



FY 2015 Papua New Guinea Country Operational Plan (COP)

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Papua New Guinea.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

- 3) *Sustainability Index and Dashboard*

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the “FY 2015 Country Operational Plan Budget and Target Report.”

PAPUA NEW GUINEA

**Country Operational Plan (COP) 2015
Strategic Direction Summary**

September 30, 2015

Table of Contents

Acronym List

Goal Statement

1.0 Epidemic, Response, and Program Context

- 1.1 Summary statistics, disease burden and country profile
- 1.2 Investment profile
- 1.3 Sustainability profile
- 1.4 Alignment of PEPFAR investments geographically to burden of disease
- 1.5 Stakeholder engagement

2.0 Core, near-core and non-core activities for operating cycle

3.0 Geographic and population prioritization

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

- 4.1 Targets for priority locations and populations
- 4.2 Priority population prevention
- 4.3 Voluntary medical male circumcision (VMMC)
- 4.4 Preventing mother-to-child transmission (PMTCT)
- 4.5 HIV testing and counseling (HTC)
- 4.6 Facility and community-based care and support
- 4.7 TB/HIV
- 4.8 Adult treatment
- 4.9 Pediatric Treatment
- 4.10 OVC

5.0 Program Activities to Maintain Support in Other Locations and Populations

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

- 6.1 Laboratory strengthening
- 6.2 Strategic information (SI)
- 6.3 Health system strengthening (HSS) – clear linkages to program

7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

Appendix A- Core, Near-core, Non-core Matrix

Appendix B- Budget Profile and Resource Projections

List of Acronyms

Papua New Guinea COP 2015

ADB	Asian Development Bank
ART	Anti-retroviral therapy
ARV	Anti-retroviral
AusAID	Australian Agency for International Development
AVARM	AVARM Corporation, CDC Contract Agency
CCM	Country Coordinating Mechanism
CD ₄	Cluster of Differentiation
CHAI	Clinton Health Access Initiative
CHP	Community Health Partnerships
CoPCT	Continuum of Prevention to Care & Treatment
CPHL	Central Public Health Laboratory
CT	Counseling & Testing
DFAT	Australian Department of Foreign Affairs and Trade
DRM	Domestic Resource Mobilization
EOA	Enhanced Outreach Approach
EQA	External Quality Assurance
FHI	Family Health International
FSW	Female Sex Workers
FY	Fiscal Year
GBV	Gender-based violence
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoPNG	Government of Papua New Guinea
HHISP	Health and HIV Implementation Services Provider
HIV TDR	HIV Transmitted Drug Resistance
HIV TWG	HIV Technical Working Group
HIVQUAL	National HIV Quality of Care Project
HSS	Health System Strengthening
HRSA	Health Resources Services Administration
HTC	HIV Testing and Counseling
IA	Implementing Agency
IBBS	Integrated Bio-Behavioral Survey
ILB	International Laboratory Branch
IM	Implementing Mechanism
INH	Isoniazid
IP	Implementing Partner
IPT	Isoniazid Prevention Therapy
ISO	International Organization for Standardization
KP	Key Populations
LCI	Local Capacity Initiative
K	Kina

M&E	Monitoring and Evaluation
MARP	Most-At-Risk Population
MDR-TB	Multi-drug resistant tuberculosis
MOU	Memorandum of Understanding
MSM	Men who have sex with men
NASA	National AIDS Spending Assessment
NCD	National Capital District
NHIS	National Health Information Systems
NHS	National HIV/AIDS Strategy
OI	Opportunistic infections
OU	Operating Unit
OVC	Orphans & Vulnerable Children
PHO	Provincial Health Office
PLHIV	People Living with HIV
PMTCT	Prevention of mother-to-child transmission
PPP	Purchasing Power Parity
PWID	People Who Inject Drugs
QM/QI	Quality Management / Quality Improvement
RDMA	Regional Development Mission for Asia (USAID)
RH/HIV	Reproductive Health/HIV
SI	Strategic Information
SLMTA	Strengthening Laboratory Management Toward Accreditation
SMS	Short Message Service
SNU	Sub-National Unit
SPECTRUM	UNAIDS Software
STI	Sexually Transmitted Infections
TA	Technical Assistance or Targeted Assistance
TB	Tuberculosis
TG	Transgender
UNAIDS	United Nation AIDS Organization
VL	Viral load
VMMC	Voluntary Medical Male Circumcision
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
XDR-TB	Extensively drug-resistant tuberculosis

Goal Statement

Through partnerships with the Government of Papua New Guinea (GoPNG), National Department of Health (NDOH), civil society, and key donors, PEPFAR-PNG aims to achieve 90:90:90 among key populations in the National Capital District (NCD) Province by 2017 and to develop essential epidemiologic and program data to inform the national HIV response.

PEPFAR-PNG will achieve this through a four-pronged strategic approach:

1. Focus geographically in NCD and saturate key populations (KP);
2. Invest in better understanding of disease burden;
3. Strengthen programmatic strategic information; and
4. Better leverage partnerships to amplify impact.

Strategic approach 1- Focus geographically in NCD and saturate KP: PEPFAR-PNG focuses on improving HIV services for KPs through the continuum of prevention to care and treatment (CoPCT) model. CoPCT focuses on all points within the continuum to strengthen outreach, identify those that test positive and ensure they are enrolled into care and initiated on treatment. Specifically, PEPFAR-PNG will scale-up the Moresby South district to achieve 90-90-90 among key populations by 2017. We will intensify outreach for KPs by targeting hot spots; we will strengthen high yield testing by introducing mobile testing in hot spots; and strengthen KP-friendly clinical services and related diagnostics to ensure people are initiated into treatment and retained and the virus is suppressed. In 2014, GoPNG endorsed the CoPCT model as a high impact HIV strategy, calling for its replication nationally; the NDOH, Global Fund and Australian Department of Foreign Affairs and Trade (DFAT) now use this KP-focused model. We will document best practices and provide technical assistance (TA) to NCD counseling and testing and treatment sites to ensure consistent implementation and quality of services across all sites. In COP 15, we will transfer the existing PEPFAR supported clinic in Madang to a transition site while the current four sites in Moresby South which have been receiving direct support from PEPFAR will be considered sustained sites.

Strategic approach 2 - Invest in better understanding of disease burden: Currently, there is insufficient data in PNG to confidently identify where the disease burden (HIV prevalence and KP concentration) is the highest. PEPFAR-PNG, in collaboration with Global Fund, NDOH, and DFAT, will conduct an Integrated Bio-Behavioral Survey (IBBS) in three Provinces, where models show HIV prevalence is highest. The IBBS will provide reliable data: on HIV prevalence in KPs and on behavioral data for KPs and that will be used to

determine size estimates of KPs. Results will be used to critically examine the HIV response and align efforts to the geographic areas with the highest disease burden.

Strategic approach 3 - Strengthen programmatic strategic information: PEPFAR-PNG will work with NDOH and other key partners to strengthen programmatic data. Specifically, we will work to: (1) link site level information from facilities within NCD to the national system, especially in the scale-up sites in Moresby South; (2) improve data collection tools at the site level; (3) provide TA to establish systems to regularly collect and report cascade information; (4) establish KP sentinel surveillance to monitor the trend of HIV prevalence among KPs; and (5) establish early warning indicators for drug resistance monitoring. Additionally, to learn from current programmatic efforts, we will conduct an outcome evaluation.

Strategic approach 4 - Better leverage partnerships to amplify impact: Cognizant that a limited budget requires strong partnerships to bring HIV to manageable levels, PEPFAR-PNG will continue to maximize the impact of our partnerships by targeting critical gaps in the response - throughout all of the proposed activities, PEPFAR-PNG will leverage partnerships across the clinical cascade. We will increase partnerships to: (1) strengthen focus on saturating KPs; (2) address drug resistance and improve clinical care quality; (3) strengthen KP data collection and utilization; and (4) establish a forum to work with KP CSOs, and strengthen gender based violence (GBV) linkages to HIV response.

PEPFAR PNG will address the **Right Things** by continuing to support and provide intensified TA to implement the CoPCT model for KPs in NCD and efforts to improve surveillance; the **Right Places**, by focusing on KPs in NCD, where disease burden is the highest, HIV prevalence is the highest, KP concentration is the highest and has the fastest population growth rate; and **Right Now**, when core interventions that target KPs can effectively bring HIV under control.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

PNG has a total population of 7.8 million per latest GoPNG estimates. Among the leading causes of mortality are lower respiratory infections, tuberculosis (TB), diabetes, pneumonia, malaria and HIV/AIDS. TB and pneumonia have high prevalence rates and are often associated with HIV infection. PNG has the highest prevalence of HIV/AIDS among the Pacific Island states. Ninety-five percent of HIV cases reported in the Pacific between 1987 and 2008 were from PNG.

HIV surveillance in PNG uses a backbone of antenatal clinics plus TB, STI and other specialist clinics for a total of 314 HIV testing sites. Only 69% of ANCs report regularly; only 53% of pregnant women attend ANC and only 51% of those are tested for HIV (2014 UNAIDS, 2013 NHIS and NDoH HIV testing database). While HIV surveillance data is limited, overall prevalence is estimated at 0.65% among the general population (UNAIDS 2014). Other HIV surveillance sites and positivity rates include: STI clinics (4%), TB clinics (14%), health facilities (6%), blood banks (0.25%), and HCT clinics (4%). Some of the reasons for ineffective HIV surveillance in PNG include: 1) the shifting priorities of GoPNG to their national disease epidemics of TB and malaria; 2) lack of supportive supervision and coordination at all levels; 3) the absence of a national road system to connect the entire country; 4) major telecommunication and IT challenges; 5) a shortage of trained health care workers and effective managers; and 6) a large network of clans with vastly different identities, languages, and cultures.

The results of a recent study by Burnett, NDOH and World Health Organization (WHO) revealed a worrisome 16% transmitted drug resistance to the first line ART regimen in the National Capital District (NCD) and 8.2% resistance in Mt Hagen in Western Highlands Province. As the study was not randomized and involved a small sample size, a larger two stage cluster DR study is planned with partial PEPFAR support. This and other factors are contributing to an increasingly complex health profile in PNG.

For example:

Western Province and NCD are currently in the middle of an extensively drug-resistant / multi drug resistant (XDR/MDR) TB outbreak. DFAT and other donors are actively contributing resources to address the outbreak, but it has yet to be controlled. The recently signed Global Fund grant increasing TB funding will no doubt help, but funding levels may not be sufficient to control TB in all the provinces and current co-infection rates with TB and HIV are around 20% (National TB Strategy 2015-2020).

Though HIV has been reported in all 22 provinces, the epidemic appears to show a geographical focus in specific provinces. Based on the 2015 Global AIDS Response Progress and Universal Access Reports (GARPR) for PNG, estimates show that the NCD region had the highest HIV prevalence of 1.07% followed by the Highlands region at 0.85%. While surveys on KPs in PNG remain limited, available data continues to indicate that prevalence is significantly higher in KPs compared to the general population.

A 2014 meta-analysis by UNAIDS reported rates as high as 17% among female sex workers (FSW) and 23.7% among transgender sex workers in Port Moresby. The GARPR reports high prevalence among male sex workers in Port Moresby, with an 8.8% rate among men who sell sex and 23.7% among transgendered males who sell sex. Injection drug use is very rare in PNG. However, criminalization, stigma and discrimination related to homosexuality contribute to men who have sex with men (MSM) remaining hidden, making data on this population less reliable and/or under-reported. Overall sexual transmission is estimated to account for most of the infections in PNG and mother to child transmission estimated to account for about 4%.

GBV is a highly pervasive problem in PNG with insufficient response from the GoPNG (Amnesty International, 2010a; Baines, 2012). In a five province study, approximately 66% of women report experiences of physical or sexual violence (Ganster-Breidler, 2009). Because of the nature of their work, FSWs are highly susceptible to GBV. In Port Moresby, FSWs have reported rates of sexual abuse as high as 78% (FHI 2011). In addition to direct transmission from sexual assault, multiple pathways lead from GBV to HIV infection. Vulnerability to HIV can increase due to gender norms and inequalities stemming from a limited ability to negotiate safer sex, engaging in transactional sex, and to a decreased ability to test, disclose and access HIV treatment because of fear of reprisal, violence and abandonment (WHO, 2013). While GBV is commonly thought of as a public health crisis for girls and women, gender norms around masculinity, sexuality, and power differentials may also contribute to elevated GBV risks for MSM. A 2011 FHI study in Port Moresby found 58% of MSM respondents had experienced sexual assault/violence.

The NDoH is currently implementing the 2011-2015 National HIV/AIDS Strategic Plan and data from the recent annual report shows substantial progress, with an overall reduction of 55% in estimated annual new HIV infections in adults 15+ years, from 3,363 in 2001 to 1605 in 2015. However, there is no recent KP IBBS or sentinel surveillance data to assess and measure the progress and impact within KPs. Available PEPFAR-supported clinic data over the last six months indicate that 22% of individuals tested and categorized as high risk (defined by having sex with more than one person in the last three months) are from KPs and 33% of those testing positive are from KPs (this may be an underestimate due to the narrow definition of high risk where unprotected sex is not included). Unfortunately, referrals to care and treatment data amongst KP patients who test positive are not available. All the key HIV stakeholders in PNG agree that in order to control the HIV epidemic within NCD, interventions focused on KPs are needed immediately.

PEPFAR-PNG is supporting the development of a patient tracking system to assist and strengthen referral following. GoPNG has made significant progress in the cascade from care to antiretroviral treatment (ART) with 80% of total eligible adults ($CD_4 \leq 500$) currently on ART (UNAIDS, 2015). Using the $CD_4 \leq 500$ treatment guidelines, UNAIDS estimates that about 75% of all PLHIV are in need of treatment. While these revised guidelines will increase the figures of patients that need to be registered in care, it is anticipated that this new group of patients will be able to quickly access treatment services due to PNG's established infrastructure and drug availability. Currently, poor HIV surveillance is the main challenge, in particular for KPs. Other critical challenges are monitoring of ART retention/adherence and understanding the impact of stigma and discrimination on access to services, particularly HIV testing and counseling.

As stated in the recently submitted Global Fund Concept Note, "it is currently difficult to accurately report the number of people living with HIV who are retained in ART programs. Numbers of those dropping out, dying or moving to other locations are not consistently monitored across all ART sites". Six major Global Fund supported ARV centers currently utilizing a computerized HIV patient database report a 2014 retention rate of 88.8% at 12 months and 60% at 60 months (UNAIDS 2015). To address the retention issue, PEPFAR-PNG is scaling up and training staff to utilize handheld smart phones which will track HIV positive patients. This mobile technology (CommCare) should improve the clinic's ability to track referrals from outreach to clinical and GBV services as well as no-shows for their appointments. The aim is to make it low-cost, efficient and effective such that it will present an attractive, scalable model for patient retention to the GoPNG. PEPFAR-PNG will focus on clinic QI to improve retention in both the sustained and scale-up treatment sites in NCD, totaling seven in all.

Clearly, inadequate surveillance and monitoring for HIV and for other diseases, along with poor retention strategies throughout the country, pose the most immediate challenge to PEPFAR and other stakeholders who want to implement program with maximum impact. This is doubly true in providing services to members of stigmatized and hidden population groups for whom testing and counseling and ART retention are key to epidemic control. While lack of data does not preclude effective program implementation, it does impede strategic, efficient, evidence-based decision making. With the information provided by the KP IBBS and smart leveraging of PEPFAR dollars, PEPFAR PNG believes it is possible to establish a government-led program that will achieve an AIDS-free generation within the next decade.

Table 1.1.1 Key National Demographic & Epidemiological Data
(2014 UNAIDS/GARPR)

	National figures	Pregnant women	FSWs	MSMs	TGs
Total Population	7,800 000	253655	38,561*	39,837*	No data available
PLHIV	32,744	1079			
HIV Prevalence (%)	0.65%	0.53%	17%**	8.8%	*23%
AIDS Deaths (per year)	1166	No data available			
Current on ART	16,896	450	No data available		
ART Coverage (all PLHIV as denominator)	51.6%				
ART Coverage for eligible pop(+15 yrs), all PLHIV +15 yrs.as denominator	85%				
ART Coverage for PMTCT		42%			
TB/HIV Co-infection	14%	No data available			

Sources: * census data estimates; **Kelly, et al (2010)

Standard Table 1.1.2 Treatment and Care Cascade HIV Care and Treatment

National Program				HIV Testing and Linkage to ART (based on 12 months data, 2014)					
Total # PLHIV	In Care	On ART	Retained on ART	Viral Suppression 12 Mon.	Tested for HIV	Diagnosed HIV+	In Care	Initiated on ART	Retained on ART 12 Months
32,744	15,848*	16,896	13010	N/A	200,711	5966	5602	4377	3852

1.2 Investment Profile

PNG is a lower-middle income country with a gross national income, PPP adjusted, of \$2,010 USD per capita (World Bank, 2013). External donor resources were the major source of financing for PNG's K 228,123,252 million (~\$86 million USD) HIV response in 2014, accounting for over 80% of the total. This funding allocation, however, is expected to decrease this year due to the GoPNG now providing free health care and procuring all ARVs and HIV test kits. In 2015, DFAT will provide about \$26 million (30%) to the HIV response with Global Fund estimated to support 11% of the total HIV response. PEPFAR provides 6% as the third largest individual donor for the HIV response (NASA 2012). The GoPNG will contribute about 22% and the remainder is covered by other bi-lateral and multi-lateral organizations, including substantial inputs by faith-based organizations.

DFAT supports a wide range of HIV activities and health systems strengthening (HSS) in both HIV clinical and non-clinical settings. Global Fund has shifted HSS from HIV to TB per GoPNG direction. A TB/HSS grant for \$18 million was signed in February 2015, and a new \$14.2 million HIV grant focusing on KPs will be signed in June 2015. Most of the funding for the new HIV grant will be directed to the highlands.

In 2012, the National HIV Program spent about \$82 million. The programmatic breakdown of the HIV spending reveals that prevention spending was about US\$18 million (22% of the total spending). A total of \$10 million (12%) was spent on care, support and treatment, while program management and administrative strengthening used \$41 million (50%). The breakdown of GoPNG spending on laboratory, strategic information, and HSS is not available, but those elements are covered under program management and administrative strengthening. The GoPNG and stakeholders are working at reducing program management costs through implementing more efficient and automated management systems. The GoPNG pays for all ARVs and commodities, allocating about \$2.6 million for ARVs annually. Although the adoption of the revised WHO treatment guidelines will ultimately save lives through reduced transmission, fewer hospitalizations, and prolonged worker productivity, in the short term, it will greatly increase costs to a total of approximately \$3.4 million for the GoPNG funded ARV procurement (plus the added costs of second line ART procurement). In addition to service delivery costs, there will be increased costs for HIV lab capacity monitoring, supply chain systems for ARV drugs and other commodities, quality assurance systems, and supervision and monitoring of the program.

Table 1.2.1 Investment Profile by Program Area (2011-2012 NASA)

Program Area	Total Expenditure (\$ millions)	%
Prevention	18.4	22
Care and Treatment	9.94	12
OVC		<1
Programmatic management & administration strengthening*	41	50
Training	3.7	5
Social protection	0.34	<1
Enabling environment	7.5	9
HIV-related research	1.3	2
Total	\$82.1	100%

*includes laboratory and strategic information and health systems strengthening

Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

PEPFAR-PNG proposes implementing the Local Capacity Initiative (LCI) to increase awareness and response to the GBV/HIV joint-epidemic and HIV among KPs. LCI will build the capacity of key family health civil society organizations to successfully advocate for populations affected by family and sexual violence by:

- 1) Effectively representing stakeholder perspectives on GBV/HIV (with an emphasis on KPs) prevention and response within the national HIV/AIDS policy dialogue.
- 2) Contributing to the nascent evidence-base demonstrating the scope of the HIV/GBV epidemic in PNG and promoting innovative community generated approaches to preventing GBV/HIV (with an emphasis on KPs).
- 3) Reducing stigma and discrimination in the clinical setting toward people living with HIV and affected by family and sexual violence.

Building civil society capacity to effectively advocate for GBV/HIV (with an emphasis on KPs) prevention and access to care and treatment services will enhance country ownership by increasing the role of civil society as an active stakeholder in the public sector response to the joint epidemic. This capacity building will promote a sustainable civil society response through continued advocacy for unencumbered access to care and treatment services along with the public investments in services to respond to GBV/HIV (with an emphasis on KPs). Groups such as “Development Legal Associates” are now playing a prominent role in both legalizing same-sex relationships among men and in strengthening the pathways and knowledge among women on how to quickly access legal services. The PNG Tribal Foundation is on the verge of releasing a world-class documentary on GBV in PNG that instead of displaying downtrodden, socially rejected women to viewers, it shows the power of women who have taken action, demonstrated leadership, and who have found the courage to create successful, fulfilling, happy lives by relocating to another village and staying away from the perpetrator. The film is in the local language, Tok Pisin, in order to allow as many local women to see it as possible. The Foundation is currently finalizing a distribution plan and welcomes partnerships with groups who want to rid PNG of GBV. Both of these groups, as well as numerous others provide opportunities for partnership and smart leveraging of resources and activities through LCI.

1.3 National Sustainability Profile

Across the 15 elements of the five domains of the Sustainability Index, one element (*Performance Data of the Institutional Data Availability Domain*) was found to be

sustainable. Four elements, two from the Domestic Program and Service Delivery Domain (*Human Resources for Health and Commodity Security and Supply Chain*) and two from the Political Will and Commitment Domain (*Enabling Policy and Legal Environment and Technical and Political Leadership*), were found to be approaching sustainability. Ten elements across the following four domains demonstrated emerging sustainability and will require increased or smarter investment:

Domain 1: Institutional Data Availability: Epidemiological/Health Data and Financial/Expenditure Data: Improving data availability is the highest priority and will rely on a commitment from GoPNG for HIV surveillance, especially for KPs. Resources that improve epidemiological and health data will facilitate GoPNG to better know their epidemic and to design a more efficient and targeted response. Australia, Global Fund and PEPFAR-PNG provide resources in this area. In addition, the Asian Development Bank is supporting the phased implementation of a new National Health Information System to improve disease reporting to NDoH, including HIV testing, care and treatment data in eleven ADB supported provinces (including the entire Highlands region). GoPNG is committed to rolling out the same system nationwide. PEPFAR-PNG is part of the working group and will support the integration of HIV data into this system and expansion to the NCD. The planned KP IBBS will provide population estimates among sex workers, MSM and TGs, thus providing an evidence base to guide future interventions. PEPFAR will fund 11% of the costs of the IBBS and Australia, Global Fund, and the GoPNG will fund the remainder.

Additional resources for financial/expenditure data tracking is highly critical and will assist in identifying financing sources, costing, and economic evaluation and in guiding cost-effective strategies. Progress in HIV Financial/Expenditure data availability will be slow as UNAIDS has a two year cycle for NASA reporting. In addition, GoPNG is slowly implementing more computerized and detailed financial management systems. We will continue to provide TA in improving quality of expenditure data.

Domain 2. Domestic Program and Service Delivery: Access and Demand; and Quality Management: Efforts to better understand the patterns of uptake and utilization of HIV/AIDS prevention, care and treatment services and programs especially among KPs and individuals infected and affected by HIV/AIDS, is anticipated to have a significant impact on PNG's HIV epidemic. Additionally, by investing in quality assurance and improvement (QA/QI) strategies, PNG will be better poised to achieve epidemic control through reduced AIDS-related deaths, reduced incidence, and improved viral load suppression. PEPFAR-PNG will provide technical assistance to the government in NCD

in its early efforts to roll out viral load as a standard of care for measuring treatment failure. Likewise, PEPFAR will continue to support QA/QI activities in NCD ART and HCT sites.

Domain 3: Health Financing and Strategic Investment: Domestic Resource Mobilization (DRM) – Resource Generation; DRM – Resource Commitments, Allocative Efficiency and Technical Efficiency: In order to meet its national HIV/AIDS prevention, care and treatment targets, PNG must be cognizant, and have a strong working knowledge of, the financial resources that are necessary to implement cost effective and efficient programs. Investments must be allocated to ensure that sufficient resources are available and that data is used to inform funding decisions that maximize positive health outcomes and lend to epidemic control. PEPFAR COP 15's Strategic Approach #4 to "Better Leverage Partnerships to Amplify Impact" should result in an increasingly shared vision of how partners will work together to bring the epidemic under control.

In regards to the areas of domestic resource mobilization and financial commitments, these elements will be challenged by the slow progress of GoPNG budgeting framework and the shifting priorities of GoPNG to their national epidemics of TB (with increasing X/MDR-TB) and malaria resulting in projected flat GoPNG funding in HIV in the future. The GoPNG's commitment to free healthcare and 100% procurement of ARVs and HIV test kits and lab reagents help offset this shift.

It is anticipated that Allocative and Technical Efficiency progress will improve with better data availability (see above) and capacity building of managers supported by Australia and Global Fund.

Domain 4: Government Accountability and Transparency: Public Transparency and Oversight: Accountability of funding and transparency of data will ensure that all investments produce the greatest and most efficient and effective impact. Importantly, this practice fulfils an obligation to PNG citizens and international stakeholders/donors for achieving HIV/AIDS results and for transparency in the use of public funds. Investing in these elements will ensure that PEPFAR is fiscally responsible in programming that aims for epidemic control, that it disseminates program progress and results in a timely manner, and provides mechanisms for eliciting feedback.

1.4 Alignment of PEPFAR investments geographically to disease burden

The Global AIDS Progress and Universal Access Report (GARPR) 2015 Report indicates that the NCD has the highest disease burden with an HIV prevalence of 1.07% among general population and 8.8% prevalence among MSMs and 17% prevalence among FSWs.

These figures were used to estimate a KP total of 10,733 persons (MSM: 5,685 and FSW: 5,048); the estimated PLHIV is 1,358 (MSM: 500 and FSW: 858). Understanding PEPFAR's contribution is only 6% of the total national HIV response, we have taken several approaches in COP 15. We will pivot from the five high burden provinces and 24 sites to concentrate in NCD in 10 sites to saturate the key populations. We will ultimately move from a combined DSD and a TA approach to a TA approach only in the scale-up and sustained sites in NCD. We will leverage partnerships to ensure that all activities are aligned to reaching the most at risk population and linking them to the continuum of care.

In the current PEPFAR supported sites (24), five sites are direct service delivery sites, and 19 are TA sites for HIV QI. All five DSD sites are focused on delivering KP services using CoPCT model; four of these sites are in NCD Province whilst the fifth one is in Madang Province. The DSD and TA sites do not cover an entire district or SNU as funding realities coupled with the concentration of HIV among KPs, narrow PEPFAR focus to a few clinic sites (both sustained and scale-up) that specifically target outreach and clinical services to KPs. PEPFAR PNG aligns its program with those of other partners with the aim of achieving effective coverage and increased access to HIV care for KPs. PEPFAR is beginning the process whereby six months into the COP 15 implementation period, PEPFAR will transition services at the Madang site and solely concentrate on sustained and scale-up sites within NCD. We will closely monitor the transition to ensure that patients continue to receive quality services.

In 2011, an evaluation of PEPFAR-PNG's CoPCT model project cited that the model effectively reduced stigma and discrimination of health providers in the Madang clinic, which led to an increase in the number of KPs accessing the clinic's services. The Madang clinic also achieved significant reductions in the loss to follow-up rate for patients on opportunistic infection (OI) medication and/or ART, from 14% in 2008 to 1% in 2011. Therefore, the continued success of the site is critical.

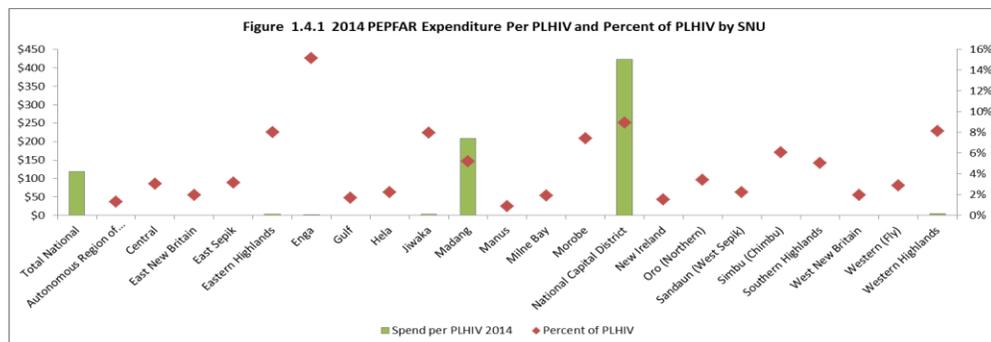
In all 10 sites in NCD, PEPFAR-PNG will continue to work with our partners to intensify outreach to reach more KP. We will strengthen HIV testing to increase yield, initiate more PLHIV KPs on treatment and ensure that those who are on ART, achieve viral suppression. We will leverage partnerships to establish virological, immunological and clinical indicators for detecting treatment failure and monitor drug resistance. We will improve data collection tools at the site level in all 7 treatment sites (both scale-up and sustained) in NCD as well as two sustained HCT sites and establish key population sentinel surveillance to monitor HIV trends among key populations. Our TA will also

focus on improving quality of data as well as quality of care at all levels of the care cascade, and rolling out viral load testing, in conjunction with the National Public Health Laboratory.

Working with WHO, NDoH and other partners, our TA will contribute to developing the KP treatment guidelines, sentinel surveillance protocol, and strengthen team efforts to sustain key population activities. For the other high burden provinces, we will work with partners at the national level to provide TA to improve system level activities in building capacity, strengthening QA, improving programmatic data collection, and improving quality of care. Whilst PEPFAR concentrates in NCD, DFAT and other partners will target Hela, Western Highlands, Enga, Jiwaka, Chimbu, Oro and Manus.

Given the prior year focus of the PEPFAR-PNG program, the majority (84%) of expenditures are for KP service delivery, SI, quality improvement in HIV care and treatment and QA for HIV related testing, with KP service delivery representing 54% of expenditures. Above-national and national expenditures comprised 49% of total PEPFAR expenditure, indicating that the portfolio is well balanced between national and sub-national technical assistance and service delivery. For Cop15, PEPFAR-PNG has tied its budget to the four strategic approaches to reach 90:90:90 for KPs in NCD. We will spend 49% of our budget on saturating KPs in the National Capital District, 16% will be spent on IBBS, whilst another 15% will be invested on strengthening programmatic SI.

2014 PEPFAR Expenditure analysis data indicates that approximately \$450 was expended per PLHIV. The PEPFAR-PNG team considered all the inputs and determined that the EA figure for Madang, a transition site, would be appropriate to apply to NCD activities as we transition to a TA model and the clinics are more established - they started offering treatment services in April 2014.



1.5 Stakeholder Engagement

Better leveraging of partnerships to amplify impact is one of the four prongs of PEPFAR-PNG’s strategic approach. With a budget that makes up 6% of PNG’s total HIV/AIDS

response, strengthening partnerships will make it possible for PEPFAR-PNG to have greater impact. PEPFAR-PNG has been a strong collaborator with government and other stakeholders; NDOH, NACS, national HIV technical working group (TWG), Global Fund, DFAT, WHO, UNAIDS, Asian Development Bank, and civil society, however, the team will expand upon its successes in stakeholder engagement for greater impact.

PEPFAR-PNG's engagement will take on two approaches; information sharing, and collaboration. We will share information through regular and special meetings to discuss planning, specific activities and results of our implementation. This will ensure that PEPFAR activities are aligned to the national response and other partner activities. PEPFAR-PNG will also collaborate with partners to: 1) strengthen focus on saturating KPs; 2) better understand the disease burden; 3) strengthen KP programmatic data and utilization; and 4) establish a forum to work with KP CSOs, and strengthen GBV linkages to the HIV response. To ensure maximum impact, we will provide technical assistance and share best practice approaches and lessons learned across the clinical cascade with all relevant stakeholders. This collaboration is described in more detail in section 4. Finally, we will expand our engagement with civil society, both at the implementation level and for information sharing (as described in the civil society engagement strategy).

2.0 Core, Near-Core and Non-Core Activities

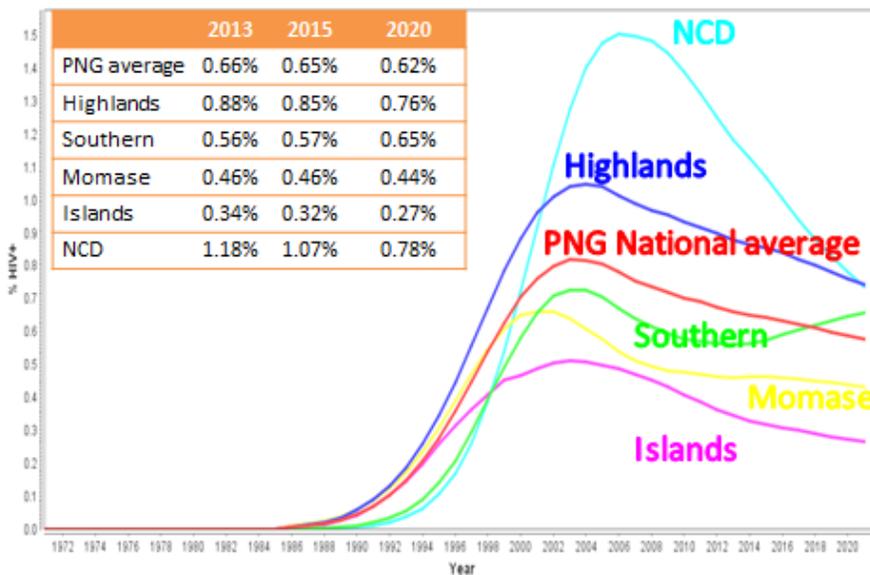
PEPFAR-PNG considered the activities required to achieve sustained epidemic control for KPs in NCD; commitments made by GoPNG, Global Fund and Australia, as well as other stakeholders; the available PEPFAR budget; and the data available to guide our programs in defining core, near-core, and non-core activities for program implementation in FY 2016. As a result, our core activities will focus on intensifying KP outreach, strengthening high yield testing, and strengthening KP-friendly clinical services and related diagnostics to ensure people are initiated into treatment and retained and the virus is suppressed. Activities will also focus on strengthening capacity of NCD NDOH and NGO health staff to deliver high quality HIV services, HIV surveillance, and improve adherence. PEPFAR-PNG will provide support through two methods: 1) continued implementation and evaluation of the CoPCT service delivery model in NCD; and 2) provision of targeted TA and training/mentoring at the national level and in NCD. With limited funds and resources, the PNG PEPFAR team will leverage partnerships to reach 90:90:90. We have included several surveillance activities (KP IBBS) and HIV testing studies as near-Core activities. In addition, the PNG PEPFAR team listed the low cost Ambassador's HIV/GBV small grant program as near-Core due to its high profile in the Embassy and importance in addressing GBV and HIV prevention in vulnerable groups of women (e.g. FSW) and men (MSM and TG) to impact the HIV epidemic. We have also included plans

for transitioning treatment services in Madang to the provincial government, and community prevention and health promotion activities to local civil society. See Appendix A for full list of core and near-core activities.

3.0 Geographic and Population Prioritization

The last Estimation and Projection exercise conducted in November 2014, revealed that the HIV epidemic in PNG has a national prevalence of 0.65%, with the highest concentration of infections in NCD and Highlands regions. The regional illustration in the graph below provides a clear presentation of the predicted progression of the epidemic by region.

Estimated HIV Prevalence for adults (15+) by region



1

NCD is both a province and the largest city in the country, with the largest and most diverse population groups and the highest prevalence rate. With the highest HIV prevalence rate, the fastest population growth rate, and the highest concentration of key populations, PEPFAR-PNG will focus its efforts on achieving epidemic control (90:90:90) in NCD.

Current KP focused activities in PNG are being funded only by DFAT and PEPFAR, however, the new HIV grant from the Global Fund will also focus on KPs. DFAT funds about six different IPs, covering ten provinces, including Jiwaka, Enga, Western Highlands and NCD. Until more KP HIV surveillance data is available from the proposed KP sentinel surveillance system and from the results of the KP IBBS, PEPFAR-PNG will prioritize activities in the KPs in NCD.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

PEPFAR-PNG will focus efforts on KPs located within NCD. We will provide both DSD and TA to support and expand the CoPCT model. We will transition services from the PEPFAR-PNG supported treatment site in Madang Province.

The GARPR 2015 Report indicates that the NCD has the highest HIV prevalence at 1.07% among general population and 8.8% prevalence among MSMs and 17% prevalence among FSWs. These figures were used to estimate a KP total of 10,733 persons (MSM: 5,685 and FSW: 5,048); the estimated PLHIV is 1,358 (MSM: 500 and FSW: 858). NCD is estimated to also have the highest population of KPs as well as the fastest population growth rate in the country.

Since there are no existing size estimates for the total population of KPs in NCD, we used the official 2011 census data and applied a 2% population growth rate (NCD Commission Report). We used the updated total population to calculate the general population PLHIV. We applied an HIV prevalence of 1.07% (GARPR, 2014). With the estimated number of PLHIV in NCD, we applied the KP prevalence data of 8.8% for MSM and 17% for FSW (NCD IMR, 2010). Additionally, we assumed that 5% of the total adult population in NCD is engaged in sex work to determine estimated KP PLHIV in NCD.

Reaching 90:90:90: targets FY 16:

SNU	KP Prevention outreach	KPs Counsel and tested	Initiated new on treatment	Virally suppressed
NCD	3,576	2,857	160	131

SNU	Total KP PLHIV	Expected current on ART*	Additional patients required for 80% ART coverage**	Target current on ART in FY 16	Newly initiated in FY 16
NCD	1,358	581 (MoH) 119 (FY14 APR)	400	261	160
Total	1,358	581 (MoH) 119 (FY14 APR)	400	261	160

*Based on National ART Program (581) and FY14 APR PEPFAR results (119)

**400 is based on UNAIDS 90-90-90 estimates by FY17

SNU	Entry Stream	Tested for HIV (FY16)	Identified Positive (FY16)	Enrolled on ART
NCD	HTC among Key Populations	2,857	178	160
Total	HTC among Key Populations	2,867	178	160

The following paragraphs provide an explanation of target setting by program area. PEPFAR-PNG, in collaboration with partners, established the Madang clinic site in 2008; the PNG-PEPFAR team has strengthened its outreach and service delivery to ensure that it is reaching KPs with much needed HIV services. Since the Madang clinic has been established longer, their absolute numbers are higher than the other four DSD sites. Of the 7 treatment sites in NCD, PEPFAR-PNG started four of them. Two were transitioned to the government in 2013 and two are still DSD sites, which will transition by 2017. The two newest DSD treatment sites in NCD, started in April 2014 and have been dispensing ART less than one year.

A major limitation to PNG's HIV response is the absence of accurate KP size estimation. In response, PEPFAR-PNG is actively participating in the Management and Technical Committees of the IBBS while at the same time leading the creation and implementation of planning a KP sentinel surveillance system in the coming year. The IBBS will be jointly funded with Global Fund, DFAT, NDHO and PEPFAR.

The PEPFAR-PNG conducts regular hotspot mapping exercises in districts in close proximity to DSD sites to document hot spots and conduct on-the-spot counts of people to ensure peer-to-peer outreach is targeting the right people in the right place, right now.

Prevention and HTC

Baseline prevention and HTC targets for FY13 were derived from the achievements of the previous 2007-2012 project under RDMA TASC III which was implemented in NCD and the city of Madang. Consideration was also given to the fact that, unlike the long-operating Madang site, PEPFAR-PNG, with NDOH and private sector, established two new KP friendly treatment sites and these new sites required time to recruit, train, and

sensitize project staff and peer educators as well as identify and recruit KP clients. At the PEPFAR supported treatment sites, since October 2012 through the end of FY14, 6,926 people were counseled and tested, 4,210 of whom were categorized as a member of a KP or at high risk, and 5,368 people have been reached with prevention interventions. The total counseled and tested includes walk-ins and self-referrals as well as people referred for testing, hence this number is larger than the 5,368 people who were reached by project staff during community outreach activities.

In FY14, the PEPFAR-PNG program encountered some significant challenges. Firstly, a major sub-award, responsible for conducting prevention activities in Madang, was terminated. A new implementing agency was identified in the last quarter of 2014 and outreach immediately resumed, however there was a delay in peer-to-peer outreach. Secondly, in NCD, civil unrest considerably slowed both the outreach and clinical operations at the two DSD treatment sites. Thirdly, there was a major turn-over of peer educators, who conduct the prevention and referral work in the community.

To address the latter issue, PEPFAR- PNG adopted an Enhanced Outreach Approach (EOA) which incentivizes peer educators to conduct KP outreach activities to enhance KPs referrals. This approach is expected to increase the number of KP individuals accessing clinical services in FY15. The EOA will require more time and effort by peer educators to ensure that a referral is successful (i.e. people are counselled and tested and receive their results). The assumption behind this approach is that peer educators will be more motivated to make successful referrals and that through the EOA there will be a “second and third wave” of referrals made by clinicians as well as those originally referred by the “first wave.”

In COP 2015, the PEPFAR-PNG team considered the total number of KP needed to be reached with prevention messages to reach 90:90:90 by 2017. As we were moving to a TA model by 2017 and there may be delays in setting up optimum TA guidance, we would reach 40% of the targets in COP 2015 through both a DSD and TA approach.

Target Populations	Population size estimates in NCD	Coverage goal	FY 16 target
KP - MSM, TG	5,685	40%	2274
KP - FSW	5,048	40%	2019
Total	10,733	40%	4,293

Care, Support and Treatment

When establishing baselines target for care, support and treatment, the PEPFAR-PNG team considered the support provided to the Madang clinic under the previous project. This meant that: 1) the case management team had already been established; 2) the clinic already trained ART prescribers and peer volunteers to provide pre-ART, adherence counselling, and psychosocial support; and 3) the clinic already had well over 200 clients actively on ART. By the end of the first quarter of FY14, the NDOH accredited the two PEPFAR supported DSD sites as full-fledged ART sites and they began registering HIV+ clients and dispensing ART in April 2014. They are expected to reach full operating capacity this COP year and will work on a transition plan by 2017. We also considered TA and DSD as well as available budget.

During the past year, PEPFAR-PNG worked with the GoPNG to review, update and change the national guidelines for starting ART from $CD_4 \leq 350$ to $CD_4 \leq 500$. The number of clients eligible to initiate ART will therefore increase in the coming year. Target calculations were thus made as follows:

ART eligibility: Since there are no existing size estimates for the total population of KPs in NCD, we used the official 2011 census data and applied a 2% population growth rate (NCD Commission Report). We used the updated total population to calculate the general population PLHIV. We applied an HIV prevalence of 1.07% (GARPR, 2014). With the estimated number of PLHIV in NCD, we applied the KP prevalence data of 8.8% for MSM and 17% for FSN (NCD IMR, 2010). Additionally, we assumed that 5% of the total adult population in NCD engage in sex work to determine estimated KP PLHIV in NCD. The FY14 positivity rate for all groups was used to estimate the number of new people living with HIV for each following year. Based on the literature, about 45% to 50% of PLHIV are eligible for treatment at enrollment; therefore, 50% of the number anticipated to be newly diagnosed KP as HIV positive were calculated as eligible. A 10% upward adjustment was made to account for using the new national guidelines of $CD_4 \leq 500$ and again, based on the literature, a 25% downward adjustment to the numbers eligible for enrollment was made to account for deaths, those lost to follow-up, and those who stop coming to clinic for care. One assumption that may result in over-estimations is that all newly identified PLHIV eligible for treatment would agree to start ART.

Currently on ART: The ART targets for FY 15 and the projected current on ART target for FY 15 were used as baselines for calculating FY 16 and FY 17 targets. The projected number of those initiating ART for each year was then added, having already taken into account anticipated losses and yield from resulting from the new CD_4 eligibility criteria.

Site level targets: The percent contribution of each site to the total program was used to assign site level targets for newly starting and currently on treatment. This methodology is based on the assumption that the contribution of each site is a reflection of the number of individuals tested for HIV and the site specific positivity rate. Site level targets take into consideration DSD and TA site and have been adjusted accordingly.

Retention and Viral Suppression: A major challenge is regular follow-up of HIV positive clients on ART who have either defaulted or been lost to follow-up. Clients often provide false addresses probably to avoid home visits from a clinic known to treat HIV positive people, but this obviously makes tracking difficult. Clients also frequently change their phone numbers, making regularly scheduled follow-up challenging. The PEPFAR-PNG supported program recently introduced electronic tracking logs to track clients on ART which alerts the case managers to start calling and tracking those defaulting or who may be lost to follow-up. The program initiated the use of mobile technology in Madang to send reminders through short message service (SMS) with the aim of assuring client adherence to treatment and to confirm that the client contact and personal information is correct and up-to-date. PEPFAR PNG is also working through WHO and HRSA to increase retention and adherence through the national rollout of a HIV QI program for HIV clinics (targeting first clinics in NCD and the Highlands region and those serving KPs). In addition, PEPFAR will support pilot viral load testing and eventually support the roll out in NCD in order to be able to measure viral suppression. We estimated that 131 KP PLHIV will be virally suppressed.

Gender: We established baseline targets for GBV and gender related indicators based on the high level of physical and sexual violence experienced by KPs in PNG as reported in the 2010 BSS. Target setting also considered the fact that peer educators needed training and orientation to GBV, and the services needed to be available before peer educators could begin referring clients. While the initial targets were too high, the main hindrance to achieving them in the first year of implementation was the long delay in establishing clinical services in NCD, getting the clinics registered under NCD Health Services and NDOH, and letting GBV issues take second place to more pressing deadlines in order to provide basic clinical services.

Given the unacceptably high incidence of violence towards women and KPs and the low results of GBV services in FY14, it is clearly necessary to strengthen staff ability to screen for GBV at all sites in FY 15. This may include instructions on how to recognize a possible victim of GBV or a woman who is afraid of talking about it by introducing a few key

phrases that lets the woman (or man) know that they are in a safe space, that the information shared is confidential, that it's "ok" to talk about it with someone, and that they are not to blame for bringing violence upon themselves. In addition to conducting sensitivity training for clinic staff, PEPFAR-PNG will also conduct training for community leaders including church leaders, local business leaders, members of police and legal aid personnel on the unique health needs and vulnerabilities of sexual minorities, especially MSM & transgenders. Acknowledging that this is one area that needs more work despite previous staff sensitivity training, PEPFAR PNG will conduct a gap analysis to identify specific actions that will improve services to those who are vulnerable to GBV. Planned activities include training clinic outreach workers on how to mobilize community leaders against GBV, training in trauma counseling for clinic staff, establishment of a phone-based counseling and referral system in collaboration with the local phone company Digicel, ensuring that comprehensive PEP services are available to GBV survivors, and improvement of the response and referral mechanisms. The two project-supported safe houses are in very close proximity to the PEPFAR-supported clinic sites, hence referrals in both directions (by the clinic staff to the safe houses and from the safe houses to the clinics) can be increased. Standard Operating Guidelines (SOPs) for Safe Houses were non-existent, but have since been developed and shared with safe house staff.

Ensuring the safety of victims of violence once they leave the safe house is an on-going challenge, and not easily or cheaply resolved. Part of the project's technical assistance is to assist counselors and service providers to develop safety plans for each safe house resident on how to avoid re-victimization. This will more than likely necessitate better referral pathways and information sharing with other organizations. Another challenge for the project is to provide safety for MSM/TG, as the current two GBV shelters in NCD are for women and girls; creation of a safe space for men is under consideration by PEPFAR-PNG, however, more engagement and planning with the organizations representing the target groups will precede such a step. Per previous text, the soon-to-be implemented centrally funded LCI project will use community mobilization efforts aimed at addressing and transforming harmful gender norms and inequities and to increase awareness and response to the GBV/HIV connection as well as the integration of KPs into the GBV discussions.

TA/TC Country - Technical Assistance: PEPFAR-PNG is working at national and in NCD to achieve accelerated and sustained epidemic control. At the national level PEPFAR-PNG will continue to contribute to clinical guideline development, improvement of SI and M & E systems and tools and development of gender programming in HIV. PEPFAR-PNG is represented in the national HIV/AIDS Technical Working Group, where

major policies and systems related to the national response are discussed and decided. Considering that PNG has a predominantly concentrated epidemic, and PEPFAR's contributions are KP focused, PEPFAR-PNG will work with NDOH to amend their data collection tools to include data related to KPs. PEPFAR-PNG will also provide support to NDOH to roll out the newly revised HIV care and treatment guidelines to reach service providers and provide TA in NCD to ensure consistent application and roll out.

Program Area Summaries 4.2-4.10

4.2. Prevention

There have not been any recent policy/guidelines changes towards HIV prevention that specifically target KPs or other high risk groups. A mid-term review of the National HIV/AIDS Strategy 2011-2015 (NHS) has however, recommended re-prioritization of the country's prevention efforts to focus on KPs and for relevant government agencies to recognize that prevention and service delivery, whether counselling and testing, PMTCT, STI services with condom promotion, or ART, are part of a continuum that requires all parts to be closely coordinated, linked and mutually reinforcing. Similarly, condom promotion, distribution and use, particularly for KPs, needs to be closely linked to other services, including STI management, counselling and testing, treatment and care. The mid-term review specifically recommended that the CoPCT model of service delivery (originally piloted by USG) be institutionalized in PNG to strengthen links between community and clinical services for those living with HIV infection as well as for KPs. The same review noted that the CoPCT model has assisted health managers and service providers to plan accessible, client centered HIV services that meet the needs of KPs and PLHIV for life. The CoPCT model was piloted under the USG RDMA TASC III funding from October 2008 to September, 2012 and has now been institutionalized.

The current PNG-PEPFAR supported program continues to promote the provision of a comprehensive package of services for KPs and KP PLHIVs that is based on the CoPCT model. The services provided include community and clinic based activities, including: (1) Risk reduction counseling (e.g. condom use and other safer sex practices, alcohol and other drug reduction, HIV serostatus disclosure); (2) Correct and consistent condom use, condom demonstration and provision; (3) Education on STI, HTC and GBV when appropriate; (4) Referrals to STI and HTC; and (5) Provision of ART to all KP members whose CD4 \leq 350 (to be changed to \leq 500 in the very near future).

4.3 Voluntary medical male circumcision (VMMC) – PEPFAR PNG does not support any VMMC activities, and it is not a priority prevention area for the National Department of Health.

4.4 Preventing mother-to-child transmission (PMTCT)

PEPFAR PNG does not directly support PMTCT activities.

4.5 HIV testing and counseling (HTC)

Stigma and an unfavorable legal environment are major barriers to the uptake of HTC services by KPs, especially FSWs and MSMs, whose sexual activities are also illegal. Despite successes in reaching these groups with HIV awareness and prevention messages via their peers, many KPs who are referred for CT and STI services do not come to clinic. Based on current data from the FHI 360 sites, 29% of KPs reached with community-based prevention messages completed referrals for HTC services in FY 14 while only 20% of those who were counselled and tested received STI management. To address these gaps, the program will adopt a three-pronged approach to strengthen high yield testing:

1. Pilot and scale up mobile HTC services for KP in identified and known KP hotspots. The testing activity will be preceded by intensified outreach, including targeted community sensitization and discussions with community leaders.
2. Integrate STI, TB, and GBV screening into testing and counseling services at out-patient clinic sites in NCD and mobile units; and
3. Increase successful referrals via implementation of the Enhanced Outreach Approach, or other ways of incentivizing effective peer educators whose work should be recognized.

4.6 Facility and community-based care and support

The current PNG PEPFAR program provides care and support to HIV positive clients by providing the knowledge, medicines, and counselling to live positively with the virus. To date, the focus has been on facility-based services including: (1) OI prophylaxis based on the WHO eligibility criteria for cotrimoxazole prophylaxis; (2) treatment of OIs; (3) STI screening; (4) routine TB screening by patient history and clinical presentation and referral to TB clinic if appropriate; (5) INH prophylaxis for eligible clients for all patients who are not TB suspects; (6) adherence counselling; and (7) condom promotion.

Based on an assessment of the status of the services in NCD that are needed for a successful cascade, targeted TA will be provided to assist in improving the quality of services and the attitudes of the staff regarding caring for KPs. We will strengthen community based services by working with PLHIV support groups to include basic

support services including adherence, nutrition counselling, screening and referral for GBV, condom promotion and safer sex practices. The program will also seek to promote patient involvement in case management through the introduction of a self-care card. Self-care cards are for PLHIV to monitor their own health, including weight, CD4 count, appointment date, and other information that is under consideration. The idea behind the card is to engage the client in his/her own care and create a sense of self-empowerment through a better understanding of what happens in the clinic and how to stay healthy.

According to the National TB Strategic plan TB/HIV co-infection in the country is about 20 percent. Though there is no change in policy or guidelines, the current nation-wide TB epidemic and the outbreak of MDR/XDR TB in NCD with its higher HIV prevalence in both the general population and KPs has called more attention to TB services. WHO will be implementing TB-HIV intensified case finding in NCD HIV clinics with QI teams. Provision of TA to ART sites in NCD will strengthen routine TB screening at all service sites; strengthen linkages between TB and HIV services.

4.7 TB/HIV

PEPFAR PNG does not directly support TB/HIV activities. We will work to leverage partnerships to ensure TB/HIV activities are covered.

4.8 Adult treatment

Currently, ART initiation is based on a CD4 of ≤ 350 . The new national guidelines, expected to be rolled out in January 2016, will change ART initiation to CD4 ≤ 500 . Once adopted, the program will ensure that eligible clients who are currently considered “pre-ART” are initiated on treatment. PEPFAR PNG will continue to coordinate the rollout of the national QI program to HIV treatment clinics in NCD in order to improve adherence and retention. A sustainable electronic medical record system will be deployed to support identification of defaulters. Peer educators will be actively involved in following up clinic no-shows and reducing the numbers of patients lost to follow-up. The national government has initiated plans to deploy viral load machines, and is currently in the process of conducting a pilot with the Roche lab reagents. PEPFAR PNG will provide TA in laboratory QI and EQAS in NCD to ensure that the VL testing is accurate. Once viral load is declared a national standard of care to monitor treatment failure, the PEPFAR-supported sites will work with the national lab in an effort to perform viral load assessment for all patients who meet the criteria set by the government.

4.9 Pediatric Treatment

Currently, the PEPFAR supported sites are not certified to conduct pediatric treatment services. All suspected pediatric cases are referred to the National Hospital, being supported by CHAI.

4.10 OVC

PEPFAR PNG does not conduct activities or provide TA around OVC.

5.0 Program Activities to Maintain Support for Other Locations and Populations

As PEPFAR-PNG shifts its focus to work exclusively in NCD, there is a need to carefully and systematically transition its services from other geographic areas. This largely refers to the Id Inad clinic and the supporting community outreach activities in Madang Province. The clinic is run by the provincial government and the community activities are supported by Volunteer Services Overseas (VSO). PEPFAR-PNG will work to identify ways to effectively transition the activities we directly support. While transition means that we will no longer be funding activities in and around In Inad, the US government is committed to ensuring that these services continue. Therefore, we will develop a strategy with Id Inad and VSO to move to a sustainable model and support the transition. It is expected that this transition will be completed over the next year so that we will no longer be funding these activities before the end of the COP15 cycle.

In addition, PEPFAR has been supporting HIVQUAL (quality improvement for clinical HIV/AIDS services) and laboratory quality improvement in several sites outside of NCD. HIVQUAL has been implemented, with funding from PEPFAR through WHO. WHO epidemiologists in PNG will continue these activities regardless of PEPFAR funding so that these activities will be sustained. QI for lab services is being supported by GoPNG. PEPFAR will explore how best government can sustain these activities in the future and will work with GoPNG to make this a reality.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 HIV Laboratory. A PEPFAR-PNG lab assessment revealed a high percentage of rapid test discordant results and low (55-62%) lab participation in HIV EQA and HIV rechecking; and lack of routine viral load testing to assess adherence and effectiveness of ART. Our response is focused on improving HIV related testing with a priority for capacity building in NCD. For maximum efficiency, TA is provided by the PEPFAR Lab Advisor with support from a TDY lab contractor and from ILB. We will partner with DFAT, seconding staff to the CPHL, and WHO, providing TA for point-of-service lab QI in NCD. Core laboratory TA activities include: 1) Strengthen test site quality assurance of HIV rapid test; 2) Strengthen LQMS for HIV Testing Labs; 3) Assist in planning/training for national rollout of VL testing; 4) SLMTA training & implementation for HIV related testing ISO 15189 accreditation; 5) Assist in planning HIV lab information system for HIV reporting; and 6) Strengthen Kila Kila & Koki clinic labs & test sites.

Brief Activity Description	Deliverables		BC and allocation(s)		Implementing Mechanism(s)	Relevant Sustainability Element and Score	Impact on epidemic control				
	2015	2016	2015	2016			HIV Testing	Linkage to Care	ART uptake	Other Combo prevent	Viral suppression
Onsite training to strengthen QA for HIV rapid test sites	two trainings to CPHL lab	QA trainings to NCD	HLAB \$10,000	HLAB \$30,000	CDC-PNG, TDY contractor	QM/QI Sys. 0 score	↑ rapid test accuracy		↑quality of care		
CDC/USAID collaboration to assist in planning & training for VL	Plan developed	VL trainings in NCD	HLAB \$5,000	HLAB \$30,000	CDC-PNG, ILB remote TA, FHI 360 #17083	VL data 0 score	↑VL testing in clinics		↑quality of care		↑adherence and ART assessment
HIV related testing ISO 15189 training (near core)	Plan CPHL mentoring & training	Plan CPHL mentoring & training documented	HLAB \$5,000	HLAB \$10,000	CDC-PNG, TDY contractor	QA lab serv. 2 score	↑ accuracy		↑quality of care		
HIV testing ISO f/u, pre audit, corrective action (near core)	Mentoring of CPHL staff & action plan follow-up	Pre-audit, corrective action & application for accreditation	HLAB \$5,000	HLAB \$10,000	CDC-PNG, TDY contractor	QA lab serv. 2 score	↑ accuracy		↑quality of care		
SLMTA training & implementation for HIV related testing (near core)	Plan for SLMTA training & implementation	TOT and SLMTA baseline for participating sites	HLAB \$2,000	HLAB \$5,000	CDC-PNG, TDY contractor	QA lab serv. 2 score	↑ accuracy		↑quality of care		
CPHL TA for PNG HIV testing algorithm (near core)	Plan for PNG HIV testing algorithm	Document algorithm as standard	HLAB \$2,000	HLAB \$5,000	CDC-PNG, ILB remote TA	QA lab serv. 2 score	↑ rapid test accuracy				
Review of discrepant HIV testing results in high prevalence areas	Plan for discrepant HIV testing results in high prevalence areas	Present & disseminate study document	HLAB \$2,000	HLAB \$5,000	CDC-PNG, ILB remote TA	QA lab serv. 2 score	↓ HIV test discordance				
TA Information system for HIV related testing	Plan for system	NDOH approved plan for system	HLAB \$2,000	HLAB \$5,000	CDC-PNG, ILB remote TA	Comp. Lab data 2.3 score	↑ HIV surveillance		↑quality of care		
Strengthen Kila Kila & Koki clinic labs	TA to train lab techs	Mentor/coach techs DBS training for EID	HLAB \$10,000	HLAB \$10,000	FHI 360 #17083	HIV inservice 1.5 score	↑HIV lab testing		↑quality of care		
Strengthen Kila Kila & Koki clinic labs	CD4 count protocol training (with CPHL)	STI microscopy diagnosis & syphilis rapid testing training	HLAB \$10,000	HLAB \$10,000	FHI 360 #17083	HIV inservice 1.5 score	↑ rapid test accuracy		↑quality of care		
Kila Kila & Koki clinic labs & sites accredited for KP services	TA to pass proficiency testing program	Regular external quality assurance performed	HLAB \$10,000	HLAB \$10,000	FHI 360 #17083	HIV inservice 1.5 score	↑ rapid test accuracy		↑quality of care		

6.2 Strategic Information (SI). SI has emerging sustainability needing some investment in the SID. Only PEPFAR-PNG supported DSD sites provide KP statistics (FSW, MSM and TG). Filling critical gaps, PEPFAR PNG, in partnership with WHO and support of the Global Fund, will be implementing KP sentinel surveillance. A KP IBBS is being implemented by leveraging DFAT, GF and NDoH funding with PEPFAR-PNG monies being used to procure laboratory equipment and supplies, print survey forms and manuals and procure training venues. Core SI TA activities include: 1) HIV/AIDS M&E capacity building in NDoH and provincial health authorities in NCD; 2) Capacity building in maintaining and enhancing HIV/AIDS National and Provincial Health Information System; 3) HIV/AIDS key population sentinel surveillance activities and IBBS surveys in NCD; and 4) Field Epidemiology Training fellows will support the intensified treatment activities, IBBS roll out, KP sentinel surveillance, data collection of national HMIS and HIVQUAL.

Brief Activity Description	Deliverables		BCodes & allocation		Implementing Mechanism(s) ID	Relevant Sustainability Element and Score	Impact on epidemic control				
	2015	2016	2015	2016			HIV Testing	Linkage to Care(LTC)	ART uptake	Other Combo prevention	Viral suppression
TA SI activities performance monitoring, data collection and results reporting	trainings to NCD & Highlands; national data quality audit plan	trainings to NCD & Highlands ; PROMEST data quality audits	HVSI \$10,000	HVSI \$30,000	WHO #17091, CDC-PNG, CDC Thailand	Comprehen. of prevalence data 0.6 score			↑ through complete clinic data		
Plan/implement QI perform. indicators to improve HIV testing, adherence, retention	site visits to NCD, Highlands region clinics and labs	site visits to NCD clinics and labs	HTXS \$20,000	HTXS \$25,000	WHO #17091 CDC-PNG HRSA (new)	Monitor/use QI data 2 score	↑ timeliness HIV testing	↑LTC thru QI projects			↑adherence and ART assessment
TA to NDOH to establish Early Warning Incident system to prevent HIV DR	Implement EW indicators using QI at 6 sites	Monitor EI indicators annually at 15 sites	HTXS \$10,000	HTXS \$15,000	WHO #17091 CDC-PNG CDC HQ	VL data 0 score			↑ through complete clinic data		↓resistance to ARVs
Support NDOH HIV Health Information System w ADB funds and train/ mentor staff	Plan for new HIS for high prevalence NCD		HVSI \$5,000		CDC-PNG, CDC Thailand	Comprehen. of prevalence data 0.6 score			↑ through complete clinic data		
FET training in GIS & HIV surveillance with Australia, WHO, NDoH leveraged funds	3 rd cohort mentoring & training	4 th cohort mentoring & training, three from 3 rd cohort advance training	HVSI \$200,000	HVSI \$180,000	TDY contractor, CDC-PNG	Comprehen. of prevalence data 0.6 score			↑ through complete clinic data		
TA in design/implementation of KP sentinel surveillance & sites; GF leveraged \$500,000	4 trainings & sites; KP surveillance in NCD	4 trainings & sites; KP surveillance in NCD	HVSI \$20,000	HVSI \$30,000	WHO #17091, CDC-PNG, CDC Thailand	KP size estimation 0 score			↑ thru KP targeted programs	↑ thru KP targeted programs	
TA & funding IBBS size est. & training with Australia, GF, NACS & NDoH funds/support	3 trainings at IBBS sites	Size estimates for MSM and FSW completed w. USG funds adding sites	HVSI \$10,000	HVSI \$10,000	CDC-PNG, CDC HQ	KP size estimation 0 score			↑ thru KP targeted programs	↑ thru KP targeted programs	
Outcome evaluation of the CoPCT service delivery model in NCD and Madang	new	Evaluation recommend. disseminated to ↑ use of CoPCT model	HVSI \$200,000		USAID-PNG GHPro #17876	Data driven prioritization 4 score	↑ effectiveness and efficiency thru implementation of evaluation recommendations				
CDC/USAID collaboration M&E support to IPs & NDOH	TWG presentation on revised templates for HCT/STI with KP groups	TWG approves revised templates for HCT/STI with KP groups	HVSI \$10,000	HVSI \$10,000	USAID-PNG FHI 360 #17083 WHO #17091	QM/QI data use 2 score	↑ thru complete testing data	↑ thru complete clinic data			

6.3 Health Systems Strengthening. All QI HSS activities are under the HIV Care and Treatment budget code. PEPFAR-PNG with WHO and GoPNG will rollout HIV quality improvement nationally with PEPFAR funds focused on training participants and site visits in NCD. Core HSS TA activities include: 1) QI training/mentoring to improve adherence and retention in NCD; 2) Supply chain strengthening including ART supplies and test kits at National and provincial level in NCD; 3) Review and adoption of WHO 2013 HIV guidelines by NDoH and Provincial health officials; 4) Review and adoption of WHO 2013 KPs HIV guidelines by NDoH and Provincial health officials; and 5) Review and adoption of WHO updated STI guidelines by NDoH and Provincial health officials (near core).

Brief Activity Description	Deliverables		BC and allocation)		Implementing Mechanism(s) ID	Relevant Sustainability Element and Score	Impact on epidemic control				
	2015	2016	2015	2016			HIV Testing	Linkage to Care (LTC)	ART uptake	Other Combo prevent	Viral suppression
QI training to improve to improve adherence, HIV testing	site visits to NCD	site visits to NCD clinics and labs	HTXS \$20,000	HTXS \$25,000	WHO #17091 CDC-PNG HRSA (new)	Monitor/use QI data 2 score	↑ timeliness HIV testing	↑LTC thru QI projects			↑adherence and ART assessment
Build capacity for provincial QI committees in NCD	3 QI committees planned in NCD	3 QI committees planned in NCD	HTXS \$20,000	HTXS \$20,000	WHO #17091 CDC-PNG HRSA (new)	HIV QM/QI nat. system 0 score	↑ timeliness HIV testing	↑LTC thru QI projects			↑adherence and ART assessment
Develop & implement of National QI framework & QI national committee	Framework designed & approved by NDOH, QI nat. committee planned	Framework implemented by NDOH, QI national committee established	HTXS \$10,000	HTXS \$10,000	WHO #17091 CDC-PNG HRSA (new)	HIV QM/QI nat. strategy 0 score	↑ timeliness HIV testing	↑LTC thru QI projects			↑adherence and ART assessment
Supply chain strengthening TA including ART supplies and test kits	National supply chain forecasting est. & SOPs, planning tools, guidelines	Process implemented at distribution chain for facility/province level	HTXS \$20,000	HTXS \$20,000	WHO #17091 CDC-PNG	Supply Chain Assessment 3 score	↑ thru reduced stock outs		↑ thru reduced stock outs		↑ thru reduced stock outs
NDoH guidelines review, adoption, printing & training 2013 WHO HIV ARV; 2014 WHO KP & 2012 WHO STI KP guidelines (3 total)	National review	Adoption & printing of guidelines & training	HTXS \$40,000	HTXS \$70,000	WHO #17091, CDC-PNG FHI #17083	QA guidelines HIV inservice 1.5 score	↑ through KP focus, ↑ STI client testing & ↑ outreach		↑ thru KP focus, ↑ HIV+ from STI clients, CD4 ≤500		↑ thru use of combo ART drugs
CDC/USAID collaboration to develop nat. guidelines on C&T of rape survivors (inc.KP)	Develop action plan and plan for guidelines development meeting	Guidelines developed with Family Hlth. Centers & stakeholders	HTXS \$1000	HTXS \$5,000	WHO #17091 FHI #17083 USAID-PNG	Service access 1 score			↑ thru GBV & KP focus		
QI/QA training & QI projects to improve key pop HIV testing, adherence & retention for PEPFAR PNG clinic sites	Clinic staff training on QA and QI, plan QI projects, create QI teams	Internal, continuous quality assurance and quality improvement cycle by IPs	HSS \$30,000	HSS \$30,000	USAID-PNG FHI #17083 HRSA (new)	Monitor/use QI data 2 score	↑ thru improved HIV testing	↑ thru improved diagnosis & qual of care	↑ thru improved eligibility assessment		
Support early warning system at sites to prevent stock outs for PEPFAR PNG clinic sites	Training in the use of stock tracking systems	Provide continuous mentoring and coaching in stock management	HSS	HSS	USAID-PNG FHI #17083 WHO #17091	Stocked HIV commodities 1.5 score	↓stock out & expiration		↓stock out & expiration		↓resistance to ARVs

7.0 Staffing Plan

The PEPFAR-PNG team's management strategy seeks strong in-country capacity to support core activities within the national HIV response. The U.S. Ambassador leads the interagency team with staff from the Department of State (DOS), U.S. Agency for International Development (USAID), Centers for Disease Control and Prevention (CDC), and the Department of Defense (DOD).

Each agency uses its unique expertise to provide focused TA in support of core activities. USAID's TA focuses on building capacity of the GoPNG and civil society to implement the CoPCT model for KPs. With core strengths in HIV quality improvement in HIV care and treatment, HIV laboratory strengthening and HIV strategic information, CDC's TA uses CDC country staff to help build capacity of national and NDOH staff in these areas in the most cost effective manner. DOS leads the PEPFAR Small Grants Program (jointly funded by CDC and USAID) that focuses on building capacity among local NGOs to impact the HIV epidemic through prevention programs that address the co-morbidities of GBV and HIV. PEPFAR/PNG also addresses GBV, a key factor in the spread of HIV through the centrally funded Local Capacity Initiative and the CoPCT model clinics.

USAID's primary PEPFAR staff is the Health Advisor who oversees USAID's HIV/AIDS assistance in PNG. The Health Advisor reports to the Regional Pacific Islands Office Director, who provides strategic leadership over USAID's entire Pacific portfolio. Currently supporting USAID's office in PNG is a Development Assistance Specialist (FSN) and an Administrative Assistant (EFM). In the FY 2014 COP, the Health Advisor was fully funded by PEPFAR, while the Director, FSN and EFM were partially supported by PEPFAR. USAID/Philippines staff also provides substantial technical, programmatic, procurement, financial and management support; however, none were funded by PEPFAR in the FY 2014 COP. For FY 2015, USAID plans to consider Philippines-based staff as part of the expanded "in-country" PEPFAR/PNG team. To more accurately reflect the total number of staff supporting PEPFAR, USAID has included the level of effort of Philippines-based staff in this year's staffing for results, however, no one is funded by PEPFAR.

The CDC office is led by a medical epidemiologist that serves as the CDC Country Director and three technical staff: Strategic Information Advisor, Laboratory Advisor (newly recruited) and HIV Senior Public Health Specialist (recruiting). All CDC staff are involved in TA to build local capacity through training, mentoring and coaching for key GoPNG counterparts. Previously, all administrative support was provided from CDC Atlanta HQ through a Deputy Director at Large (DDAL). Recent elimination of this

remote support from CDC HQ has necessitated CDC-PNG to request a new budget/administration specialist.

To better align staffing with the new PEPFAR business model, the PEPFAR/PNG team proposes the following staffing changes:

1. **Create a new USAID M&E FSN position focused on supporting PEPFAR's new data-driven approach.** With expertise in monitoring, data collection and analysis, this FSN position will assist with PEPFAR's new data initiatives, including Monitoring and Evaluation Reporting (MER), Expenditure Analysis (EA) and Site Improvement Monitoring System (SIMS). Additionally, the new staff member will assist with strengthening programmatic data efforts at the site level.

The new FSN position will allow the Health Advisor to focus on providing TA and strategic leadership for USAID's HIV/AIDS program. Through participation in technical working groups and coordination with health partners, the Health Advisor provides oversight and TA to the GoPNG on service delivery and the CoPCT model. The Health Advisor also provides technical advice as part of the USG in-country health team.

2. **Create a new CDC management and operations FSN position** that will support the CDC-PNG office for program budget, COP budget planning, WHO cooperative agreement and AVARM task order budgeting, and expenditures, and office administrative support. This position is necessary due to elimination of the CDC-PNG DDAL position in Atlanta that was funded by CDC HQ.

Although recruitment of local staff is not always easy, the PEPFAR/PNG team recognizes the invaluable insight and expertise that local staff provide to program effectiveness and sustainability and adding to national expertise through their career growth and capacity building.

APPENDIX A (no non-core activities)

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15		
Level of Implementation	Core Activities	Near-core Activities
Site Level	<ul style="list-style-type: none"> -Pilot TA model to implement the CoPCT for KPs -Scale Up Treatment for KPs -Scale up implementation of direct service delivery of the Continuum from Prevention to Treatment for KPs at two sites in NCD 	<ul style="list-style-type: none"> -Address harmful gender norms by prioritizing and preventing gender-based violence via trainings of clinical and community staff
Sub-national Level		<ul style="list-style-type: none"> - Collaborate with NACS to implement HIV prevention intervention activities during the Pacific Games in PNG from July 8-14, 2015.
National Level	<ul style="list-style-type: none"> -Strategic Information -Clinic QI to improve ART adherence and retention -HIV Laboratory Testing -Create a national forum to regularly exchange ideas and lessons learned with the national KP groups to discuss improved access to and quality of services -Provide technical support for the roll out of the new care and treatment guidelines in collaboration with NDOH. This will include printing, providing refresher trainings on the utilization of the curriculum, and preparing algorithms for easy access and referrals. 	<ul style="list-style-type: none"> - Ambassador's HIV/GBV small grant program - Production of new job aids and educational materials on STIs -Develop an early warning system for HIV and TPHA tests to prevent stock-out
Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15		
Technical area	Core Activities	Near-core Activities
HTC	<ul style="list-style-type: none"> -Support increased uptake of HTC and HTC yield in KPs in high priority provinces using the clinic CoPTC and mobile testing -Train HTC counselors for KPs 	
Care and Treatment	<ul style="list-style-type: none"> -Coordinate of rollout of HIVQUAL to all HIV care & treatment sites in NCD -Coordinate HIV QI policy at NDOH and Provincial Health Authority in NCD -Coordinate revision/rollout of HIV C&T guidelines -TA for adherence support interventions at HIV clinics -Pilot viral load testing in select service delivery sites in NCD 	<ul style="list-style-type: none"> -Transition treatment services in Madang to the provincial government
Prevention	<ul style="list-style-type: none"> -Consolidate PEP services for survivors of GBV 	<ul style="list-style-type: none"> -Increase demand for HIV services through development of new SBCC materials & strengthening implementation enhanced outreach -Transition community prevention/promotion in Madang to local civil society
Cross Cutting		
Strategic Information	<ul style="list-style-type: none"> -HIV M&E capacity building on national/local levels -TA for capacity building for HIV NHIS -TA for clinic Early Warning Indicators surveillance -TA for implementing HIV sentinel surveillance for KPs -TA to improve HIV routine reporting from antenatal, TB and STI clinics -TA and pilot for intensified case findings in KP in NCD -KP IBBS for size estimations and prevalence of KP 	<ul style="list-style-type: none"> -TA for HIV TDR study in PNG in 2015-2016 -TA for size estimation from IBBS KP study 2015-2016 -FET fellows support intensified treatment activities, IBBS, KP surveillance, national HMIS and HIVQUAL
Laboratory	<ul style="list-style-type: none"> -Training/support of EQAS for HIV serology -Develop national HIV lab QMS -Plan/implement/evaluate computerized lab HIV information system for the CPHL -QI projects to improve HIV -Establish network of clinics with Heduru as lab hub 	<ul style="list-style-type: none"> -Investigation of discrepant HIV testing -Review PNG HIV testing algorithm to ensure it meets current international standards

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level			
		New Funding	Total Spend
		\$ 6,600,000	\$6,600,000
Table B.1.2 Resource Allocation by PEPFAR Budget Code			
PEPFAR Budget Code	Budget Code Description	Amount Allocated	
		TOTAL (\$)	
MTCT	Mother to Child Transmission		
HVAB	Abstinence/Be Faithful Prevention		
HVOP	Other Sexual Prevention	1,866,048	
IDUP	Injecting & Non-Injecting Drug Use		
HMBL	Blood Safety		
HMIN	Injection Safety		
CIRC	Male Circumcision		
HVCT	Counseling and Testing	244,453	
HBHC	Adult Care and Support	762,880	
PDCS	Pediatric Care and Support		
HKID	Orphans and Vulnerable Children		
HTXS	Adult Treatment	869,234	
HTXD	ARV Drugs		
PDTX	Pediatric Treatment		
HVTB	TB/HIV Care		
HLAB	Lab	502,426	
HVSI	Strategic Information	1,151,915	
OHSS	Health Systems Strengthening		
HVMS	Management and Operations	,1,203,044	
TOTAL		6,600,000	

B.2 Resource Projections

PEPFAR PNG used a combination of unit expenditures from the most recent available EA results, information from implementing partners on specific outputs, and estimates for cost centers anticipated for proposed activities in FY 2016 to establish the budget by implementing mechanism and PEPFAR budget code.

Please note that the NCD unit expenditures from the latest EA exercise are higher than expected as they include one-time, start-up costs and because they were divided over a low patient volume as the NCD sites only started providing services in April 2014. Therefore, PEPFAR-PNG used lower unit expenditures for COP 15 planning, assuming

that the start-up costs will no longer be incurred and assuming that the NCD sites will achieve capacity and reach a much higher volume in FY 2016. PEPFAR-PNG also expects that the transition from a combination DSD and TA approach to a solely TA approach by the end of 2017, will contribute to the reduction of unit expenditures.

PEPFAR-PNG estimates that 2/3 of the Management and Operations (M&O) costs are actually costs of technical assistance provided by USG staff to support the strategic approaches outlined in the SDS. Removing the costs associated with delivering this technical assistance will bring M&O costs down to 18% of the total \$6.6 million planning level.

Papua New Guinea COP15 Targets by Province: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
_Military Papua New Guinea	-	-	-	-	-
Autonomous Region of Bougainville	-	-	-	-	-
Central Province	-	-	-	-	-
Chimbu Province	-	-	-	-	-
East New Britian	-	-	-	-	-
East Sepik Province	-	-	-	-	-
Eastern Highlands Province	-	-	-	-	-
Enga Province	-	-	-	-	-
Gulf Province	-	-	-	-	-
Hela Province	-	-	-	-	-
Jiwaka Province	-	-	-	-	-
Madang Province	1,000	116	369	40	369
Manus Province	-	-	-	-	-
Milne Bay Province	-	-	-	-	-
Morobe Province	-	-	-	-	-
National Capital District	2,857	194	310	160	263
New Ireland Province	-	-	-	-	-
Oro (Northern) Province	-	-	-	-	-
Southern Highlands Province	-	-	-	-	-
West New Britain Province	-	-	-	-	-
West Sepik Province	-	-	-	-	-
Western (Fly) Province	-	-	-	-	-
Western Highlands	-	-	-	-	-
Total	3,857	310	679	200	632

Papua New Guinea COP15 Targets by Province: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
_Military Papua New Guinea	-	-	-
Autonomous Region of Bougainville	-	-	-
Central Province	-	-	-
Chimbu Province	-	-	-
East New Britain	-	-	-
East Sepik Province	-	-	-
Eastern Highlands Province	-	-	-
Enga Province	-	-	-
Gulf Province	-	-	-
Hela Province	-	-	-
Jiwaka Province	-	-	-
Madang Province	-	-	-
Manus Province	-	-	-
Milne Bay Province	-	-	-
Morobe Province	-	-	-
National Capital District	-	3,576	-
New Ireland Province	-	-	-
Oro (Northern) Province	-	-	-
Southern Highlands Province	-	-	-
West New Britain Province	-	-	-
West Sepik Province	-	-	-
Western (Fly) Province	-	-	-
Western Highlands	-	-	-
Total	-	3,576	-



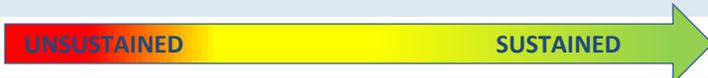
HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural **Sustainability Index and Dashboard (SID)** during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

Dark Green Score (17-20 pts) (sustainable and requires no additional investment at this time)
Light Green Score (13-16.9 pts) (approaching sustainability and requires little or no investment)
Yellow Score (7-12.9 pts) (emerging sustainability and needs some investment)
Red Score (0-6.9 pts) (unsustainable and requires significant investment)

Sustainability Analysis for Epidemic Control: PAPUA NEW GUINEA

Epidemic Type: Concentrated
Income Level: Lower Middle Income
PEPFAR Categorization: Targeted Assistance
COP 15 Planning Level:

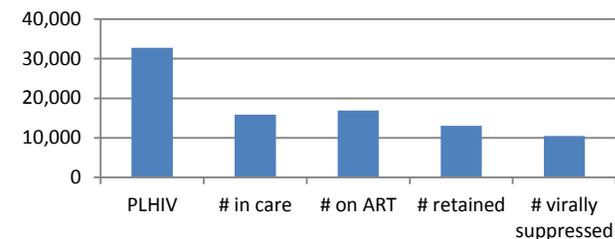


SUSTAINABILITY DOMAINS AND ELEMENTS

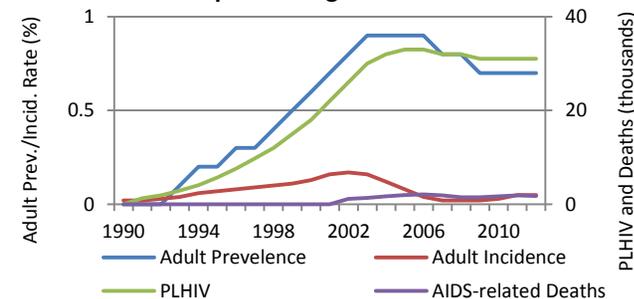
Institutionalized Data Availability		Score
1. Epidemiological and Health Data	Yellow	8.9
2. Financial/Expenditure Data	Yellow	10.0
3. Performance Data	Green	18.0
Domestic Program and Service Delivery		
4. Access and Demand	Yellow	9.2
5. Human Resources for Health	Light Green	14.1
6. Commodity Security and Supply Chain	Light Green	16.0
7. Quality Management	Yellow	10.7
Health Financing and Strategic Investments		
8. DRM: Resource Generation	Light Green	14.0
9. DRM: Resource Commitments	Yellow	8.0
10. Allocative Efficiency	Yellow	11.0
11. Technical Efficiency	Yellow	11.8
Accountability and Transparency		
12. Public Access to Information	Light Green	14.0
13. Oversight and Stewardship	Yellow	7.5
Enabling Environment		
14. Policies, Laws, and Regulations	Light Green	13.0
15. Planning and Coordination	Light Green	15.0

CONTEXTUAL DATA

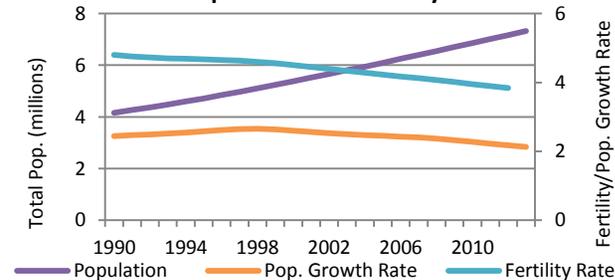
Care and Treatment Cascade



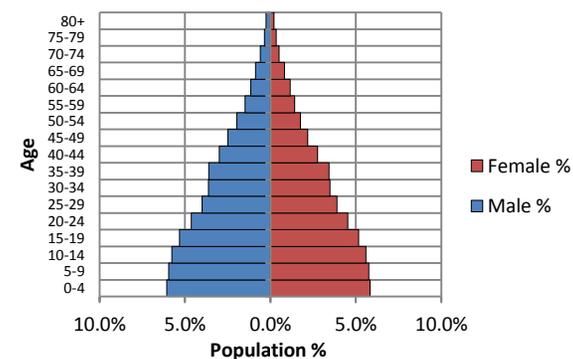
Epidemiological Data



Population and Fertility

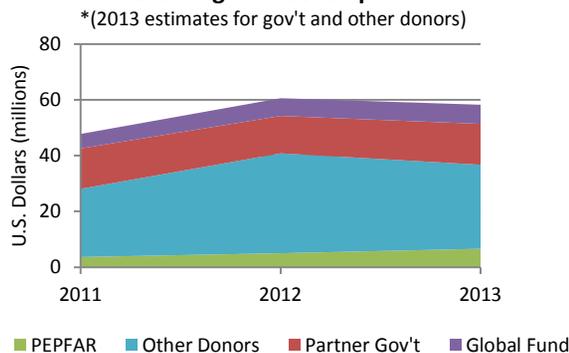


Population Pyramid (2014)

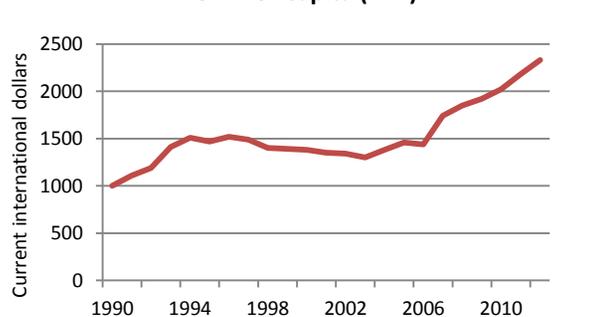


CONTEXTUAL DATA

Financing the HIV Response



GNI Per Capita (PPP)



Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

1. Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.

		Source of data	Notes/Comments
<p>Q1. Who leads: Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?</p>	<p><input type="radio"/> A. Host Country Government/other domestic institution</p> <p><input checked="" type="radio"/> B. External agency with host country government</p> <p><input type="radio"/> C. External agency, organization or institution</p> <p><input type="radio"/> D. Not conducted</p>	3	<p>HIVTWG minutes (2014), NASA (2012), National HIV and AIDS Strategy 2010-2015. Stakeholders mtg. for this domain attended by Nat. Dept. of Hlth., WHO, and National AIDS Council (Jan 2015)</p>
<p>Q2. Who finances: Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?</p>	<p><input type="radio"/> A. 80-100% of the total cost of latest survey was financed by Host Country Government</p> <p><input type="radio"/> B. 60-79% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> C. 40-59% of the total cost of latest survey financed by Host Country Government</p> <p><input checked="" type="radio"/> D. 20-39% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> E. 10-19% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> F. 0-9% of the total cost of latest survey financed by Host Country Government</p>	2	<p>This is a guesstimate arrived at during the stakeholders mtg. and based on the source of funding for the 2006 DHS.</p> <p>There have been no general population-based surveys by the gov. in the past three years. The GoPNG will contribute to the planned IBBS but the proportion funding by them is currently unknown</p>
<p>Q3. Comprehensiveness of Prevalence and Incidence Data: Does Host Country Government collect HIV prevalence and or incidence data?</p>	<p><input type="radio"/> No, the government does not collect HIV prevalence or incidence data</p> <p><input checked="" type="radio"/> Yes, the government collects (check all that apply):</p> <p><input checked="" type="checkbox"/> A. HIV prevalence</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Sub-national data</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected every 3 years</p> <p style="margin-left: 20px;"><input type="checkbox"/> Data analyzed for trends</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data made publicly available</p> <p><input type="checkbox"/> B. HIV incidence</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input type="checkbox"/> Sub-national data</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected every 3 years</p> <p style="margin-left: 20px;"><input type="checkbox"/> Data analyzed for trends</p>	2.3	<p>Response is based on consensus during stakeholder mtg., and the 2014 UNAIDS Report using Spectrum modeling. There are forms and data collection systems in the early stages of implementation but data collection, entry, aggregation, representativeness, and analysis are lagging behind, therefore current accurate prevalence data is not available.</p> <p>There has been no population level analysis of HIV incidence based on RITA/STARHS nor is there national lab capacity to conduct these assays. Incidence rates in PNG are based on UNAIDS spectrum estimates.</p>

	<input type="checkbox"/> Data made publicly available			
Q4. Comprehensiveness of Viral Load Data: Does Host Country Government collect viral load data?	<input type="radio"/> No, the government does not collect viral load data <input checked="" type="radio"/> Yes, the government collects viral load data (check all that apply): <input type="checkbox"/> Collected by age <input type="checkbox"/> Collected for children <input type="checkbox"/> Collected by sex <input type="checkbox"/> Collected by key population <input type="checkbox"/> Sub-national data <input type="checkbox"/> Collected every 3 years <input type="checkbox"/> Data analyzed to understand trends	1.6	Answer based on stakeholder meeting knowledge of VL testing conducted by CHAI and the national lab, the Central Public Health Laboratory; Presentation by CPHL, CHAI & Burnette Institute (2015)	Viral load testing is still in the pilot stage to determine best pricing options and HR capacity. The National Dept. of Health (NDOH) has the intention of scaling it up nationally to monitor treatment failure. There has been one pilot training of clinicians and future trainings are planned.
Q5. Key Populations: Does the Host Country Government conduct size estimation studies for key populations?	<input checked="" type="radio"/> No, the host country government does not conduct size estimation studies for key populations <input type="radio"/> Yes, the government conducts key population size estimates (check all that apply): <input type="checkbox"/> Men who have sex with men (MSM) <input type="checkbox"/> Female sex workers <input type="checkbox"/> Transgender <input type="checkbox"/> People who inject drugs (PWID) <input type="checkbox"/> Government finances at least 50% of the size estimation studies <input type="checkbox"/> Government leads and manages the size estimation studies	0	Response is based in consensus during stakeholder mtg.	Size estimates have been attempted by using %ages of based on one-off studies, but real data is lacking. The GoPNG & partners are planning an IBBS in 2015/2016. CDC has been advocating and assisting with IBBS protocol development for years, but politics & finances have impeded implementation.

Epidemiological and Health Data Score:

8.9

2. Financial/Expenditure data: Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness.		Source of data	Notes/Comments
Q1. Expenditure Tracking: Does the host country government have a nationally agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?	<input type="radio"/> No, it does not have a national HIV/AIDS expenditure tracking system <input checked="" type="radio"/> Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies): <input checked="" type="checkbox"/> A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others <input type="checkbox"/> B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening <input type="checkbox"/> C. Collected sub-nationally <input type="checkbox"/> D. Collected annually	2	NASA (2012); GAR-UNAIDS (2014) The Global AIDS Report and the 2012 NASA are the current sources of data, but a thorough, systematic national expenditure exercise by GoPNG & partners has yet to be implemented. The best figures are around commodity procurement by gov. but a thorough breakdown by partners, services and

	<input checked="" type="checkbox"/> E. Data is made publicly available			partners, services and provinces doesn't exist.
<p>Q2. Quality of Expenditure Tracking: Is the Host Country Government tracking expenditures based on international standards? What type of expenditure data are available in the country, i.e. NHA, NASA, others:</p> <p>—</p>	<p><input type="radio"/> No, they are not using any international standards for tracking expenditures</p> <p><input checked="" type="radio"/> Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model.</p>	5	NASA, (2012) - See quote from NASA 2012 in next column.	"Institutionalization of the NASA exercise remains a big challenge for the country" and "The quality of the results of the NASA can be significantly improved by also obtaining data on the consumption/distribution of commodities..." The data for the 2013 NASA is still being entered.
<p>Q3. Transparency of Expenditure Data: Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?</p>	<p><input type="radio"/> No, they do not make expenditure data available to the public</p> <p>Yes, check the one that applies:</p> <p><input type="radio"/> A. Annually</p> <p><input checked="" type="radio"/> B. Bi-annually</p> <p><input type="radio"/> C. Every three or more years</p>	3	NASA, (2011-2012).	Available information is not up to date, but when becomes available, is made public
<p>Q4. Economic Studies: Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?</p>	<p><input checked="" type="radio"/> No, they are not conducting special health economic studies for HIV/AIDS</p> <p><input type="radio"/> Yes, check all that apply:</p> <p><input type="checkbox"/> A. Costing studies or analyses</p> <p><input type="checkbox"/> B. Cost-effectiveness studies or analyses</p> <p><input type="checkbox"/> C. Efficiency studies or analyses</p> <p><input type="checkbox"/> D. Cost-benefit studies or analyses</p>	0	Stakeholders mtg. for this domain attended by Nat. Dept. of Hlth., WHO, and National AIDS Council (Jan 2015)	No such studies of which we are aware.

Financial/Expenditure Data Score: 10

3. Performance data: Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.		Source of data	Notes/Comments	
<p>Q1. Collection of service delivery data: Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?</p>	<p><input type="radio"/> No, the government does not have an HIV/AIDS service delivery data collection system</p> <p><input checked="" type="radio"/> Yes, service delivery data are collected/reported for (check all that apply):</p> <p><input checked="" type="checkbox"/> A. For HIV Testing</p> <p><input checked="" type="checkbox"/> B. For PMTCT</p> <p><input type="checkbox"/> C. For Adult Care and Support</p> <p><input checked="" type="checkbox"/> D. For Adult Treatment</p> <p><input type="checkbox"/> E. For Pediatric Care and Support</p> <p><input checked="" type="checkbox"/> F. For Pediatric Treatment</p> <p><input checked="" type="checkbox"/> G. For AIDS-related mortality</p>	5	National HIV/AIDS ANC Testing Data, (2014); National HIV/AIDS Provincial Summary (2014); HIV Mid- term review 2011-2015 (2013); Surf 1,2 & 4 HIV Testing, and Treatment Data	Updated/revised surveillance & M&E tools have been rolled out towards the end of last year, however routine accurate data collection and reporting is still very far from being timely or routine. HIB & TB reporting are still vertical and not integrated into the national HMIS.
	<p><input type="radio"/> No, the government does not routinely analyze service delivery data to measure performance</p>	5	GARPR UA, (2014); Cohorts analysis for PLHIV on ARTs-WHO (2014)	Those in care for TB, STI, etc.. is not available or not

<p>Q2. Analysis of service delivery data: Does the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS-related mortality rates?</p>	<p><input checked="" type="radio"/> Yes, service delivery data are being analyzed to measure (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> A. Continuum of care cascade, including testing, care, treatment, retention and adherence <input checked="" type="checkbox"/> B. Results against targets <input checked="" type="checkbox"/> C. Coverage <input checked="" type="checkbox"/> D. Site specific yield for HIV testing (HTC and or PMTCT) <input checked="" type="checkbox"/> E. AIDS-related death rates 			<p>reported timely</p>
<p>Q3. Comprehensiveness of service delivery data: Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive?</p>	<p><input type="radio"/> No</p> <p><input checked="" type="radio"/> Yes, service delivery data are being: (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> A. Collected at least quarterly <input checked="" type="checkbox"/> B. Collected by age <input checked="" type="checkbox"/> C. Collected by sex <input checked="" type="checkbox"/> D. Collected from all clinical sites <input checked="" type="checkbox"/> E. Collected from all community sites <input checked="" type="checkbox"/> F. Data quality checks are conducted at least once a year 	<p>6</p>	<p>Annual HIV/AIDS Reports, 2011, (2012, ready for print), 2013, & 2014 Data entry up in speed</p>	<p>There are some delays but the system is in place. New, comprehensive logbooks for data collection have been developed and hopefully will be distributed nationally in the near future.</p>
<p>Q4. Transparency of service delivery data: Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely?</p>	<p><input type="radio"/> No, they do not make program performance data available to the public</p> <p>Yes, check the one that applies:</p> <ul style="list-style-type: none"> <input checked="" type="radio"/> A. At least annually <input type="radio"/> B. Bi-annually <input type="radio"/> C. Every three or more years 	<p>2</p>	<p>Source: Annual HIV/AIDS Reports</p>	<p>There has been lots of delays in producing these reports due to data quality issues as well as infrastructure challenges</p>
<p align="right">Performance Data Score:</p>			<p>18</p>	

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIV/AIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

4. Access and Demand: There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.		Source of data	Notes/Comments
<p>Q1. Access to ART: What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing ART.</p> <p><input checked="" type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing ART.</p>	<p>Q1 Score: 1</p>	<p>Stakeholders meeting for this domain attended by Catholic Health Services, Christian Health Society, Australian Dept. of Foreign Affairs & Trade, and FHI 360. In country data sources include: National ART databases; Surf 1 HIV testing data; and Annual HIV/AIDS reports</p>
<p>Q2. Access to PMTCT: What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input checked="" type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.</p>	<p>Q2 Score: 1</p>	<p>Based on Stakeholders mtg. for this domain attended by DFAT, FHI360, Catholic health services, Churches Medical Council, (Jan 2015). The National PMTCT Coverage is 42% (GARPR, 2014)</p>
<p>Q3. Who is delivering HIV/AIDS services: What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p>	<p>Q3 Score: 3</p>	<p>Mid- term review 2011-2015</p>
<p>Q4. Access to PMTCT: What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p>	<p>Q4 Score: 0</p>	<p>Based on Stakeholders mtg. for this domain attended by DFAT, FHI360. Catholic health</p>

Precise answer unknown.

Precise percentage for high burden provinces is unknown.

More of the sites in rural areas are run by the Churches with the support of the government

Because of huge stigma, lots of the KPs receiving services at the public

<p>Q4. Services to key populations: What percent of key population HIV/AIDS prevention program clients receive services at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input checked="" type="radio"/> D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p>		<p>services, Churches Medical Council, (Jan 2015).</p>	<p>facilities do not disclose their identity, thus making it difficult for recording; real numbers may be more accessing public services</p>
<p>Q5. Uptake of services: What percent of PLHIV are currently receiving ART? _____%</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. 80% or more of PLHIV are currently receiving ART</p> <p><input checked="" type="radio"/> B. 50-79% of PLHIV are currently receiving ART</p> <p><input type="radio"/> C. 20-49% of PLHIV are currently receiving ART</p> <p><input type="radio"/> D. Less than 20% of PLHIV are currently receiving ART</p>	<p>Q5 Score 3</p>	<p>National ART Database, (2014); GARPR, (2014)</p>	<p>Of the total 32000, over 16 000 PLHIV are currently on ART</p>
<p>Q6. Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations.</p> <p><input checked="" type="radio"/> Yes, there are efforts by the government (check all that apply):</p> <p><input type="checkbox"/> educates PLHIV about their legal rights in terms of access to HIV services</p> <p><input type="checkbox"/> educates key populations about their legal rights in terms of access to</p> <p><input checked="" type="checkbox"/> National policy exists for de-stigmatization in the context of HIV/AIDS</p> <p><input checked="" type="checkbox"/> national law exists regarding health care privacy and confidentiality protections</p> <p><input type="checkbox"/> government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found</p>	<p>Q6 Score 1.2</p>	<p>Tha National HIV and AIDS Management and Prevention Act (HAMP), (2003); 1974 Criminal Code Act, sections 210, 212 and 231 and the 1977 Summary Offences Act, sections 55, 56 and 57 Criminilizes Homosexuality and sex work in PNG;</p>	<p>The HAMP Act protects the rights of PLHIV and tried to reduce stigma and discrimination; whilst the sections of the main constitution spells out penalties for MSMs and sex workers</p>

Access and Demand Score 9.2

<p>5. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.</p>		<p style="text-align: center;">Source of data</p>	<p style="text-align: center;">Notes/Comments</p>
	<p>Check the one answer that best describes the current situation:</p>	<p>Q1 Score: 0</p>	<p>Based on Stakeholders mtg. for this domain attended by DFAT, FHI360, Catholic health As in most low & middle</p>

<p>Q1. HRH Sufficiency: Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?</p>	<p><input type="radio"/> This information is not available</p> <p><input checked="" type="radio"/> A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand</p> <p><input type="radio"/> B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply)</p> <p><input type="checkbox"/> HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand</p> <p><input type="checkbox"/> HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites</p>		<p>services, Churches Medical Council, (Jan 2015).</p>	<p>income countries, HRH is a huge problem here. Task shifting has been effectively and actively implemented but recent concerns about ART resistance, anti-biotic resistance, and MDR & XDR TB lead to questions regarding quality of care.</p>
<p>Q2. HRH Transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers</p> <p><input type="radio"/> B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date</p> <p><input type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date.</p> <p><input checked="" type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan</p> <p><input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated</p>	<p>Q2 Score: 3</p>	<p>Based on Stakeholders mtg. for this domain attended by DFAT, FHI360, Catholic health services, Churches Medical Council, (Jan 2015).</p>	<p>Individual programs have this spelt out in their TORs but there is no national guidance/plan on how the transition of health workers under local government salary should look like.</p>
<p>Q3. HRH Financial reform: Has financial reform been undertaken in the last 5 years to address government financing of health workers?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. No financial reform has been undertaken in the last 5 years to address government financing of health workers</p> <p><input checked="" type="radio"/> B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply):</p> <p><input checked="" type="checkbox"/> Wage reform to increase salaries and or benefits of health workers</p> <p><input checked="" type="checkbox"/> Increase in budget allocation for salaries for health workers</p>	<p>Q3 Score: 2</p>	<p>Based on Stakeholders mtg. for this domain attended by DFAT, FHI360, Catholic health services, Churches Medical Council, (Jan 2015). ; A booklet titled "A Lost Decade? Service Delivery & Reforms in PNG 2002 - 2012" by the Policy Development Center reports "a deteriorating performance in PNG's primary health care center is linked to weak finances" and that 41% of clinics reported receiving no external financial support in 2012</p>	<p>The Government has recently increased salaries of medical doctors, nurses and allied health workers throughout the country.</p>
	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p>	<p>Q4 Score: 2.6</p>	<p>SIMS Above Site-SF Tool, "Pre-Service Education" CEE (Review with WHO as the above site IM, 2014); IMAI Training Materials available for ART prescribes training programs; HIV Care and treatment guidelines, (2012)</p>	<p>The latest 2014 updated HIV care and treatment guideline with the new CD4 criteria is in print</p>

<p>Q4. Pre-Service: Does current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?</p>	<input checked="" type="checkbox"/> content updated for all HIV/AIDS services <input checked="" type="checkbox"/> updated content reflects national standards of practice for cadres offering HIV/AIDS-related services <input checked="" type="checkbox"/> updated curriculum is problem based/competency based <input checked="" type="checkbox"/> updated curriculum includes practicums at high volume clinical/ social services sites <input type="checkbox"/> institutions that track students after graduation			
<p>Q5. In-Service: To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training.</p> <p><input type="radio"/> B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented.</p> <p><input checked="" type="radio"/> C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date.</p> <p><input type="radio"/> D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.</p>	<p>Q5 Score: 1</p>	<p>Based on Stakeholders mtg. for this domain attended by DFAT,FHI360, Catholic health services, Churches Medical Council, (Jan 2015); and based on Country team knowledge:HIVQUAL Framework;;</p>	<p>HIVQUAL is in the process of being integrated into the National HIV QI program</p>
<p>Q6. HRIS: Does the government have a functional Human Resource Information System (HRIS) for the health sector?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. No, there is no HRIS</p> <p><input checked="" type="radio"/> B. Yes, the government does have a HRIS (check all that apply)</p> <p><input checked="" type="checkbox"/> The HRIS is primarily funded by host country institutions</p> <p><input checked="" type="checkbox"/> There is a national interoperability strategy for the HRIS</p> <p><input type="checkbox"/> The government produces HR data from the HRIS at least annually</p> <p><input checked="" type="checkbox"/> The government uses data from the HRIS for HR planning and management</p>	<p>Q6 Score: 1.5</p>	<p>Yes,Based on Stakeholders mtg. for this domain attended by DFAT,FHI360, Catholic health services, Churches Medical Council, (Jan 2015)</p>	<p>Could not verify with the HR Department but many stakeholders are of the opinion that it is weak</p>
<p>Q7. Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input type="radio"/> A. Less than 20%</p> <p><input type="radio"/> B. 20-49%</p> <p><input type="radio"/> C. 50-79%</p> <p><input checked="" type="radio"/> D. 80% or more</p>	<p>Q7 Score: 4</p>	<p>Based on Stakeholders mtg. for this domain attended by DFAT,FHI360, Catholic health services, Churches Medical Council, (Jan 2015)</p>	
<p>Human Resources for Health Score</p>			<p>14.1</p>	

6. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.		Source of data	Notes/Comments
Q1. ARV domestic financing: What is the estimated obligated funding for ARV procurement from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: <input type="radio"/> This information is not known <input type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources <input type="radio"/> C. 30-79% obligated from domestic public sources <input checked="" type="radio"/> D. 80% or more obligated from domestic public sources	Q1 Score: 3	NASA, (2012); GARPR, (2014); GF Financial GAP analysis, (2014) Gov covers 100% for ARVs and other commodities
Q2. Test Kit domestic financing: What is the estimated obligated funding for Rapid Test Kits from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: <input type="radio"/> This information is not known <input type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources <input type="radio"/> C. 30-79% obligated from domestic public sources <input checked="" type="radio"/> D. 80% or more obligated from domestic public sources	Q2 Score: 3	NASA, (2012); GARPR, (2014); GF Financial GAP analysis, (2014) Gov covers 100% for ARVs and other commodities
Q3. Condom domestic financing: What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: <input type="radio"/> This information is not known <input type="radio"/> A. 0-9% obligated from domestic public sources <input type="radio"/> B. 10-29% obligated from domestic public sources <input type="radio"/> C. 30-79% obligated from domestic public sources <input checked="" type="radio"/> D. 80% or more obligated from domestic public sources	Q3 Score: 3	NASA, (2012); GARPR, (2014); GF Financial GAP analysis, (2014) Gov covers 100% for ARVs and other commodities
Q4. Supply Chain Plan: Does the country have an agreed-upon national supply chain plan with an implementation plan or a thorough annually-reviewed supply chain SOP?	<input type="radio"/> A. No, there is no plan or thoroughly annually reviewed supply chain SOP <input checked="" type="radio"/> B. Yes, there is a Plan/SOP. It includes these components: (check all that apply) <input checked="" type="checkbox"/> Human resources <input checked="" type="checkbox"/> Training <input checked="" type="checkbox"/> Warehousing <input checked="" type="checkbox"/> Distribution <input checked="" type="checkbox"/> Reverse Logistics <input checked="" type="checkbox"/> Waste management <input checked="" type="checkbox"/> Information system <input checked="" type="checkbox"/> Procurement <input checked="" type="checkbox"/> Forecasting <input checked="" type="checkbox"/> Supply planning and supervision	Q4 Score: 4	The Ministry of Health and CHAI manages it; UNICEF assists procurement; We were unable to get the name of the Plan/SOP from the stakeholders

<p>Q5. Stock: Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?</p>	<p><input type="radio"/> A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time</p> <p><input checked="" type="radio"/> B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time</p> <p><input checked="" type="checkbox"/> Both public and (if they exist in the country) private storage facilities at central level</p> <p><input type="checkbox"/> Both public and (if they exist in the country) private storage facilities at intermediate level</p>	<p>Q5 Score: 2</p>	<p>The Area Medical Store Stores Drugs, The Suply Chain Management Team lead by NDoH and WHO and CHAI coordinate, LD Logistics transports drugs across the country and provinces</p>		
<p>Q6. Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment?</p> <p>(If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)</p>	<p><input type="radio"/> A. No assessment has been conducted nor do they have a system to oversee the supply chain</p> <p><input type="radio"/> B. Yes, an assessment was conducted but they received below 80%</p> <p><input checked="" type="radio"/> C. No assessment was conducted, but they have a system to oversee the supply chain that reviews:</p> <p><input type="checkbox"/> Commodity requirements</p> <p><input type="checkbox"/> Commodity consumption</p> <p><input type="checkbox"/> Coordinates procurements</p> <p><input type="checkbox"/> Delivery schedules</p> <p><input type="radio"/> D. Yes, an assessment was conducted and they received a score that was 80% or higher</p>	<p>Q6 Score: 1</p>	<p>Based on Stakeholders mtg. for this domain attended by DFAT,FHI360, Catholic health services, Churches Medical Council, (Jan 2015):</p>		
Commodity Security and Supply Chain Score		16			
<p>7. Quality Management: Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.</p>			Source of data	Notes/Comments	
<p>Q1. Existence of System: Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?</p>	<p><input type="radio"/> A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH</p> <p><input checked="" type="radio"/> Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply):</p> <p><input type="checkbox"/> Routinely reviews national HIV/AIDS performance and clinical outcome data</p> <p><input type="checkbox"/> Routinely reviews district/regional HIV/AIDS performance and clinical outcome data</p> <p><input type="checkbox"/> Prioritizes areas for improvement</p>	<p>Q1 Score: 1</p>	<p>IQM/QI strategic plan and protocol being put in place. Stakeholder Meeting Consensus</p>	<p>National Framework is presently being developed and currently being supported by CDC and Healthqual New York</p>	

<p>Q2. Strategy: Is there a current (updated within the last 2 years) national QM/QI strategy that is either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?</p>	<p><input checked="" type="radio"/> No, there is no HIV/AIDS-related QM/Q strategy</p> <p><input type="radio"/> B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years)</p> <p><input type="radio"/> C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements</p> <p><input type="radio"/> D. Yes, there is a current HIV/AIDS program specific QM/QI strategy</p>	<p>Q2 Score: 0</p>	<p>QM/QI Strategy document currently being worked on by NDoH and WHO</p>		
<p>Q3. Guidelines: Does national HIV/AIDS technical practice follow current WHO guidelines for PMTCT and ART?</p>	<p><input type="radio"/> A. No, the national practice does not follow current WHO guidelines for PMTCT or ART</p> <p><input checked="" type="radio"/> B. Yes, the national practice does follow current WHO guidelines for:</p> <p><input checked="" type="checkbox"/> PMTCT (option B+)</p> <p><input checked="" type="checkbox"/> Adult ART</p> <p><input checked="" type="checkbox"/> Pediatric ART</p> <p><input checked="" type="checkbox"/> Adolescent ART</p> <p><input type="checkbox"/> Test and treat for specific populations</p>	<p>Q3 Score: 3.2</p>	<p>IMA; HIV Care and Treatment Guideline, (2012)</p>		
<p>Q4. QI Data use: Does the host country government monitor and use data for HIV/AIDS quality improvement?</p>	<p><input type="radio"/> A. No, there is no monitoring for HIV/AIDS quality improvement</p> <p><input checked="" type="radio"/> B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes:</p> <p><input type="checkbox"/> All sites</p> <p><input checked="" type="checkbox"/> Use of data to determine quality of program or services</p> <p><input checked="" type="checkbox"/> Making recommendations and action plan for mid-course corrections</p>	<p>Q4 Score: 4</p>	<p>ART Databases; HIVQI Sites for monitoring indicators</p>	<p>PEPFAR supports few HIVQUAL sites for QI</p>	
<p>Q5. Post-transition: Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned from a direct implementation role?</p>	<p><input type="radio"/> A. No, there is no quality monitoring at sites post-transition</p> <p><input checked="" type="radio"/> B. Yes, there is quality monitoring at transition sites. Monitoring includes:</p> <p><input type="checkbox"/> All transition sites</p> <p><input checked="" type="checkbox"/> Review of service outcomes</p> <p><input type="checkbox"/> Client feedback on changes in quality</p> <p><input type="checkbox"/> Quality improvement action plan</p> <p><input type="radio"/> C. PEPFAR/other donors have never supported direct service delivery in the country</p>	<p>Q5 Score: 2.5</p>	<p>Based on Stakeholders mtg. for this domain attended by DFAT,FHI360, Catholic health services, Churches Medical Council, (Jan 2015):</p>	<p>Approx. 50% of the health care in PNG is delivered by churches so a lot of the direct implementation is done by churches, but a former PEPFAR site has declined in service quality after EOP.</p>	
<p align="right">Quality Management Score</p>		<p align="right">10.7</p>			

THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN

Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

			Source of data	Notes/Comments
8. Domestic Resource Mobilization: Resource Generation: The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS.				
Q1. Domestic budget: Is there a budget line item for HIV/AIDS in the national budget?	<input type="radio"/> A. No, there is no budget line item for HIV/AIDS in the national budget <input type="radio"/> B. Yes, there is an HIV/AIDS budget line item under the Health budget <input checked="" type="radio"/> C. Yes, there is an HIV/AIDS program-based budget across ministries <input type="radio"/> D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators	Q1 Score: 4		One stakeholder meeting was held for Domains C,D, & E. Attendees included the GF HIV PR, UNAIDS, WHO, and NDOH; (Feb 2015); NDoH Agreed to this answer
Q2. Budgetary Framework: Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?	<input type="radio"/> A. No <input type="radio"/> B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program <input checked="" type="radio"/> C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program	Q2 Score: 6		stakeholder meeting: Attendees included the GF HIV PR, UNAIDS, WHO, and NDOH; (Feb 2015); NDoH Agreed to this answer
Q3. Fiscal Policy: Does the country pass the MCC scorecard indicator for fiscal policy? (Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)	<input type="radio"/> Yes <input checked="" type="radio"/> No	Q3 Score: 0		OGAC-provided data sheet (follows tab E) derived from: http://www.mcc.gov/pages/election/scorecards
Q4. Domestic public revenue: What was annual domestic government revenue as a percent of	Check the appropriate box for your country's income category: <u>FOR LOW INCOME</u> <input type="radio"/> A. More than 16.4% (i.e. surpasses category mean) <input type="radio"/> B. 14.8%-16.4%, (i.e. 90-100% of category mean) <input type="radio"/> C. Less than 14.8%, (less than 90% of category mean) <u>FOR LOW MIDDLE INCOME</u>	Q4 Score: 4		OGAC-provided data sheet (follows tab E) Original Source: IMF Government Finance Statistics

<p>GDP in the most recent year available? (domestic revenue excludes external grants)</p>	<p><input checked="" type="radio"/> D. More than 22.3% (i.e. surpasses category mean)</p> <p><input type="radio"/> E. 20.1-22.3% (i.e. 90-100% of category mean)</p> <p><input type="radio"/> F. Less than 20.1% (less than 90% of category mean)</p> <p><u>FOR UPPER MIDDLE INCOME</u></p> <p><input type="radio"/> G. More than 27.8% (i.e. surpasses category mean)</p> <p><input type="radio"/> H. 25.0%-27.8% (i.e. 90-100% of category mean)</p> <p><input type="radio"/> I. Less than 25.0% (less than 90% of category mean)</p>			
---	---	--	--	--

Score for Domestic Resource Mobilization: Resource Generation: 14



<p>9. Domestic Resource Mobilization: Resource Commitments: Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.</p>		<p>Source of data</p>	<p>Notes/Comments</p>
<p>Q1. Benchmarks for health spending:</p> <p>African countries: Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)?</p> <p>Non-African countries: Is government health expenditure at least 3 percent of GDP?</p>	<p><input checked="" type="radio"/> A. Yes</p> <p><input type="radio"/> B. No</p>	<p>Q1 Score: 5</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Original sources: WHO and World Bank</p>
<p>Q2. Domestic spending: What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? <u>22</u> %</p>	<p><input type="radio"/> A. Less than 10%</p> <p><input checked="" type="radio"/> B. 10-24%</p> <p><input type="radio"/> C. 25-49%</p> <p><input type="radio"/> D. 50-74%</p> <p><input type="radio"/> E. 75% or Greater</p>	<p>Q2 Score: 2</p>	<p>NASA 2011-2012</p>
	<p><input type="radio"/> A. None or information is not available</p> <p><input checked="" type="radio"/> B. 1-9%</p>	<p>Q3 Score: 1</p>	<p>NASA 2011-2012</p>

<p>Q3. Key population spending: What percent of key population-specific interventions are financed with domestic public and domestic private sector funding (excluding out of pocket expenditure)?</p>	<p><input type="radio"/> 10-24%</p> <p><input type="radio"/> 25-49%</p> <p><input type="radio"/> 50-74%</p> <p><input type="radio"/> 75% or Greater</p>			
---	---	--	--	--

Score for Domestic Resource Mobilization: Resource Commitments:	8
--	----------



<p>10. Allocative Efficiency: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).</p>	Source of data	Notes/Comments		
<p>Q1. Data-driven allocation: Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?</p>	<p><input type="radio"/> A. No, data are not used annually</p> <p><input checked="" type="radio"/> B. Yes, data are used annually. Check all that apply:</p> <p><input checked="" type="checkbox"/> Epidemiological data are used</p> <p><input checked="" type="checkbox"/> Health/service delivery data are used</p> <p><input checked="" type="checkbox"/> Financial data are used</p> <p><input type="checkbox"/> There is integrated analysis across data streams</p> <p><input checked="" type="checkbox"/> Multiple data streams are used to model scenarios</p>	<p>Q1 Score: 8</p>	<p>National HIV and AIDS Strategy 2011-2015</p>	
<p>Q2. Geographic allocation: Does the host country government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?</p>	<p><input type="radio"/> A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites</p> <p><input type="radio"/> B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p> <p><input checked="" type="radio"/> C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p> <p><input type="radio"/> D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p>	<p>Q2 Score: 3</p>	<p>GARPR, (2014);</p>	<p>Because HIV is concentrated in urban areas, this response is probably true, but a site-by-site yield and volume analysis has not been done.</p>

	<input type="radio"/> E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients		
Q3.Data driven reprogramming: Do host country government policies/systems allow for reprogramming investments based on new or updated program data during the government funding cycle?	<input checked="" type="radio"/> A. No, there is no system for funding cycle reprogramming <input type="radio"/> B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used <input type="radio"/> C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data <input type="radio"/> D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data	Q3 Score: 0	stakeholder meeting:Attendees included the GF HIV PR, UNAIDS, WHO,and NDOH; (Feb 2015);
Allocative Efficiency Score:		11	

11. Technical Efficiency: Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.		Source of data	Notes/Comments
Q1. Unit costs: Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services? (note: full score of five points can be achieved without checking all disaggregate boxes).	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes (check all that apply): <input type="checkbox"/> Annually <input checked="" type="checkbox"/> For HIV Testing <input type="checkbox"/> For Care and Support <input checked="" type="checkbox"/> For ART <input checked="" type="checkbox"/> For PMTCT <input type="checkbox"/> For VMMC <input type="checkbox"/> For OVC Service Package <input type="checkbox"/> For Key population Interventions	Q1 Score: 2.75	NASA 2011-2012

<p>Q2. Improving efficiency: Which of the following actions is the Host Country Government taking to improve technical efficiencies?</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Using findings from cost-effectiveness or efficiency studies to modify operations or interventions <input checked="" type="checkbox"/> Streamlining management to reduce overhead costs <input type="checkbox"/> Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling <input checked="" type="checkbox"/> Improving procurement competition <input type="checkbox"/> Integration of HIV/AIDS into national or subnational insurance schemes (private or public) <input checked="" type="checkbox"/> Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact <input checked="" type="checkbox"/> Geographic targeting in high burden/high yield sites to increase impact <input type="checkbox"/> Analysis of expenditure data to establish appropriate range of unit costs 	<p>Q2 Score: 2</p>	<p>stakeholder meeting:Attendees included the GF HIV PR, UNAIDS, WHO,and NDOH; (Feb 2015);</p>	
<p>Q3. Loss ratio: Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)?</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes</p>	<p>Q3 Score: 3</p>	<p>stakeholder meeting:Attendees included the GF HIV PR, UNAIDS, WHO,and NDOH; (Feb 2015);</p>	
<p>Q4. Benchmark prices: Are prices paid by the government for first-line ARVs and Test Kits within 5% variance of international benchmark prices (UNAIDS Investment Case)?</p>	<p>Check boxes that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> They are not paying for any ARVs <input type="checkbox"/> They are not paying for any test kits <input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for first line ARVs <input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for test kits 	<p>Q4 Score: 4</p>	<p>http://apps.who.int/hiv/amds/price/hdd/Default.aspx</p>	
<p>Q5. ART unit costs: Have average unit costs for providing ART in the country reduced within the last two years?</p> <p>Unit cost 2 years ago: \$ _____</p>	<p><input checked="" type="radio"/> A. No</p> <p><input type="radio"/> B. Yes</p>	<p>Q5 Score: 0</p>	<p>WHO, Global Price Reporting Mechanism - http://apps.who.int/hiv/amds/price/hdd/</p>	

Current unit cost: \$ _____				
Technical Efficiency Score:				11.75

THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN

Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

12. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.	Source of data	Notes/Comments
<p>Q1. OBI: What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)</p>	<ul style="list-style-type: none"> <input type="radio"/> A. Extensive Information (OBI Score 81-100; or PEFA score of A- or better on element PI-10) <input type="radio"/> B. Significant Information (OBI Scores 61-80; or PEFA score of B or B+ on element PI-10) <input checked="" type="radio"/> C. Some Information (OBI Score 41-60; or PEFA score of B-, C or C+ on element PI-10) <input type="radio"/> D. Minimal Information (OBI Score 21-40; or PEFA score of C- or D+ on element PI-10) <input type="radio"/> E. Scant or No Information (OBI Score 0-20; or PEFA score of D or below on element PI-10) <input type="radio"/> F. There is neither Open Budget Index score nor a PEFA assessment to assess the transparency of government budget 	<p>Q1 Score: 6.0</p> <p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Open Budget Index (http://survey.internationalbudget.org/) and PEFA data (www.pefa.org)</p>
<p>Q2. National program report transparency: Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?</p>	<ul style="list-style-type: none"> <input type="radio"/> A. No, the national HIV/AIDS program progress report or presentation of results is not made public <input checked="" type="radio"/> B. Yes, the national HIV/AIDS program progress report and/or results are made publically available (Check all that apply): <ul style="list-style-type: none"> <input checked="" type="checkbox"/> On Website <input type="checkbox"/> Through any type of media <input checked="" type="checkbox"/> Disseminate print report or presentation of results 	<p>Q2 Score: 4.0</p> <p>In country source, i.e., last annual national HIV/AIDS progress report or presentation:</p>
<p>Q3. Audit report transparency: Is the host country government making an annual national HIV/AIDS program audit report and or results publically available?</p>	<ul style="list-style-type: none"> <input type="radio"/> A. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically 	<p>Q3 Score: 4.0</p> <p>In country source, i.e., last HIV/AIDS audit report:</p>

<p>Q3. Audit transparency: Does the host country government make an annual national HIV/AIDS program audit report publically available?</p>	<p><input checked="" type="radio"/> B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply:</p> <p><input checked="" type="checkbox"/> On website</p> <p><input type="checkbox"/> Through any type of media</p> <p><input checked="" type="checkbox"/> Disseminate print report</p>			
--	--	--	--	--

Public Access to Information Score: 14

<p>13. Oversight and Stewardship: Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.</p>		<p align="center">Source of data</p>	<p align="center">Notes/Comments</p>
<p>Q1. Availability of Information on Resources Received by Service Delivery Units. PEFA score on PI-23 was C or higher in most recent assessment.</p>	<p><input checked="" type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input type="radio"/> B. PEFA was conducted and score was below C</p> <p><input type="radio"/> C. PEFA was conducted and score was C</p> <p><input type="radio"/> D. PEFA was conducted and score was B</p> <p><input type="radio"/> E. PEFA was conducted and score was A</p>	<p>Q1 Score: 0.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p>
<p>Q2. Quality and timeliness of annual financial statements. PEFA score for element PI-25 was C or higher in most recent assessment.</p> <p>Actual scores are ____</p>	<p>Check A or B; if B checked, select appropriate disaggregates:</p> <p><input checked="" type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input type="radio"/> B. PEFA was conducted and score was C or higher for:</p> <p><input type="checkbox"/> (i) Completeness of the financial statements</p> <p><input type="checkbox"/> (ii) Timeliness of submission of the financial statements</p> <p><input type="checkbox"/> (iii) Accounting standards used</p>	<p>Q2 Score: 0.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p>
	<p>Check A, B, or C; if C checked, select appropriate disaggregates:</p>		<p>In country source, i.e., reports indicating CSO</p>

<p>Q3. Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?</p>	<p> <input type="radio"/> A. No, there are no formal channels or opportunities <input type="radio"/> B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback <input checked="" type="radio"/> C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply: </p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> During strategic and annual planning <input checked="" type="checkbox"/> In joint annual program reviews <input checked="" type="checkbox"/> For policy development <input checked="" type="checkbox"/> As members of technical working groups <input checked="" type="checkbox"/> Involvement on evaluation teams <input type="checkbox"/> Giving feedback through social media <input type="checkbox"/> Involvement in surveys/studies <input type="checkbox"/> Collecting and reporting on client feedback 	<p>Q3 Score: 4.5</p>	<p>engagement, policies or SOPs:</p>	
<p>Q4. Civil society Enabling Environment: What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society?</p> <p>If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?</p>	<p> <input type="radio"/> A. EEI score of 0-0.38; or if no EEI score, there are laws or policies that restrict civil society playing an oversight role <input checked="" type="radio"/> B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government <input type="radio"/> C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight </p>	<p>Q4 Score: 3.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Civicus Enabling Environment Index (civicus.org/eei/)</p>	
<p>Oversight and Stewardship Score: 7.5</p>				

THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN

Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

14. Policies, Laws, and Regulations: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.

Source of data

Notes/Comments

Q1. Structural obstacles: Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?

- A. No, there are no such laws or policies
- B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score):
- Criminalization of HIV transmission
 - HIV testing disclosure policies or age requirements
 - Non-disclosure of HIV status laws
 - Anti-homosexuality laws
 - Anti-prostitution legislation
 - Laws that criminalize drug use, methadone use or needle exchange

Q1 Score: 1.0

In country source, i.e., name of law or policy: Criminal Code s349(a)s.s(i)

Q2. Access protection: Is there a National HIV/AIDS Policy or set of policies and laws that creates a legal and policy environment that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated?

(note: full score of six points possible without checking all boxes)

- A. No, there are no such policies or laws
- B. Yes, there are such policies and laws. Check all that apply:
- For people living with HIV
 - For men who have sex with men
 - For transgendered persons
 - For sex workers
 - For people who inject drugs

Q2 Score: 4.0

Constitution of PNG, PNG Dev. Strat. Plan 2010-2030, PNG Med. Term Dev. Plan 2010-2015, PNG Nat. HIV & AIDS Strat.2011-2015, PNG Nat. Hlth Pln 2011-2020, HIV/AIDS Management & Prev. Act 2003, Nat AIDS Council Act 1997, Public Hlth. Act

	<input checked="" type="checkbox"/> For children orphaned or affected by HIV/AIDS <input checked="" type="checkbox"/> For young girls and women vulnerable to HIV <input checked="" type="checkbox"/> For survivors of gender-based violence			
Q3. Civil society sustainability: Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages?	<input type="radio"/> A. No, there are no special provisions or advantages for CSOs <input checked="" type="radio"/> B. Yes, there are special provisions and advantages for CSOs. Check all that apply: <input checked="" type="checkbox"/> Significant tax deductions for business or individual contributions to not-for-profit CSOs <input checked="" type="checkbox"/> Significant tax exemptions for not-for-profit CSOs <input checked="" type="checkbox"/> Open competition among CSOs to provide government-funded services <input checked="" type="checkbox"/> Freedom for CSOs to advocate for policy, legal and programmatic change	Q3 Score: 4.0	In country source, name of legislation: Public Hlth Act, Provincial Hlth. Authority Act, Organic Law on Provincial & Local Level Govs, Church and Gov. Partnership Established	
Q4. Enabling legislation: Are there policies or legislation that govern HIV/AIDS service delivery?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, there are. Check all below that are included: <input checked="" type="checkbox"/> A national public health services act that includes the control of HIV <input checked="" type="checkbox"/> A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services	Q4 Score: 4.0	In country source, name of legislation or policy: Nat. HIV & AIDS Strat. 2011-2015, PNG Hlth Pln 2011-2020	
Policies, Laws, and Regulations Score:			13	
15. Planning and Coordination: Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated.			Source of data	Notes/Comments
	<input type="radio"/> A. No, there is no national strategy for HIV/AIDS	Q1 Score: 4.0	In country source, name of current	

<p>Q1. National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?</p>	<p><input checked="" type="radio"/> B. Yes, there is a national strategy. Check all that apply:</p> <p><input checked="" type="checkbox"/> It is multiyear</p> <p><input checked="" type="checkbox"/> It is costed</p> <p><input checked="" type="checkbox"/> Its development was led by the host country government</p> <p><input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy</p>		<p>strategy: PNG National HIV & AIDS Strategy 2011-2015</p>	
<p>Q2. Data driven prioritization: Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?</p>	<p><input type="radio"/> A. No data-driven prioritization approach was used</p> <p><input type="radio"/> B. Yes, a data-driven prioritization approach was used but it did not coordinate the investment of multiple funding sources</p> <p><input checked="" type="radio"/> C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources</p>	<p>Q2 Score: 4</p>	<p>In country source, i.e., data analysis government used:</p>	
<p>Q3. CCM criteria: Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?</p>	<p><input type="radio"/> A. No or there is no CCM</p> <p><input checked="" type="radio"/> B. Yes, with conditions</p> <p><input type="radio"/> C. Yes</p>	<p>Q3 Score: 1</p>	<p>Global Fund Eligibility List 2014</p>	
<p>Q4. Coordination of national response: Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?</p>	<p><input type="radio"/> A. No, it does not track or map all HIV/AIDS activities</p> <p><input checked="" type="radio"/> B. the host country government coordinates all HIV/AIDS activities. Check all that apply:</p> <p><input checked="" type="checkbox"/> Of Civil Society Organizations</p> <p><input type="checkbox"/> Of private sector</p> <p><input checked="" type="checkbox"/> Of donor implementing partners</p> <p><input type="checkbox"/> Activities are tracked or mapped</p> <p><input type="checkbox"/> Duplications and gaps are addressed</p>	<p>Q4 Score: 2.0</p>	<p>In country source, i.e., Coordination data or reports:</p>	

	<input type="checkbox"/> Joint operational plans are developed that include key activities of all implementing agencies			
Q5. Civil society engagement: Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders, and/or networks representing affected populations) are actively engaged. Check all that apply: <input checked="" type="checkbox"/> In advocacy <input checked="" type="checkbox"/> In programmatic decision-making <input checked="" type="checkbox"/> In technical decision-making <input checked="" type="checkbox"/> In service delivery	Q5 Score: 4.0	In country source for each checked: Verbal report from local partner that GoPNG and church partnership document exists, but PEPFAR team unable to access it.	
Planning and Coordination Score:		15		

THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN