360 has documented that many people engage in high-risk behaviors (including infrequent transactional sex or multiple, concurrent sexual partnerships) without necessarily falling into any of the traditionally defined MARPs categories. There are also few MARPs-specific venues (i.e. gay clubs, brothels, bath houses etc.) in PNG where interventions can be targeted – MARPs seek for sexual partners either in the community or in the same hotspots frequented by non-MARP members of the general population. This situation complicates intervention planning and targeting. The decision tree tool was designed to help address this challenge and, as this report has shown, has successfully increased the accuracy with which project outreach workers identify high-risk targets. A side effect of more accurate targeting has however been a drastic reduction in the number of individuals reached by the project. In addition to investigating more innovative HIV prevention models to expand intervention coverage, it is also appropriate to reconsider the traditional MARPs definitions in light of the most up-to-date research data available and to work with other international organizations and local partners to reach consensus on how MARPs are defined.

Lack of support for night interventions

Another strategy for improving coverage of most-at-risk populations, night interventions were launched mid-way through the project in the hotspots such as bars and dance halls where both MARPs and members of the general population gather to seek sexual partners. The implementation of night interventions by HBYP peer educators in NCD did not commence smoothly. Management of several entertainment venues, identified through a mapping exercise, deemed these interventions to be a hindrance to business and refused to participate – some other venues initial cooperated

with the project but later withdrew their support. Reasons for the lack of support included reluctance to host drag performances and other, HIV-related “edutainment” events. It should also be noted that outreach staff targeted a relatively small subset of the overall number of identified “hotspots” and visited these hotspots frequently and with these same activities and messages – burn out on the part of venue management and patrons may have contributed significantly to the lack of support. For this approach to be implemented successfully in the future, more initial work must be done to generate buy-in from venue management, and individual venues should be targeted less frequently and outreach workers must constantly refresh their approaches.

On-going security concerns

Security concerns in PNG (and particularly in NCD) are well documented and served as a barrier to successful implementation across all components of the project. Outreach volunteers and peer educators were in some cases reluctant to conduct hotspot-based night interventions, and in many cases clients (and particularly women) reported a reluctance to attend clinic services because clinics were located too far from their home communities without adequate, safe transportation options.

The operation of FHI 360-supported clinics was also disrupted numerous times and for extended periods over the life of the project due to security concerns. These included a deteriorating security situation which disrupted operations at the 9 Mile clinic in 2010 and again in 2011, as well as car jackings and robberies which affected the Lawes Road Clinic for an extended period in 2011. While FHI 360 and local partners have held discussion with community leaders and the NCD provincial health office toward a long-term solution, it is likely that these disruptions will continue for the immediate future.

Difficulty retaining qualified and effective project staff

High staff turnover within local partner agencies affected project performance throughout the life of the project. FHI 360 found that, once staff members gain skills and experience, they transition into other, more highly-paid or stable positions. This challenge affected all levels of project implementation, from community-based outreach volunteers to CoPCT coordinators, to clinic service providers and members of the case management teams. While some level of staff attrition is to be expected and is desirable for bringing in new team members with different ideas and perspectives, it is difficult to build up institutional capacity and

technical expertise within local partners if a basic level of staffing is not maintained. In the future, a staff retention strategy should be put in place, and implementing agencies should consider how to acknowledge the efforts of project staff; for instance, community awards, opportunities to participate in trainings or conferences for the purpose of professional advancement, the chance to serve on coordinating or advisory boards, etc.

Conclusion

FHI 360 has worked in close engagement with national-, provincial- and local-level partners over the five years of the RDMA project in order to provide technical assistance for HIV/AIDS services among MARPs in Papua New Guinea. Innovative new service delivery models have been demonstrated (CoPCT) and significant external support has been leveraged to expand and replicate project services. PLHIV have played a key role in project design and implementation, and FHI 360 has taken significant strides to integrated approaches for preventing and responding to gender-based violence into HIV prevention, treatment, care and support interventions. Some of the successes achieved, and lessons learned, under this project are being documented through an on-going CoPCT process evaluation, which will, it is hoped, support model replication in other sites throughout the country.

These successes notwithstanding, the HIV epidemic in PNG continues to grow, with signs of increasing spread toward a generalized epidemic. And while there have been clear improvements in the country's capacity to deliver care and treatment for PLHIV, for the epidemic to be slowed prevention programming must be further strengthened and approaches must be found to effectively reach those populations at highest risk of infection, and to motivate increased condom use and uptake of health services. It is hoped that this report contributes to the evidence for continued support of the USAID model in PNG, so that these goals may be addressed.

APPENDIX 1

WORKS CITED

1. UNAIDS. Global AIDS Report 2012 – Country Progress Report: Papua New Guinea. 12 March 2012.
2. UNAIDS. UNGASS 2010 Country Progress Report: Papua New Guinea. March 2010.
3. USAID/FHI 360. Behaviors, Knowledge and Exposure to Interventions: Report from a Behavioral Surveillance Survey, Port Moresby, Papua New Guinea. May 2011.
4. Bernstein, Kyle T.; Liu, Kai-Lih; Begier, Elizabeth M.; Koblin, Beryl; Karpati, Adam; Murrill, Christopher. Same-Sex Attraction Disclosure to Health Care Providers Among New York City Men Who Have Sex With Men. *Arch Intern Med.* 2008; 168(13):1458-1464.
5. Knight, Daniel. Health Care Screening for Men Who Have Sex with Men. *Am Fam Physician.* 2004 May 1;69(9):2149-2156.
6. Mayer, Kenneth H.; Klausner, Jeffrey D; Handsfield, H. Hunter. Intersecting Epidemics and Educable Moments: Sexually Transmitted Disease Risk Assessment and Screening in Men Who Have Sex with Men. *Sexually Transmitted Diseases: Volume 28(8) August 2001 pp 464-467.*
7. PNG National AIDS Council. Review of Coverage & Quality of VCT Services in PNG. Nov. 2006.
8. Lauwo, Jackson AK.; Kevau, Isi H.; Muga, Florence; Gaure, Megan. HIV/AIDS Stigma: Main barrier to VCT and other health services in four suburban villages in National Capital District, Papua New Guinea. *Pacific Journal of Medical Sciences: Vol. 9, No. 2, March 2012.*
9. Kelly, A., Kupul, M., Man, W.Y.N., Nosi, S., Lote, N., Rawstorne, P., Halim, G., Ryan, C. & Worth, H. (2011) Askim na save (Ask and understand): People who sell and/or exchange sex in Port Moresby. Key Quantitative Findings. Papua New Guinea Institute of Medical Research and the University of New South Wales: Sydney, Australia.

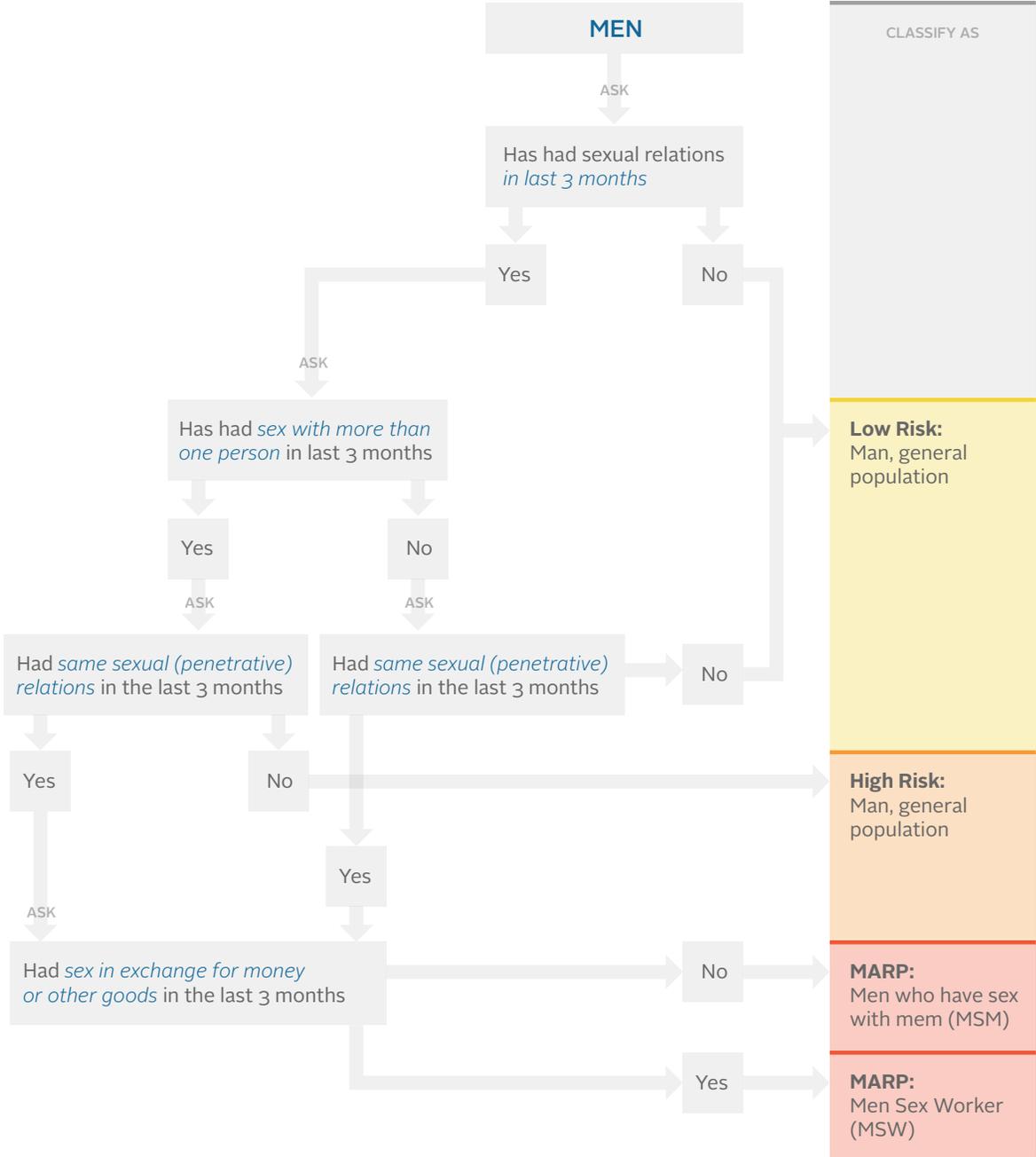
APPENDIX 2

PROJECT PARTNERS

Implementing Agency Name	Scope of Work	Funding by U.S. Fiscal Year In US Dollars					
		FY08	FY09	FY10	FY11	FY12	Total
HOPE Worldwide (Helvim Bilong Yumi Project)	Outreach, prevention, care and treatment services and clinical care in Port Moresby for CoPCT	449,974	357,042	403,360	595,608	575,000	2,380,984
National Capital District Provincial AIDS Committee	CoPCT coordination	17,108	19,562	11,680	18,033	24,968	91,351
Madang Provincial AIDS Committee	CoPCT coordination	4,733	26,366	13,705	20,841	18,844	84,489
People Living with Higher Aims (PLWHA; Madang)	Promote PLHIV coordination and engagement	16,263	27,310	24,224	41,186	59,371	168,356
Papua New Guinea Red Cross Society, NCD/Central	Prevention outreach for MARPs with self-care training for PLHIV in NCD and Central provinces in FY08	60,790	2,204	N/A	N/A	N/A	62,994
National Spiritual Assembly of Bahai's (Sirus Naraq Project)	Prevention outreach for adults, youth and PLHIV in NCD and Central provinces in FY08	32,747	1,046	N/A	N/A	N/A	33,793
TOTAL							2,821,965

APPENDIX 3

DECISION TREE (MEN)



APPENDIX 3 (2)

DECISION TREE (WOMEN)

