Continuum of Prevention to Care and Treatment (CoPCT)
Site Assessment
Findings and Recommendations

Papua New Guinea
18-29 November, 2007

Assessment team
National AIDS Council
Secretariat
UNAIDS
WHO
USAID Regional
Development Mission Asia
AusAID
US Centers for Disease Control and Prevention
Family Health
International
Igat Hope
Clinton Foundation
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November 2007
### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<td>CoPCT</td>
<td>Continuum of Prevention-to-Care and Treatment</td>
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<td>GFATM</td>
<td>Global Fund to Fight AIDS, TB and Malaria</td>
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<td>HC</td>
<td>Health Center</td>
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<td>HBC</td>
<td>Home-based care</td>
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<td>HIV</td>
<td>Human Immunodeficiency virus</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>FBO</td>
<td>Faith Based Organization</td>
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<td>FSW</td>
<td>Female sex worker</td>
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<td>GoPNG</td>
<td>Government of Papua New Guinea</td>
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<td>NDoH</td>
<td>National Department of Health</td>
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<td>PLHIV</td>
<td>Person/People Living with HIV</td>
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<td>PMIS</td>
<td>Patient Management Information System</td>
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<td>PMTCT</td>
<td>Prevention of mother-to-child transmission of HIV</td>
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<td>PNG</td>
<td>Papua New Guinea</td>
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<td>MARP</td>
<td>Most at risk population</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NAC</td>
<td>National AIDS Council</td>
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<td>NACS</td>
<td>National AIDS Council Secretariat</td>
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<td>PAC</td>
<td>Provincial AIDS Council</td>
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<td>PACS</td>
<td>Provincial AIDS Council Secretariat</td>
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<tr>
<td>OI</td>
<td>Opportunistic Infection</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UNAIDS</td>
<td>The United Nations Joint Programme on HIV/AIDS</td>
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<td>USG</td>
<td>United States Government</td>
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<td>U.S. CDC</td>
<td>United States Centers for Disease Control</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Background

The HIV/AIDS epidemic is rapidly expanding in Papua New Guinea (PNG). Recent estimates of HIV prevalence among adults aged 15-49 is 1.28%, making PNG one of the worst affected countries in the region. (NAC 2007). The epidemic is spread across the general population and is driven by factors such as unprotected sex, multiple sexual partners, early age of sexual debut and high rates of sexually transmitted infections. The highest levels of HIV infection have been found among female sex workers (10-17% in Port Moresby and 3% in Lae). (UNAIDS 2006). Prevalence estimates among men who have sex with men are not available.

There are an estimated 46,275 people living with HIV in Papua New Guinea. However, few people living with HIV are aware of their status. It is estimated that in 2007, 1727 children will be living with HIV infection and 3730 children will be orphaned due to AIDS. (NAC 2007)

The National AIDS Council Secretariat (NACS) and the National Department of Health (NDoH) have outlined a plan to increase access to HIV prevention, care and treatment services, with an aim to achieve universal access by 2010. The NACS National HIV/AIDS Strategic Plan 2006-2010

After wide consultation within the Government of Papua New Guinea and the community, the National AIDS Council developed the document Papua New Guinea National Strategic Plan on HIV/AIDS 2006-2010. This plan forms the basis for a national coordinated multisectoral response to the HIV/AIDS epidemic for the next five years and calls on the government and partners to scale up access to HIV prevention, care and treatment in health facilities and through community and home based care. The development partners have committed to supporting the Government for implementing the plan.

The Papua New Guinea (PNG) response to HIV/AIDS has developed rapidly in the last few years as greater political, financial and technical support have been made available. The United Nations Country Team (WHO, UNICEF and UNDP) is providing technical assistance in several areas, including ART, PMTCT, programs with youth and traditional leaders and advocacy for gender issues and legal rights for PLHIV. The Global Fund’s overall goal is to reduce the spread of HIV, improve care for those infected and minimize the social and economic impact on affected individuals, families, communities and the country as a whole.
The proposal has three strategic objectives:

- To reduce HIV transmission in young people and create a supportive environment for PLWA by 2009
- To scale up voluntary counseling and testing in 20 provinces by 2009 and
- To scale up quality ARV treatment and monitoring facility through 30 public, private, NGO and faith-based clinics by 2009

A major donor in the area of HIV/AIDS is AusAID. The Sanap Wantaim (Stand Together) project commenced in January 2007, building on the achievements of the PNG National HIV/AIDS Support Project (NHASP) which concluded in December 2006. Sanap Wantaim is supporting PNG to respond to its own priorities as outlined in the PNG National Strategic Plan on HIV/AIDS 2006 - 2010. The program is working through PNG Government systems as well as with civil society and the private sector to not only prevent the spread of HIV, but also to provide treatment, care and support for those infected and affected by HIV/AIDS.

In addition, the Clinton Foundation provides support in care and treatment and HIV testing and the Asian Development Bank supports rural and economic development enclaves through public and private partnership to improve primary Health Care, behavior change communication and condom social marketing.

A recent assessment carried out by United States Agency for International Development (USAID) and United States Centers for Disease Control (U.S. CDC) recommended increased United States Government (USG) support to PNG to develop a Continuum of Prevention, Care and Treatment (CoPCT) model for eventual scale up. The continuum of care concept has been implemented successfully in many countries in the region and focuses on development of systems that provide high-quality, comprehensive and continuous care to PLHIV and their families. The CoPCT augments the National HIV/AIDS Strategic Plan since it links, coordinates and consolidates prevention, care, treatment and support services for people living with HIV (PLHIV) and strengthens the group of services that together provide comprehensive care (see figure below ).
Goals and Objectives

The purpose of the joint mission in Papua New Guinea was to conduct a site assessment for establishing a model of Continuum of Prevention to Care to Treatment (CoPCT) in the National Capital District (NCD), Eastern Highlands Province and Madang Province.

Specific objectives of the assessment were to:

- Map existing services including quality, coverage and sustainability
- Identify gaps in CoPCT in each site
- Identify which stakeholders will be responsible for establishing interventions and/or services to fill the identified gaps
- Identify strategies to ensure effective linkages between all interventions and services at each site
- Review Antiretroviral Therapy (ART) services, including laboratory capacity, existing Patient Management Information System (PMIS) and supply chain systems
- Report the findings of the assessment and recommendations for establishing and scaling up the CoPCT model to Government of PNG and key stakeholders.

**Methodology**

Site assessments were conducted from 18-29 November, 2007 in the National Capital District (NCD), Eastern Highlands (Goroka and Kainantu) and Madang. The joint USG-stakeholders team was comprised of representatives from U.S. Government (USAID, U.S. CDC), Government of Papua New Guinea (National AIDS Council Secretariat and Provincial AIDS Council Secretariat), international organizations (Family Health International, WHO, Clinton Foundation, and UNAIDS), donors (AusAID) and PLHIV (Igat Hope). See Annex I for a complete list of team members.

The National AIDS Council Secretariat (NACS) and Family Health International (FHI) provided background documents and coordinated the site assessment. The joint assessment activities included:

- Review of national and provincial background documents
- Meetings with National Department of Health, National AIDS Council, Department of Community Development, partners and stakeholders
- Site visits to Eastern Highlands, Madang and NCD. At each site, the team was hosted by the Provincial AIDS Council (PAC) and met with the PAC secretariat; staff of health facilities and community and faith-based organizations providing prevention, VCT, PMTCT, STI/OI/ARV treatment and home-based care; and PLHIV support groups. (For a complete list of contacts, see Annex II.)
- Preparation of an initial assessment report with synthesis of findings and specific recommendations for implementation of the Continuum of Prevention to Care to Treatment (CoPCT) in each province.
- Dissemination meeting for government and key stakeholders.
Overall Findings and Recommendations

Selected findings are presented below based on observations made during site visits. Since the team only spent two days per site, a complete assessment was not made. Recommendations are focused on priorities identified for USG funding and are not comprehensive. For recommendations for specific provinces, see Annex III.

1. Program management, coordination and partnership

The team noted that significant efforts are already underway to provide prevention, care and treatment services at the provincial level. NACS has established a network of PACs at each province and efforts are underway to establish and support District AIDS Councils.

While many services are in place at the provincial level, links among different services (within the hospital, between the community and hospital, and among organizations working in the community) are not well established. Many PLHIV describe difficulty accessing the full range of services and/or are lost to follow-up. Improving the referral linkages between services and follow-up mechanisms would facilitate client-centered care and allow PLHIV easier and more complete access to the full range of services available.

Recommendations for strengthening the CoPCT model:

⇒ Strengthen collaboration and partnership for CoPCT

At National Level:

- Introduce the CoPCT model to key stakeholders
- Establish coordinating mechanisms through the technical working groups chaired by the NDOH/NACS
- Fully integrate CoPCT into the Health Care System

At Provincial Level:

- Establish CoPCT sub-committee within PACS
- Map existing services
- Develop/support linkages and formalize referral mechanisms (within hospital and among hospital, NGOs and community)
- Incorporate CoPCT into community awareness/mobilization programs already underway
2. Prevention

Knowledge about HIV is high and prevention programs with most-at-risk populations (MARPs) are underway in all sites visited. Reaching MARPs in PNG is more challenging than in most other countries in the region. Few MSM openly identify themselves and most remain hidden among the general population. Similarly, the majority of women who engage in transactional (which is sometimes also cross-generational) sex do not identify themselves as sex workers. Based on the evaluation of the Poro Sapot Project in Goroka and Port Moresby indicated a marked improvement in knowledge about HIV sexual transmission among FSWs and MSM, but there is still a need to increase prevention program coverage to sufficient scale. (Source: Prybylski P., Yeka, W. and Meteo R: Evaluation of the Poro Sapot Project: baseline and post Intervention studies).

To reach the maximum number of people engaging in MSM and transactional sex behaviors, behavior change messages will need to be embedded in general population and out-of-school youth interventions. In addition, more focus on meaningful behavior change, as opposed to awareness-raising, is needed.

According to sex worker representatives, many clients don’t use condoms and may become violent when sex workers refuse sex without condoms. Condoms and lubricant are distributed at STI clinics, VCT centers and OI/ART services supported by NDoH, with occasional stock-outs. There is no condom social marketing program in place, although PSI is planning to implement a program in the near future.

STI treatment is available at government facilities and some private clinics. Hospital and health centers use syndromic management and follow national guidelines with the exception of substitution of azithromycin for doxycycline for the treatment of chlamydia. Stock-outs of STI medications were reported to be common. USAID/FHI-supported clinics prescribe cefixime instead of Augmentin/probenicid for the treatment of gonorrhea. PLHIV, MSM and FSWs in some sites report difficulties accessing STI services because of attitudes of health care providers. ART and STI services are provided in the same clinic area at sites visited by the assessment team. In all sites, the number of patients on ART is increasing rapidly and limiting the time available for staff to treat HIV-negative patients with STIs.

“Prevention with positives” is not routinely included in PLHIV treatment programs, although condoms are provided for PLHIV in some VCT sites. In addition, Prevention with Positives is not systematically integrated into home and community-based care and support.
Recommendations for strengthening the CoPCT model:

⇒ Improve treatment for STI

- Assess and facilitate improvements in the accessibility and acceptability of STI treatment services for FSW, MSM and PLHIV at facility and provincial levels
- Ensure adequate clinic capacity for STI treatment as ART patient load increases at facility and provincial levels
- Support quality assurance/quality improvement for STI at all levels (e.g. use of monitoring and supervision checklists at clinic level, review of national guidelines and frequency/results of antibiotic susceptibility monitoring)

⇒ Integrate prevention with positives into clinical, VCT and community-based services at provincial level

⇒ Ensure that prevention messages move beyond awareness to behavior change at national and provincial level

3. HIV testing and counseling

VCT services are available within the hospital and at community-based locations in all three sites visited. Tools, such as counseling checklists and IEC materials, are available. Testing is generally carried out by rapid test screening on-site and confirmation at the hospital laboratory. Confirmatory results are available within one week at most sites. VCT centers report high rates of follow-up for test results after introduction of rapid tests. However, VCT uptake remains low, particularly among FSWs and MSM (clinic reports and Prybyliski P., Yeka, W. and Meteo R: Evaluation of the Poro Sapot Project: baseline and post Intervention studies). Counseling training is carried out by IEA as a single training, without refresher training or on-going monitoring and supervision.

Recommendations for strengthening the CoPCT model:

⇒ Support quality assurance/quality improvement process for VCT at national level
- Develop SOPs for VCT services and review training curriculum
- Evaluate the quality of VCT training and performance of counselors
- Review accreditation process
⇒ Improve the quality of counselling and testing services and improve access in targeted areas at provincial level

- Implement QA/QI for counseling (in line with national plan)
- Facilitate accreditation process
- Ongoing supervision, support and refresher training
- Support and facilitate rollout of new guidelines for rapid test algorithm
- Improve linkages between HIV testing and the full range of CoPCT services

⇒ Support universal HIV testing for ANC attendees and formalize linkages to CoPCT services at national and provincial levels

4. **Care, Treatment and Support**

*Clinical and community-based care and support:* ART rollout is underway in all three provinces, although in different phases. In Goroka, Clinton Foundation is supporting three ART sites: Goroka Base Hospital, Asaro Health Center and Kainantu Hospital, and more health center sites are planned. Modilon Hospital in Madang started providing ART services recently and has 28 registered PLHIV with 13 currently on ART. Heduru Clinic at Port Moresby has reached its maximum capacity for ART and roll-out of services to Laws Road Clinic is planned very soon. All sites have recently acquired CD4 count capability and provide STI and OI management as well as HIV testing. Clinicians have been trained using IMAI curriculum. ARV drugs are provided by GFATM and while there were no reported stockouts, Modilon Hospital in Madang was deferring ART initiation in new patients because of low stock levels.

At Goroka Base Hospital, a system of case management has been established within the hospital to assist patients to access all existing services. This system is not in place at Port Moresby or Madang. Referrals between hospital and community services need to be strengthened and formalized in all three sites to reduce loss to follow-up. While community and home-based care services are available in all the sites visited, further scale-up in terms of scope and coverage is needed.

All sites report problems with regular patient attendance for follow-up appointments due to patients’ inability to pay for transportation costs. Adherence is assessed during patient clinic visits by counting pills and interviewing patients at some sites and there is a need to strengthen adherence support as part of CoPCT.
Active TB patients are offered HIV testing, but commitment/completeness varied by site. HIV-infected persons are screened for TB only if infection is suspected clinically.

PLHIV involvement: The national PLHIV support group, Igat Hope, was established in 2003 and has undergone recent changes in personnel and composition of the Board of Directors. They currently have 150 members and 3 paid staff. In meetings with the group, they were unclear about the organization’s overall mission and goals and had not yet developed a workplan for the coming year. Their main activity appears to be providing community and home-based care and they have about 40 trained PLHIV providers. They are working to establish a national network of PLHIV groups and have developed relationships with Good Samaritan, a PLHIV group in Madang.

While two PLHIV groups are in existence in Madang (Good Samaritan and Higher Aims), none have been established in Goroka. Bethany Center in Madang supports Higher Aims and their members are often called upon to provide counseling for people testing positive at the center’s VCT services. Similar practices are in place in Goroka at St. Joseph’s VCT center, although a formal group of PLHIV has not been established there. In general, PLHIV involvement should be increased at all sites, with incorporation into the CoPCT approach.

PMTCT: Most ANC attenders are offered HIV testing but PMTCT services are limited by the lack of strong, formalized referral systems, non-facility based PMTCT, and follow-up of children born to HIV-positive mothers to monitor their HIV status, infant feeding practices and nutritional status. The links from hospital to community-based services are not well-coordinated or structured to address the needs of pregnant women.

Recommendations for strengthening the CoPCT model:

⇒ Strengthen quality of pre-ART and ART services and promote integration of components at provincial level
  - Ensure that all ART clinic sites are integrated into CoPCT networks for referrals and follow-up, especially as new ART sites roll out
  - Strengthen the team approach within the clinical setting at Port Moresby Modilon (Madang) Hospitals to improve coordination, collaboration and referrals between departments using the case management model developed at Goroka Base Hospital
• Develop formal linkages between health facilities and the community (adopt a client-centered approach).

⇒ **Strengthen linkages between TB and HIV**
  • Joint strategic planning between TB and HIV programs at the national level
  • Increase HIV testing among TB patients and early TB screening among PLHIV at the facility level.

⇒ **Support current efforts to improve logistics for supply chain management** at both national and provincial levels for condoms and drugs for treatment of OI, ARV and STI

⇒ **Increase coverage and range of home and community-based care services**
  • Work with national technical working group to train HBC providers on best practices model
  • Leverage existing community networks and support for services at the local level

⇒ **Strengthen the involvement of PLHIV in CoPCT at provincial level**
  • Develop new PLHIV support groups and/or strengthen existing groups
  • Enhance roles of PLHIV as the part of CoPCT (in VCT counseling, adherence support, CHBC, prevention (including prevention with positives) and income generation)

5. Monitoring and Evaluation

The Monitoring, Evaluation and Surveillance working group has established at national level and in 20 provinces throughout country including the three provinces. NAC is planned to put in place M&E officer at PAC. Of those 20 provinces, GFATM is funding a paid M&E officer position for PACS in five provinces for two years. Unified national forms have been developed to collect program level data for VCT based data, health facility based data (including STI, ART) and non-health facility based data (prevention, home and community based care). Training was conducted in October 2007 on how to use forms but the system is not fully rolled out yet. Particularly, most of PACS have no human and financial plan for effectively implementing national monitoring plan at provincial level, no data management and data analysis plan.

Some hospitals are computerizing their monitoring data. Clinton Foundation is piloting a database for ART services at Heduru Clinic in Port Moresby. Modilon Hospital has
plans to set up a database and has ordered computers. Current data are entered into EpiInfo. Plan is in progress to adapt ART patient monitoring database based on Tanzania model. Capacity for analysis at the provincial level needs to be developed.

At present, most indicators are numerator only. Systematic data collection to monitor quality of care is not in place. Monitoring data is not collated and synthesized at provincial level and is not used to inform program improvement. Data flow has not systematically implemented (difference province by province). Non-health facilities send their monitoring data to PACS for forwarding to NACS and clinical facilities send their reports to the Provincial Health Office for forwarding to NDoH. These might be resulting in limitation of PACS’ ability to manage big picture of all HIV/AIDS responses in province and use as empirical data for provincial strategic planning.

**Recommendations for strengthening the CoPCT model:**

⇒ **Strengthen implementation of national M&E system at provincial level**
  - Aggregate data at provincial level in addition to forwarding to national level
  - Support development of a data management plan (including hardware, software and human resource requirements)
  - Build capacity of DAC and PAC to effectively use data to guide the strategic plan and program implementation

⇒ **Strengthen data and capacity for QI of clinical services**
  - Build capacity of health care facilities for quality improvement by introducing HIVQUAL (a performance measurement and quality improvement approach developed by New York State Department of Health with U.S. HRSA support and adapted for international use by U.S. CDC in Thailand.)

⇒ **Documentation of implementation of CoPCT**
  - Develop system to utilize routine data to monitor success
  - Document process for rolling out CoPCT sites and develop PNG-specific tools for scale-up
  - Disseminate reports and tools to relevant stakeholders in other provinces and districts
  - Utilize documentation data and experience from model projects to leverage funding for scale-up of CoPCT, e.g. GFATM round 9, World Bank, ADB, etc.
Roles of U.S. Government partners

1. Role of U.S. CDC

U.S. CDC will support existing national systems and the provincial CoPCT model by providing technical assistance and capacity building in response to needs identified by GoPNG and stakeholders. Possible areas for CDC collaboration include:

- Surveillance and data use
- Laboratory quality systems and training
- Quality monitoring and improvement for HIV services
- VCT

Further discussion between the U.S. CDC technical team, GoPNG and stakeholders is needed to finalize areas of collaboration and develop a work plan.

2. Role of USAID/Family Health International

USAID will support the following activities through Family Health International:

- Provide technical support for establishing CoPCT at national and provincial levels
- Strengthen linkages and referral systems
- Develop systems and provide technical support to utilize provincial M&E data to strengthen and improve programs
- Strengthen PLHIV input in CoPCT
- Develop a communication strategy for CoPCT and supporting IEC materials.

Next steps for immediate follow-up

- Technical officer will join FHI-PNG in January 2008.
- Identify technical assistance needs and develop detailed USG workplans (FHI/USAID, U.S. CDC) based on stakeholder feedback from assessment reports
- Provide technical support (USG Washington) to GFATM in early 2008 with possible additional support as identified by CCM and PR.
Annex I
Assessment Team Members

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Ms. Nayer Kaviani, Country Director, Family Health International, PNG

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Mr. Peter Izard, AusAID, First secretary HIV/AIDS Sanap Wantaim, PNG

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Mr. Taoufik Bakkali, UNAIDS, PNG

Mr. Nick Evera, Treasurer and Board Member Igat Hope, PNG
Annex II
Contacts

National Program
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Dame Carol Kidu, Minister for Community Development
National AIDS Council Secretariat (NACS)
National Department of Health
Global Fund for AIDS, TB, and Malaria (GFATM)
Asian Development Bank (ADB)
AusAID Health Team
World Health Organization (WHO)

National Capital District
Provincial AIDS Council Secretariat (PACS)
Port Moresby General Hospital
Department of Community Development
Hope Worldwide (Laws Road and Nine Mile Clinics)
MARPs representatives
Igat Hope representatives

Eastern Highlands
Provincial AIDS Council Secretariat (PACS)
Goroka General Hospital
Clinton Foundation
University of Goroka STI/VCT clinic
St Joseph’s VCT Clinic
Save the Children/Tingim Laif Project
Kainantu Hospital
Salvation Army CHBC & VCT Site
Friends Frangapani
PLHIV representatives

**Madang**
Provincial AIDS Council Secretariat (PACS)
Modilon Hospital
Divine Word University
Bethany Center (VCT)
VSO
Save the Children drop-in center
Tingim Laip
PLHIV support groups - Higher Aims & Good Samaritan
Annex III
Key findings and recommendations by province

Eastern Highlands

- Scale up CoPCT at provincial and district level
  - Clinton Foundation and Provincial Health Department already working on institutional care and treatment at Goroka Base Hospital with roll out of ART services to health centers A case management system is in place in the hospital for referrals between departments and services
  - Identify and link community services providers to clinical services
  - As clinical services are decentralized, ensure that community/NGO support services are available
- Increase community and home-based care and support services
  - Leverage resources to train HBC providers on best practices model
  - Enhance quality of services within the CoPCT framework
  - Implement “Prevention with Positives”
  - Increase PLHIV involvement at health facilities and communities

National Capital District

- Implement model of comprehensive CoPCT
  - Identify core partnership for CoPCT coordination sub-committee (PAC) among large numbers of stakeholders
  - Support decentralization of HIV clinical services and link new ART sites at health centers to CoPCT network
- Support rollout of HIV clinical services at health centers
  - Need to reduce workload at Heduru clinic
  - Potential strategy is to set up ART satellite clinics at the 9 miles and Laws Road clinics
  - Strengthen the partnership with other stakeholders in scaling up ART
- Increase CHBC services
- Strengthen capacity of existing NGO/CBOs to expand their services in order to provide a comprehensive CoPCT (one stop service)

Madang

- Improve clinical services for ART/OI/STI/VCT at Modilon Hospital
  - Support improvements in infrastructure (AusAID-funded)
  - Implement case management system (using the Clinton model from Goroka)
  - Training for sensitization of hospital staff to MARPs and PLHIV to increase acceptability of services for marginalized groups
  - Capacity building of clinical staff (train new staff and better utilize previously trained staff)
- Capitalize on Divine Word University’s presence in community
  - President of University is also Chairman of the board of the hospital. He expressed the university’s commitment to community service role and has already provided offices for several NGOs (and offered office space to FHI) and is currently building a new pathology lab for Modilon Hospital.
  - Involve university faculty in training programs and utilize student resources in community BCC (Goroka Univ. model)
  - Collaborate on university-funded research related to HIV/AIDS
- Assess Bethany Center’s model and disseminate lessons learned on VCT, management of referrals and follow up of PLHIV, and involvement of PLHIV in service provision
- Identify at least one local partner to implement CHBC services
- Incorporate CoPCT into VSO rural community dialogue