

# Papua New Guinea Country Operational Plan (COP) 2016 Strategic Direction Summary



PAPUA NEW GUINEANS AND AMERICANS  
IN PARTNERSHIP TO FIGHT HIV/AIDS

**PEPFAR**

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## List of Acronyms - Papua New Guinea COP 2016

ANC	Antenatal Clinic
ART	Anti-retroviral therapy
ARV	Anti-retroviral
CCM	Country Coordinating Mechanism
CD4	Cluster of Differentiation
CDC	Center for Disease Control and Prevention
CHAI	Clinton Health Access Initiative
CHP	Community Health Partnerships
CoPCT	Continuum of Prevention to Care & Treatment
CPHL	Central Public Health Laboratory
CY	Calendar Year
DOS	Department of State
DFAT	Australian Department of Foreign Affairs and Trade
DRM	Domestic Resource Mobilization
DSD	Direct Service Delivery
EQA	External Quality Assurance
FSVAC	Family Sexual Violence Action Committee
FSW	Female Sex Workers
FY	Fiscal Year
GBV	Gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoPNG	Government of Papua New Guinea
GSD	Gender and Sexual Diversity
HCT	HIV Counseling & Testing
HHISP	Health and HIV Implementation Services Provider
HIVTDR	HIV Transmitted Drug Resistance
HIVTWG	HIV Technical Working Group
HPDB	HIV Patient Database
HSS	Health System Strengthening
HTS	HIV Testing Services
HRSA	Health Resources Services Administration
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
K	Kina

KP	Key Populations
LCI	Local Capacity Initiative
LES	Locally Engaged Staff
LTFU	Loss to Follow up
M&E	Monitoring and Evaluation
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
NDOH	National Department of Health
NHIS	National Health Information Systems
NHS	National HIV/AIDS Strategy
OI	Opportunistic infections
OU	Operating Unit
OVC	Orphans & Vulnerable Children
PBAC	PEPFAR Budget Allocation Calculator
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
POC	Point of Care
PNG	Papua New Guinea
PMTCT	Prevention of mother-to-child transmission
PWID	People Who Inject Drugs
QM/QI	Quality Management / Quality Improvement
QA	Quality Assurance
SI	Strategic Information
SID	Sustainability Index Dashboard
SOP	Standard Operating Procedure
SMS	Short Message Service
SNU	Sub-National Unit
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBTWG	Tuberculosis Technical Working Group
TG	Transgender
TSW	Transactional Sex Worker
UNAIDS	United Nation AIDS Organization
UIC	Unique Identifier Code
USG	United States Government
VL	Viral load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
XDR-TB	Extensively drug-resistant tuberculosis

## Goal Statement

In FY2016, PEPFAR Papua New Guinea (PNG) refocused its support to a geographical approach focusing on the Right Places - high HIV-burdened populations and geographic locations, the Right Things - intensifying outreach efforts and streamlining clinical services, strengthening gender based violence (GBV) efforts, and continuing to improve surveillance and laboratory networks, the Right Way -with GoPNG leadership and in partnership with bi-lateral and multilateral representatives, civil society organizations and other stakeholders, through demonstration and technical assistance to multiply the lessons learned, and Right Now - in order to reverse the trajectory of the epidemic in PNG.

Latest estimates indicate a national prevalence of 0.79%, up from 0.70% in 2014, and 52.8% of HIV+ adults and children currently on treatment, 21,189 of 40,148 (UNAIDS, 2016). The Government of PNG (GoPNG) revised its treatment guidelines in 2015 from a CD4 count of  $\leq 350$  to that of  $\leq 500$  for initiation of services and is discussing the transition to Test and Start. The current guidelines do allow for test and start in a significant portion of those who are HIV+, including pregnant women, TB patients, KP, HIV+ partners of serodiscordant couples, and children under 5. GoPNG funds the cost of ARV drugs and HIV testing and is solidifying how to sustainably support the country's HIV response. PEPFAR PNG continues to maximize partnerships by targeting critical gaps in the national response, developing cost-effective service delivery models and building service delivery capacity across the prevention, treatment and care continuum. Major activities include:

Service Delivery - supporting models to improve HIV/AIDS services to KP and GBV survivors:

- Community prevention and outreach by peers
- User-friendly clinical services for KP and GBV survivors
- Community prevention/case management/adherence
- Piloting new models of treatment and test and start
- Improving cost-effectiveness of service delivery models
- Active and on-going collaboration with relevant CSOs
- Training of HCWs on prescribing ART, roll-out of VL, and addressing treatment failure

Strategic Information (SI) - accurately tracking improvements in the cascade:

- Roll out IBBS and KP Sentinel Surveillance to provide KP size estimates
- Roll out real time HIV/TB-HIV reporting
- Include KP and GBV indicators
- Build national/local HIV surveillance capacity

Clinic Quality Improvement at the NCD and national level to improve the cascade:

- HIVQUAL focus and active case management in NCD HIV clinics to reduce ART lost to follow up
- Monitor Early Warning Indicators to prevent drug resistance
- Roll out of the NDOH HIVQUAL Framework and HIV Patient Data Base

Laboratory Strengthening to improve the cascade:

- VL rollout based on current availability of testing equipment
- Validation of DBS for VL testing.

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## 1.0 Epidemic, Response, and Program Context

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### 1.1 Summary statistics, disease burden and country or regional profile

PNG has a population of approximately 8 million per latest GoPNG estimates. Leading causes of mortality are perinatal conditions; pneumonia, malaria, TB, meningitis, heart diseases, diarrhea and diseases of the digestive system. TB and pneumonia have high prevalence rates and are often associated with HIV infection. There are known cases of multiple (MDR) and extreme drug resistant (XDR) TB in the capital, but recent statistics on co-infection rates are not available. There are currently 40,148 (UNAIDS, 2016) PLHIV in PNG, by far the greatest number of PLHIV in the Pacific. Over ninety-five percent of HIV cases reported in the Pacific between 1987 and 2015 have been from PNG.

The preliminary 2015 UNAIDS estimates show that HIV prevalence for PNG increased to 0.79% from 0.70%, among adults, and there was a total of 2,649 new infections during the year (UNAIDS, 2016). Preliminary data also shows that HIV is concentrated in the Highlands Provinces and in NCD. In the four Highlands provinces, the HIV prevalence is increasing and remains above 1%: (Enga 1.75%; Jiwaka 1.51%; Western Highlands 1.30%; Eastern Highlands 1.00%) whilst in NCD, the HIV prevalence is 1.29% (an increase from 1.07%). The backbone of HIV surveillance in PNG is 329 antenatal clinics (ANC) providing HIV testing, complemented by 94 HIV counseling and testing (HCT) sites. Although HIV surveillance data has improved substantially over the past couple of years, it still has limitations. With PEPFAR PNG and partners' support, HIV testing sites have increased by 19% (from 356 sites to 423 sites in 2014). Reporting coverage has improved from 68% to 75% in 2014, ART sites have increased from 54 to 77, and PMTCT reporting coverage has increased to 90% from 82%. To further strengthen the surveillance system, PEPFAR PNG, in partnership with WHO and Global Fund, is supporting a case-based surveillance system to track and monitor patients. PEPFAR PNG has supported NDOH data cleaning, verification and consolidation. The 2015 data is much improved from previous years, with three years of data, more complete reporting and more data points being used. KP data at the national level is unavailable, but program-level KP data from PEPFAR PNG supported sites show higher positivity rates among KPs. To gain a better

understanding of the KP HIV epidemic at the national level, as well as the relationship of gender-based violence to HIV, PEPFAR PNG, with other partners, is supporting KP and GBV program level data collection tools that will be rolled out nationally. With the availability of the national KP IBBS data results later in 2016 and 2017, the epidemic among KPs will be better understood. A 2014 UNAIDS meta-analysis of previous IBBS results showed rates as high as 17% among female sex workers (FSWs) and 24% among transgender sex workers (TSWs) in Port Moresby. UNAIDS reported a high prevalence among male sex workers (MSWs) in Port Moresby, with a 9% rate among men who sell sex and 24% 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 under-reported. Other HIV surveillance sites and positivity rates include: STI clinics (4%), TB clinics (5%), health facilities (6%), blood banks (0.3%), and HCT clinics (4%).

Resistance to ARVs may also be an issue in PNG. The results of a recent study in two large HIV clinics by Burnett Institute, National Department of Health (NDOH) and WHO revealed a worrisome 16% transmitted resistance to the first line ART regimen in the NCD and 8% resistance in Mt Hagen province<sup>1</sup>. PEPFAR PNG is partially supporting a transmitted drug resistance study to verify these numbers nationally. The expansion of viral load testing will allow for a better understanding of the magnitude of treatment failure and will allow clinics to better deal with this problem.

**Table 1.0 National and SNU level epidemiological data**

Parameters	2015 Estimates (preliminary)*	2014 Estimates*
HIV prevalence	0.79	0.70
Total PLHIV	40,148	37,000
New infection (total)	2,649	2,000
New infection (0-14 children)	421	<500
Annual AIDS Deaths	887	<1000
Mothers needing PMTCT	1496	1,309
Enga Province –prevalence	1.75	1.64
Jiwaka Province – prevalence	1.51	1.04
Western Highlands Province –prevalence	1.30	1.05
National Capital District – prevalence	1.29	1.07
Eastern Highlands Province – prevalence	1.00	0.66
Morobe Province prevalence	0.77	0.53
Madang Province prevalence	0.60	0.50

\*\*Note: Previous Spectrum modeling 2014 estimates are used for comparison only until updated in mid-May 2016

Papua New Guinea ranks 140 out of 155 countries in the 2014 Gender Inequality Index. Few women are elected to office, they lag behind men in education, participation in the labor market, have high maternal mortality, high adolescent pregnancy and low family planning rates. GBV is also extremely high in PNG. A five-province study indicated approximately 66% of women report experiences of physical or sexual violence (Ganster-Breidler, 2009). PEPFAR

PNG's Gender Analysis maintains that "one of the greatest barriers to each of the "90: 90: 90" fast track targets in PNG is GBV." Violence can be a barrier in accessing HIV prevention, care, and treatment services. The passage of the 2014 Family Protection Act represents a major milestone in the protection of women and establishment of legal rights for women. While the Act provides a firm legal basis for jailing perpetrators of domestic violence and allows female GBV survivors and children to remain in the home, while requiring that the male perpetrator of violence leave the house, meaningful interventions by the justice and other sectors lag far behind the intent of the law.

In Port Moresby, transactional sex workers (TSW) have reported rates of sexual abuse as high as 78% (FHI, 2011). Vulnerability to HIV can increase unequal power differentials stemming from a limited ability to negotiate safer sex, engaging in transactional sex, and to a decreased ability to test, disclose and access to 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, harmful 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 GoPNG has achieved substantial progress in HIV epidemic control, with an overall reduction of 34% in estimated annual new HIV infections in adults 15+ years. However, prevalence does continue to rise and high-prevalence provinces of Enga, Western Highlands Province, Jiwaka, Eastern Highlands, Morobe and NCD are among the provinces that have reported increased prevalence from 2014 to 2015. The NDoH is implementing the 2011-2015 National HIV/AIDS Strategic Plan, which has been extended to 2017. FY15 data from PEPFAR-supported clinical sites reveals that 27.4% of all those tested self-disclosed as being a member of a KP. While this number is much higher than the proportion of KP in the general population, the 27.4% self-identified portion may still be an underestimation of the KP numbers PEPFAR PNG sites are serving. Seventy-five percent of those tested in FY15 at PEPFAR supported sites were assessed, via self-disclosure, as being at high risk for HIV infection due to risky sexual practices. Of those who tested positive, 34.5% were KP members and 53.2% were categorized as high risk. It is also possible that many of those categorized as high-risk are not members of a KP, but are heterosexual adults with more than one sexual partner.

GoPNG has made progress in the continuum of care cascade with 53% of all PLHIVs currently on ART (UNAIDS, 2015). Full adoption of the WHO 2015 Test and Start guidelines will increase the number of patients that need to register in care. With careful forecasting and procurement planning by the GoPNG, this new group of patients will access treatment services fairly quickly due to PNG's established infrastructure, available drug stocks, and policy of free healthcare. With PEPFAR PNG support the NDOH plans to adopt the new guidelines through a process of expert consultations, starting late in FY16. Current challenges to reaching 90-90-90 include ART retention/adherence and understanding the impact of stigma, discrimination, and GBV on access to HIV testing and counseling services. To address




retention issues, PEPFAR PNG, in collaboration with GoPNG, has scaled up and mentored staff to utilize handheld smart phones to track HIV positive patients, and will be strengthening community case management to reduce loss to follow up and defaulting. PEPFAR PNG is intensifying monthly site level coaching and mentoring of clinic staff from 10 HIV clinics through the HIVQUAL program to strengthen the quality of care within the HIV care and treatment cascade. The Government has embraced the HIVQUAL program and adopted it as a national program. The NDOH has developed a national framework which serves as a foundation to use the tool in the HIV program throughout the country. HIVQUAL is using clinic specific indicators to track improvement in the quality of care at the site level. This includes reducing loss to follow up, intensifying HIV case finding and strengthening ongoing mentoring for clinic staff. PEPFAR PNG is also strategically focusing on improving the case-based surveillance and monitoring by strengthening and linking case reporting and patient monitoring systems to obtain national and sub-national level data for measuring progress towards prevention, testing and treatment targets. This allows for longitudinal follow up of individuals across sentinel events, from testing to diagnosis, treatment and current clinical status. The case-based surveillance and monitoring is a sustainable surveillance and patient monitoring approach that will enable the NDOH to track its efforts towards achieving 90-90-90 treatment targets at national, sub-national and site levels. The need for more timely, detailed information on the surveillance and monitoring for HIV, strengthening the laboratory network for HIV viral load and three test algorithm for HIV rapid testing, pose some of the most immediate challenges for PEPFAR PNG. This is doubly true in providing services to members of stigmatized and hidden population groups for whom testing and counselling and ART retention are key to epidemic control.

PNG is listed on the WHO high burden country list for TB, TB-HIV and TB MDR. The incidence rate of TB (417/100 000 population) is the highest in the WHO Western Pacific Region and tenth highest globally. In PNG's NCD, TB case notification rates are nearly 4 times the national average (1200/100000). In addition, drug resistant TB is common (9% of all cases), TB related mortality is high (33 cases per 100,000 population excluding HIV+ TB patients) and the TB case notification rate is increasing.

**Table 1.1.1 Key National Demographic and Epidemiological Data**

	Total		<15				15+				Source, Year
	N	%	Female		Male		Female		Male		
			N	%	N	%	N	%	N	%	
Total Population	8,000,000										National Statistics Office estimates
HIV Prevalence (%)		.79%									UNAIDS, 2016
AIDS Deaths (per year)	887										UNAIDS, 2016
# PLHIV	40,148										UNAIDS, 2016
Incidence Rate (Yr.)		*									
Total New Infections (Yr.)	2649										UNAIDS 2016
Annual births	25 births/1000										World Factbook,

	population										2015
% of Pregnant Women with at least one ANC visit		53%									UNAIDS/GARPR, 2014
Pregnant women needing ARVs (needing PMTCT)	1496										UNAIDS, 2016
NCD Notified TB cases (2014)	6,390										WHO 2016
% of TB cases that are HIV infected		11%									TB Control Program-Annual Report, 2014
Estimated Population Size of MSM	39,837										2014 UNAIDS/GARPR
MSM HIV Prevalence		9%									2014 UNAIDS/GARPR
Estimated Population Size of FSW	38,561										2014 UNAIDS/GARPR
FSW HIV Prevalence		17%									Kelly, et al (2010)
Estimated Population Size of PWID	N/A	N/A									
PWID HIV Prevalence	N/A	N/A									PWID is very rare
Estimated Size of Transgender											
Transgender Prevalence		24%									Kelly, et al (2010)

 Data not available

**Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)**

				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	On ART (#)	Retained on ART 12 Months* (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population - national	8,000,000	0.79	40,148	21, 198	18, 823	N/A	65,362	2,649	N/A
National Capital District	424,174**	1.29	3672	1, 832	1626	N/A	11439	171	N/A

Source: 2016 UNAIDS, preliminary 2015 estimates

\*\* NCD total population estimates based on Census and applied annual growth rate

## 1.2 Investment Profile

PNG is a lower-middle income country with a gross national income of \$2,240 USD per capita (World Bank, 2014). External donor resources were the major source of financing for PNG's K 228,123,252 million (~\$86 million USD) HIV response in 2015, accounting for over 80% of the total resource envelope. In 2015, the Australian government provided approximately \$26 million (30%) to the HIV response with Global Fund for AIDS, Tuberculosis (TB), and Malaria (GFATM) estimated to support 16.5% of the total HIV response (Total GFATM grant is \$14,207,542). PEPFAR PNG provides approximately 8% and is the third largest individual

donor for the HIV response (NASA 2012). The GoPNG will contribute about 22% and the remainder is covered by bi-lateral and multi-lateral organizations, including inputs by faith-based organizations. Australia supports a wide range of HIV activities and HSS in both HIV clinical and non-clinical settings. GFATM focuses on PMTCT, HIV care and support, TB/HIV, and GBV and is geographically focused in the Highlands.

The most recent National AIDS Spending Assessment (NASA 2012) revealed that prevention spending was about 22% of the total spending (see Table 1.2.1), care, support and treatment 12%, and program management and administrative strengthening about 50%. Although resource allocation of KPs had increased by five-fold in 2012 compared to previous years, this accounted for only 33% of overall HIV prevention spending. The breakdown of GoPNG spending on laboratory, strategic information, and health systems strengthening is not available. The GoPNG and stakeholders are working at reducing program management costs through implementing more efficient and automated management systems. The GoPNG pays for HIV testing and commodities, allocating about 14.1 million kina (about US \$4.6 million) for ARVs annually. The adoption of the revised WHO treatment guidelines and Test and Start will be beneficial in many ways. Approximately, an additional \$3.4 million will be needed to fund ARV procurement (plus the added costs of second line ART procurement); The recent donation to the GoPNG from the Government of India to support HIV/AIDS activities provides funding to support Test and Start. In addition to service delivery costs, there are 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.

Because of the lack of funding to carry out another expenditure analysis, there hasn't been an updated NASA since 2012. PEPFAR PNG will be working with UNAIDS to ensure this is updated.

**Table 1.2.1 Investment Profile by Program Area<sup>1</sup> (2011-2012 NASA)**

<b>Program Area</b>	<b>Total Expenditure (USD millions)</b>	<b>% PEPFAR</b>	<b>% GF</b>	<b>% Host Country</b>	<b>% Other</b>
Care and Treatment	9.94			12	
Prevention	18.4			22	
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	
<b>Total</b>	<b>82.1</b>				

\*includes laboratory and strategic information and health systems strengthening

<sup>1</sup> (GRP, National AIDS Spending Assessment , 2012 ), all amounts in 2012 USD

**Table 1.2.2 Procurement Profile for Key Commodities**

<b>Commodity Category</b>	<b>Total Expenditure</b>	<b>% PEPFAR</b>	<b>% GF</b>	<b>% Host Country</b>	<b>% Other</b>
ARVs				100%	
Rapid test kits				100%	
Other drugs				100%	
Lab reagents				100%	
Condoms					
Viral Load commodities					
Other commodities					
<b>Total</b>	US\$ 4.6				

**Not Applicable - Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration**

**Not Applicable - Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP**

### **Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives**

PEPFAR PNG is implementing the Local Capacity Initiative (LCI) to increase the capacity of community based organizations in Papua New Guinea to effectively work within communities to help reduce HIV associated stigma and discrimination, including violence, particularly against FSW and MSM, and women in general, in NCD communities. These efforts should increase the number of KPs and GBV victims accessing HIV care and treatment services. Successfully funded projects are expected to support the priorities of the PNG National HIV and AIDS Strategy 2011- 2015; Priority area 1 – prevention, and Priority area 2 – counseling, testing, treatment, care, and support. These areas include the following outcomes in NCD:

- Interventions are established to address stigma and discrimination associated with accessing HIV prevention, counselling, testing, and treatment, care and support services
- KPs and GBV survivors facing HIV related stigma and discrimination (including violence) have access to comprehensive services to reduce HIV related vulnerability
- The community is effectively involved in programs that address stigma and discrimination (including violence) among the KP and GBV survivors.

### **1.3 National Sustainability Profile**

Partnering with UNAIDS, PEPFAR PNG met regularly to develop a first draft of the Sustainability Index questions to share with a broader group of stakeholders for their input. PEPFAR PNG and UNAIDS led a joint stakeholder meeting to gather input from and discuss with GoPNG, civil society organizations, faith based health service providers, multi-lateral and bi-lateral donors, and the GFATM Principal Recipient.

Across the 15 elements of the four domains of the Sustainability Index, planning and coordination emerged as a significant strength during the review process. The stakeholders identified that the GoPNG leads a strong coordination process through multiple fora, including the national HIV TWG, the national TB TWG, a monthly Health Partners meeting, and the CCM, where information is shared regularly. Parliament recently conducted an inquiry on HIV/AIDS to identify salient issues and guide policy. KP CSOs participated in the process and submitted their own documents and testimonies to Parliament.

Under National Health System and Service Delivery, service delivery was highlighted as vulnerable. HIV prevalence rates are much higher among KP; prevailing culture, strongly held religious beliefs, and societal taboos serve as barriers to utilization of health services. Additionally, GBV was an issue identified that is not adequately addressed within the health service delivery system. Quality management and laboratory were also identified as having vulnerabilities. The national and provincial laboratory network needs increased capacity for HIV testing, Quality Assurance and oversight of clinic point of care mini labs. In addition, viral load testing roll out is heavily dependent upon donor financial and technical resources. Under strategic information, epidemiological and health data, financial/expenditure data and performance data were all identified as vulnerabilities. While much data is collected and available, there are some delays in reporting and national compiling and reporting of results. The total resource funding envelope is not well understood, as progress in HIV Financial/Expenditure data availability is slow. In addition, the lack of funding has slowed progress including delays in implementing NASA reporting updates. Finally, GoPNG is introducing computerized and detailed financial management systems that require additional training.

PEPFAR PNG identified comparative advantages on which the team can focus their COP 16 efforts. The group prioritized enhancing KP services by sensitizing health care workers to the needs of KP and individuals who experience GBV as well as improving the screening for GBV and creating customized GBV indicators to better understand the issue. Improving data collection and increasing understanding of PNG's HIV epidemic among KP is another critical area of PEPFAR support. The PEPFAR PNG team will continue providing TA to the IBBS, thus providing critical data on KP in NCD as well as two other high HIV prevalence areas. Preliminary IBBS data for NCD should be available in November 2016 thus allowing all key stakeholders to analyze to make programmatic decisions based on evidence. The PEPFAR PNG team will also enhance the routine collection of KP and GBV data through providing TA to include this data and roll out the National HIV patient database (HPDB) to major ART centers. The use of HPDB case based reporting will improve data collection capabilities of the HIV national patient management system, improve collection and use of the national HIV clinical cascade data. Through a strong quality improvement program, the PEPFAR PNG team will provide TA to strengthen case management to improve retention in NCD and assist in national rollout of HPDB.

To strengthen laboratory efforts, the PEPFAR PNG team will integrate viral load testing into the HIV/AIDS response by providing TA to support the implementation of viral load testing in several sites through strengthening of the specimen collection and transport system, as well as testing and reporting, to ensure not only that specimens are properly tested, but the results reach the clients. In addition to the viral load testing scale up, the PEPFAR PNG team will collect early warning indicators from all HIVQUAL-supported clinics and provide mentorships for enhanced adherence counseling to minimize treatment failure and further enhance its management.

#### **1.4 Alignment of PEPFAR investments geographically to disease burden**

PEPFAR PNG is supporting four clinical sites in NCD through Direct Service Delivery (DSD) and technical assistance and six additional sites with TA only, through HIVQUAL and other technical assistance. The site in Madang is primarily TA and all current DSD will be phased out during FY 17. The TA sites include one clinic that exclusively serves MSM and TGs while others serve the general population, but the PEPFAR focus is on providing access to friendly and high quality care to KPs.

A 2011 evaluation of PEPFAR's CoPCT (Continuum of Prevention, Care and Treatment) model cited that the model effectively reduced stigma and discrimination of health providers in the Madang clinic, which increased the number of KPs accessing the clinic's services. The Madang clinic also achieved significant reductions in the lost-to-follow-up (LTFU) rate for patients on OI prophylaxis and/or ART, from 14% in 2008 to 1% in 2011. The GoPNG has adopted the CoPCT model for HIV services throughout the country and other donors are in the process of rolling it out with their partners. A key component of the FY16 COP is assuring the transition of the Madang site to the provincial government and strengthening of the CoPCT model, specifically looking at making the model more cost effective, strengthening outreach, scaling up test and start and viral load testing and testing new service delivery models. Ongoing laboratory quality assurance activities will continue at the Central Public Health Laboratory (CPHL) in NCD and HIV high burden provinces in a coordinated effort with NDOH and all USG partners including DFAT, GF, CHAI and WHO with future expansion to "mini-labs" at the facility level.

FY 16 expenditures support services that target KP include: 2% for care, 21% for treatment services, 19% for lab strengthening/capacity building and SI, and 34% for prevention, including peer-to-peer outreach and HTS.

DFAT and GFATM resources are supporting high HIV-burden areas in the Highlands Region. PEPFAR PNG will leverage resources and TA from partners and share lessons learned in NCD

to assist DFAT and GFATM to help improve quality of services and improve data quality in high burden provinces.

**Table 1.4.1 Total PEPFAR Expenditures and total PLHIV by SNU by Fiscal Year**

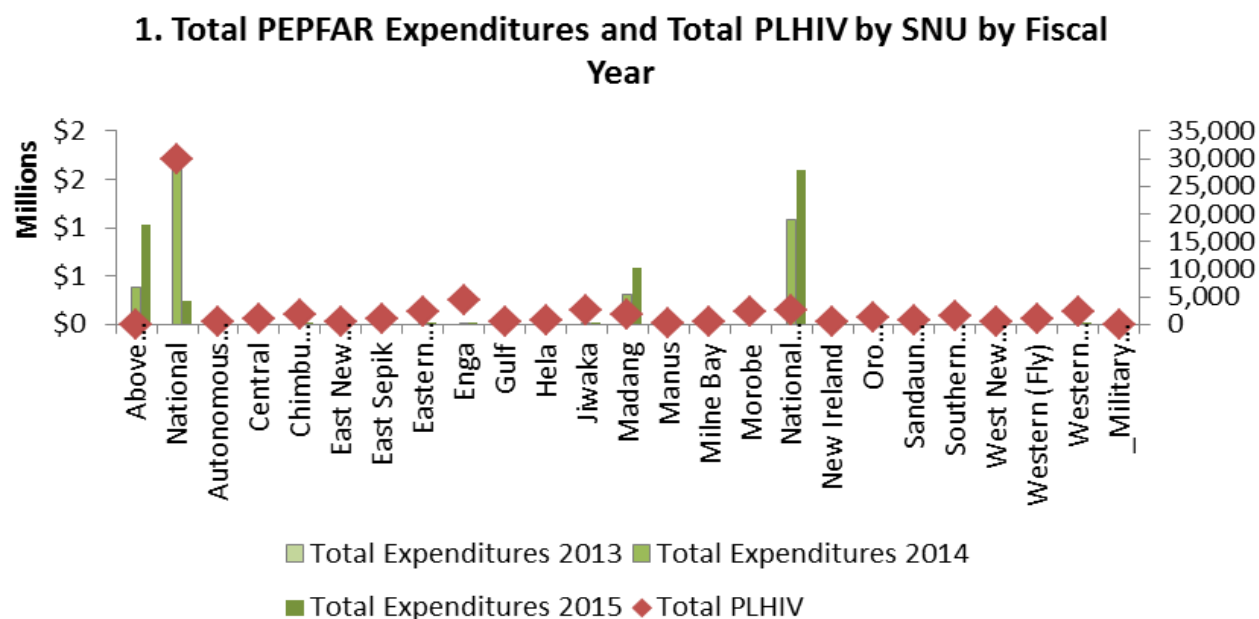


Table 1.4.2 UNAIDS Provincial Data for High Priority Provinces (+15 years), (UNAIDS, 2015)								
Adults 15+	Papua New Guinea	NCD	Madang	Enga	Eastern Highlands	Jiwaka	Morobe	Western Highlands
<i>HIV population</i>	36,911	3,376	1,871	4,856	3,610	3,482	3,221	3,014
<i>Prevalence (15-49)</i>	0.79	1.29	0.60	1.75	1.0	1.51	0.77	1.30
<i>New HIV infections</i>	2,228	143	166	261	257	377	225	162
<i>Total receiving ART</i>	20,028	1,832	1,015	2,635	1,959	1,889	1,748	1,635

### 1.5 Stakeholder Engagement

COP16 activity-based collaborations will continue to expand. PEPFAR PNG work closely with UNAIDS to strengthen partner engagement, especially with civil society, through quarterly meetings of the HIV Civil Society Forum, PEPFAR will hold quarterly stakeholder meetings

with government, civil society and other partners and collaborate with clinical and administrative staff.

The PEPFAR PNG team and the NDOH have increased collaboration and identified ways to ensure greater collaboration throughout the year. In addition, PEPFAR PNG regularly consults with NCD Health Services, the Madang Provincial Health Office, and the national HIV TWG, TB TWG, CCM, and with GFATM officials.

## **2.0 Core, Near Core and None- Core Activities**

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Our core activities will focus on continuing improving HIV testing and ART coverage of KPs through the CoPCT model and building capacity of provincial and NCD health staff in delivering high quality KP friendly HIV services. PEPFAR PNG will provide support through two methods: 1) continued implementation and evaluation of the CoPCT service delivery model in NCD and Madang; 2) providing targeted technical assistance and mentoring in NCD; and 3) providing TA support to national programs to improve HIV surveillance at the major ART centers, rollout of HIVQUAL and laboratory support. No non-core activities or transition plans are necessary. See Appendix A for full list of core and near-core activities.

## **3.0 Geographic and Population Prioritization**

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Using UNAIDS estimates for 2015, 7 of 22 provinces (NCD, Magang, Enga, Western Highlands, Jiwaka, Morobe and Eastern Highlands) represent 63% of the PLHIV among 15+ years and of 71% the HIV new infections in PNG. New infections in these provinces are increasing from 2013 to 2015 while other provinces are decreasing. Current KP focused activities in PNG are being funded by GoPNG, GF, DFAT and PEPFAR PNG. DFAT currently provides funds to six IPs, covering ten provinces, including NCD, Jiwaka, Enga, and Western Highlands. PEPFAR PNG KP activities will continue to focus on urban areas, particularly NCD, since that is where KPs are thought to be concentrated.

The PEPFAR PNG team will also enhance the routine collection of KP and GBV data through the new Health Informatics Advisor, who will be instrumental in the GoPNG's efforts to ensure an accurate and effective data collection system. Furthermore, PEPFAR PNG will provide TA to include GBV and KP surveillance data in the roll out the National HIV patient database (HPDB) to major ART centers.

Based on the UNAIDS preliminary estimates for 2015, the national ART coverage rates for eligible adults is approximately 53% ( $CD_4 \leq 500$ ). ART coverage percentages are presently not available by KPs. With elevated HIV positivity reported among KPs in PEPFAR PNG supported clinics, PEPFAR PNG will continue to conduct DSD in four clinics (2 ART sites) in NCD and one clinic in Madang and provide TA to eight ART sites in NCD to reach saturation. PEPFAR PNG will review geographic and population prioritization once results from the IBBS and data from the planned 2016 KP HIV surveillance activities become available. PEPFAR PNG



is anticipating potential geographic shifts in 2018 after achieving the NCD pivot outcomes. Strengthening national HIV surveillance and laboratory systems and using the NCD HIVQUAL lessons learned to begin roll out of HIVQUAL in HIV high burden provinces would facilitate scaling out these programs to other areas of need in a coordinated effort with NDOH and all USG partners including DFAT, GF, CHAI and WHO.

## **4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations**

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### **4.1 Targets for priority locations and populations**

Given the KP focus of PEPFAR PNG's program, all five DSD clinical sites (4 in NCD and 1 in Madang) have achieved rates in testing yield that are far higher than the national average and will continue to be prioritized. Within NCD, PEPFAR PNG continues to provide TA to build capacity in laboratory, including viral load testing, KP and GBV sensitization, CoPCT model, including; cost efficiencies, intensified outreach for case identification, surveillance, and clinical QM/QI to improve adherence and retention.

PEPFAR PNG strengthened its outreach and service delivery to ensure that it is reaching KPs with critical HIV services. Lessons learned from the Madang clinic's model of case management have been applied to the two NCD sites, which began dispensing ART in March 2014.

PEPFAR PNG is actively participating in the management and technical committees of the IBBS, while at the same time playing a leading role in the creation and implementation of a national KP sentinel surveillance system. The IBBS is being carried out in NCD, Lae and Mt. Hagen peri-urban areas, and will provide data to ensure that PEPFAR PNG is working in the right places. Preliminary data for NCD will be available by late-2016.

PEPFAR PNG supported hotspot mapping exercises in NCD and Madang to document hot spots and conduct on-the-spot counts of people to ensure peer-to-peer outreach is taking the right targeting approach. This information is used to conduct incentivized peer-to-peer outreach in our priority areas. PEPFAR PNG will support TA to successfully replicate this model in other geographic areas.

PEPFAR PNG has begun implementing activities in support of women who have experienced GBV. Beginning with COP16 and based on the recently completed gender analysis, PEPFAR PNG will expand its GBV services. Through an approach to better understand the issues around GBV and expand the availability of GBV survivor friendly services, PEPFAR PNG hopes to increase the use of HIV/AIDS services by GBV survivors. Incorporating GBV indicators in

the ART centers HPDB and NHIS HIV surveillance will help us continue to improve this understanding.

The GBV implementation strategy will focus on addressing all of the recommendations in the gender analysis, which will span multiple years, and include scaling up the GBV clinical and support services, improving the quality of those services and community outreach.

PEPFAR PNG participates in the national Family Sexual Violence Action Committee (FSVAC), which coordinates efforts among various donors and implementers. The FSVAC is expanding their thinking beyond family violence to GBV including against key affected populations.

PEPFAR PNG supported development of a 10-hour prevention curriculum which has been pilot tested and is being finalized, in collaboration with the NDOH. Please refer to table 6.1.1 for additional details on GBV activities.

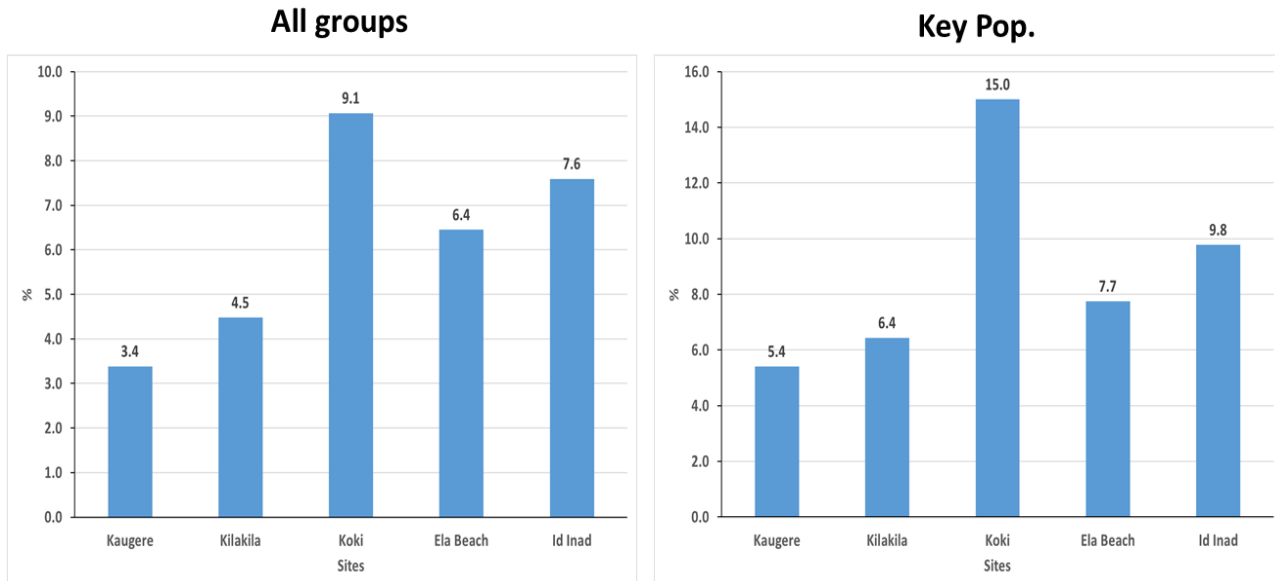
### **Prevention and HIV Testing Services (HTS)**

In FY15 PEPFAR supported sites, program data shows that 26% of all those tested were members of a KP, while in the first quarter of FY16, the figure is about 33% of all tested. The initiation of mobile testing in late FY15 served to boost the total number tested by 157 people, however out of three mobile testing sessions, only three people were positive. Future mobile testing sites will be more strategically chosen and with more attention to potential hot spots and greater HIV testing yield.

The positivity rate is higher among KPs than other populations attending at each of the PEPFAR-supported clinics, with Koki having the highest rate at 15% (see graph below). Overall, the highest rates are found among TSWs. In FY 16 and in FY17, increased attention will be put on 'gender-sensitive' outreach, such that, outreach staff who visit communities must also make efforts to reach adolescents and women vulnerable to GBV. In NCD, PEPFAR PNG is implementing an Enhanced Outreach Approach (EOA), which incentivizes peer educators to conduct KP outreach activities to enhance KP referrals. This approach increased the number of KP individuals accessing clinical services in FY15. The EOA requires 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).

In order to prevent potential overlap with other implementing partners in target populations served with prevention services, in FY15 the PNG team collaborated with other donors to map NCD catchment areas and reached an agreement on where groups should work between the main PEPFAR PNG IM and an Australian-supported NGO targeting KP. Findings indicated that there was duplication between outreach workers of the Australian-supported NGO and the PEPFAR PNG IM, creating confusing for clients. Recognized the possibility of duplication of services and double counting at the provincial and national level, the two are meeting regularly. Additionally, PEPFAR PNG has built stronger donor collaboration to discuss these issues; the group meets regularly prevent duplication.

## HIV positivity rates



The IBBS results, the positivity yield of the GF-supported clinics in NCD in the coming year, the decisions of other stakeholders as well as the yield in PEPFAR-supported sites will inform future decisions of where PEPFAR PNG resources can maximally contribute to epidemic control in PNG.

**ART eligibility:** Using the numbers in the Performance Monitoring Plan, the HTS targets for each year were used as primary data since there are no existing size estimates for the total population of KPs in PEPFAR PNG geographic priority areas. The FY15 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 as HIV positive was calculated as eligible. A 10% upward adjustment was made to account for using the new national guidelines of CD4  $\leq$ 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 at our sites.

**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 CD4 eligibility criteria.

**Table 4.1.1 ART Targets in Scale-up Sub-national Units for Epidemic Control**

SNU	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) TX_CURR	Newly initiated (APR FY 17) TX_NEW	ART Coverage (APR 17)
NCD	3,376	1832	868	449*	231*	61%*
<b>Total</b>	<b>3,376</b>	<b>1823</b>	<b>878</b>	<b>449</b>	<b>231</b>	

**Table 4.1.2 Entry Streams for Newly Initiating ART Patients in PEPFAR Program Sites (FY 17)**

Entry Streams for ART Enrollment	Tested for HIV (in FY17)	Identified Positive (in FY17)	Enrolled on ART (in FY17)
Clinical care patients not on ART	n/a	n/a	n/a
TB-HIV Patients not on ART	n/a	n/a	n/a
HIV-positive Pregnant Women	n/a	n/a	n/a
Other priority and KPs	5,557	332	300
<b>Total</b>	<b>5,557</b>	<b>332</b>	<b>300</b>

**Site level targets:** In FY16, the percent contribution of each site was used to assign site level targets for newly starting and currently on treatment. For FY17 the same positivity rate for all sites was used to generate targets. While there may be variations among sites, the overall provincial rate is used and should account for the variation. Individual site percentages were used only to project the number of individuals receiving HIV testing and counseling since those numbers tend to be site-specific.

**Retention:** Some clients “clinic shop” and often provide false addresses possibly, to avoid home visits from a clinic known to treat HIV positive people. This makes tracking difficult. Clients also frequently change their phone numbers, making regularly scheduled follow-up challenging. PEPFAR PNG supported the introduction of 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 HIVQUAL

At the site level, PEPFAR PNG will support HIVQUAL phased scale up in 10 ART clinics in NCD and is now focused on ART retention rates. By the end of the last quarter, QI activities resulted in all ART sites having the HIV Patient Database (HPDB) installed which is critical in

improving data and monitoring retention rates in the clinics. In the next quarter we should have results for NCD on the improvements contributed through QI efforts.

HEALTHQUAL will collaborate with PEPFAR PNG staff, FHI360, NCDHS, and NDOH in a coordinated effort with all USG partners including DFAT, GF, CHAI and WHO to build capacity in QI at the NCD and National level through:

- Facilitating training/mentoring NCD Health Services and NDOH managers on:
  - Implementing NDOH HIVQUAL National Framework
  - Running a provincial QI collaborative (focusing on LTFU)
  - Managing a provincial TB-HIV testing QI project
- Facilitating training/mentoring clinicians and office managers:
  - Incorporating the Stigma and Discrimination Index in clinic QI
  - Using QI indicators to improve clinic operations
  - Implementing a clinic TB-HIV testing QI project
- Providing TA in national planning and implementation of the NDOH National HIVQUAL framework
- Providing TA for national rollout of the HPDB, HIVQUAL and Lab QA in the HIV high burden provinces (Highlands region and Morabe) in a coordinated effort with NDOH and all USG partners.

PEPFAR PNG supported DSD sites have tracking systems to follow clients from outreach to linkage to care. The HIVQUAL electronic system is a database which uses inpatient information records to show the quality of care. The HIV Patient Database is a patient management information system, at the clinic level, containing patient level information on testing results, CD4, reviews, blood tests, ART information, etc.

TB screening via patient history is conducted at all three DSD ART sites. Suspected cases are referred to the adjacent TB clinic for sputum testing. In FY17 PEPFAR PNG will continue work to improve the referral pathways between TB and HIV clinics, including follow-up of referrals in both directions. Also, sputum microscopy will be introduced into selected ART clinics in NCD.

## **Gender**

Although infection rates in girls and women are not the same as those in southern Africa, Papua New Guinean girls and women are particularly vulnerable to HIV in a culture where violence and accusations of sorcery are notoriously common. PEPFAR PNG baseline targets for GBV and gender related indicators were initially established based on the high level of physical and sexual violence experienced by KPs in PNG as reported by FHI 360's 2010 BSS as well as other documents that address the levels of GBV in PNG.

Although consistent data are lacking, it is commonly acknowledged that PNG continues to have an unacceptably high incidence of violence towards women and KPs. Given the low results of identifying the need for and providing GBV services in FY14 - FY15, in FY16 - FY17 PEPFAR PNG will increase efforts significantly by providing innovative and effective interventions at the intersection of GBV and HIV prevention, care, and treatment. Interventions include strengthening staff ability to screen for GBV at all sites. In addition to conducting sensitivity training for clinic staff, PEPFAR PNG will also conduct training for church leaders, local business leaders, legal aid personnel on the unique health needs and vulnerabilities of sexual minorities, especially MSM & TGs. Already planned and partially implemented activities include training clinic outreach workers on mobilizing community leaders against GBV, training in trauma counseling for clinic staff, ensuring that comprehensive PEP services are available to GBV survivors and improving response and referral mechanisms and support services.

Ensuring the safety of victims of violence once they left our services is an on-going challenge. Part of the project's TA is to assist counselors and service providers to develop safety plans for victims 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 MSM and TG is under consideration, more engagement and planning with the organizations representing these groups is needed.

The LCI project will increase the capacity of community based organizations in Papua New Guinea to effectively work within communities to help reduce HIV associated stigma and discrimination (including violence) particularly against KP of FSW and MSM in NCD communities.

### **TA/TC Country - Technical Assistance**

PEPFAR PNG is working at national and sub-national levels to achieve accelerated and sustained epidemic control. PEPFAR PNG staff are members of the national HIV/AIDS, SI, IBBS and TB Technical Working Groups, where major policies and systems related to the national response are discussed and decided. PEPFAR PNG has been working with NDOH and other stakeholders to amend national data collection tools to include data related to KP. While there is overall buy-in to the process by the government and other implementing partners, implementation challenges will be addressed by PEPFAR PNG in FY17. PEPFAR PNG is advocating for a test and start treatment policy.

PEPFAR PNG will provide limited TA to high burden provinces in a coordinated effort with NDOH and all USG partners including DFAT, GF, CHAI and WHO based on improving the 90:90:90 cascade with a focus on improving KP HIV testing yield, PLHIVs on ART, and providing VL testing to improve viral suppression. PEPFAR PNG will collaborate with NDOH

and Provincial Health Authorities and Health Officials to provide TA and support country leadership and sustainability. The Health Informatics Advisor will add value to the PEPFAR PNG program by enhancing quantitative and qualitative attributes of data collection for KPs and GBV data through the existing data collection tools and systems and finally, coordinate partnership resources to improve data quality for program planning and implementation.

## **Program Area Summaries 4.2-4.10**

### **4.2. Prevention**

There have not been any recent policy/guidelines changes toward HIV prevention that specifically target KPs or other high risk groups. A mid-term review of the National HIV/AIDS Strategy 2011-2015 (extended to 2017) recommended re-prioritization of the country's prevention efforts to focus on KPs and for relevant government agencies to recognize the CoPCT model, emphasizing 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 reinforced. Similarly, condom and lube 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 assisted health managers and service providers to plan accessible, client centered HIV services that meet the needs of KPs and PLHIV for life.

The current PEPFAR PNG program continues to promote a comprehensive package of services for KPs and PLHIV that is based on the CoPCT model. Community and clinic based services are provided, including:

1. Intensified case finding through incentivized peer-to-peer outreach;
2. Risk reduction counseling (e.g. condom use and other safer sex practices, alcohol and other drug reduction, HIV serostatus disclosure)
3. Correct and consistent condom use, condom demonstration and provision of condoms and lube
4. Education on STI, HTS and GBV when appropriate
5. Referrals to STI and HTS
6. Provision of ART to all KP members

**4.3 Voluntary medical male circumcision (VMMC)** – PEPFAR PNG does not support any VMMC activities.

#### **4.4 Preventing mother-to-child transmission (PMTCT)**

While PMTCT is not a part of the PEPFAR PNG strategy, the team will support some PMTCT efforts. PEPFAR PNG will work with the NDOH to roll out the new ART guidelines to eliminate missed opportunities to provide pregnant women with ART and referrals of infants to pediatric treatment sites.

#### **4.5 HIV testing services (HTS)**

Stigma and an unfavorable legal environment are still major barriers to the uptake of HIV testing services by KPs, whose sexual activities are illegal and by survivors of GBV. Despite successes in reaching these groups, there are still too many KPs who are not accessing HTS.

PEPFAR PNG will implement a three-pronged approach to address this HTS gap:

1. Pilot, strengthen and scale up models of HTS for KP. This will build upon the successes to date, but also look at models that might produce higher yield and reach those not accessing services.
2. Integrate GBV screening into testing and counseling services at clinic and mobile units. GBV screening is an area that will be strengthened during COP16 and beyond, to both better understand the issues and scale up interventions to address these.
3. PEPFAR PNG will expand on current successes and support scale-up of TB screening. STI will continue to be a routine part of services for KP at PEPFAR-supported clinics and lessons used to enhance services at other clinics.
4. Increase effective 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 program will continue to provide care and support to HIV+ clients by providing knowledge, medicines, and counselling to live positively with the virus. To date, the focus has been on facility-based services, however, a community-based focus, with linkages to necessary clinical services, will reduce loss-to-follow-up and increase appropriate initiation of ARVs.

Community-based services will include working with PLHIV support groups on adherence counselling, screening and referral for GBV, and condom and lube promotion. The program will also seek to promote patient involvement in case management for PLHIV. This will help patients monitor their own health, including weight, CD4 count (or viral load as this gets rolled out), appointment date, and other information. PEPFAR PNG will work with GoPNG and facilities to ensure that as many KP clients are initiating treatment as soon as possible.

#### **4.7 TB/HIV**

According to the National TB Strategic plan TB/HIV co-infection in the country is about 20 percent and TB screening for all diagnosed as HIV+ is the protocol in PNG, but this does not always happen. PEPFAR PNG will continue to strengthen routine TB screening at all sites it is supporting, with both direct service delivery and TA, and strengthen linkages between TB and



HIV services. PEPFAR PNG will work with the NDOH, WHO, and other key partners to advocate that the following services will be provided to all clients:

- TB screening for all clients at all services provided;
- Isoniazid Preventive Therapy (IPT) for all eligible HIV positive clients;
- TB infection control;
- Adequate light and ventilation in all waiting rooms;
- Immediate ART initiation for all TB patients;
- Referral and follow-up of HIV positive patients referred to a TB clinic; and
- Limited TB-HIV lab equipment and supplies using GeneXpert dual use (TB and HIV VL) machines plus cartridges.

#### **4.8 Adult treatment**

PEPFAR PNG will support strengthening adult treatment with direct service and TA. By rolling out the new guidelines to allow for test and start for KP in clinics supported by PEPFAR, PEPFAR PNG will help GoPNG to reach epidemic control. PEPFAR PNG will also continue to coordinate the rollout of the national QI program to HIV clinics in order to improve adherence and retention. A national patient management system will be deployed to support identification of defaulters and peer educators linked with clinics will be actively involved in following up clinic no-shows and reducing the numbers of patients lost to follow-up.

The GoPNG also initiated plans to roll out viral load testing, and has conducted and validated and approved plasma-based VL testing. In COP15, PEPFAR PNG is supporting the roll out in two sites in NCD and will provide TA in laboratory QI and EQAS to ensure that the VL testing is accurate and available. Based on a successful roll out of the initial sites, PEPFAR PNG in COP 16 will work with GoPNG to roll out viral load for all patients in NCD. PEPFAR PNG will also address systems barriers of plasma transportation to CPHL by supporting policy development, including guideline development and an implementation strategy, stakeholder engagement to address the barriers of transportation, developing a laboratory network system, and advocate for national leadership and direction. In addition, PEPFAR PNG will support education at communities and clinics to ensure not only that clients receive their VL results, but fully understand the meaning of these.

PEPFAR PNG is part of the Viral Load Sub-committee of national HIV TWG, to develop a strategy to roll out viral load services in PNG. To date, the sub-committee has developed a national algorithm for viral load monitoring and a strategy for the phased roll out of services in NCD starting with two clinics: Koki and Begabari. In FY 17, PEPFAR PNG will continue to work with members of the viral load subcommittee to implement the phased roll out of viral load services to other ART sites in NCD and to other provinces. See table 6.1.3 for additional details.

#### **4.9 Pediatric Treatment**

Currently, PEPFAR PNG supported sites are not certified to conduct pediatric treatment services. All suspected pediatric cases are referred to the Port Moresby General Hospital Pediatric HIV clinic, which is being supported by CHAI.

#### **4.10 OVC**

PEPFAR PNG does not support OVC activities.

## **5.0 Program Activities in Sustained Support Locations and Populations**

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There are no PEPFAR PNG funded activities outside the locations or populations already described. The purpose of PEPFAR PNG program is to provide models of service delivery and support the roll out through technical assistance. PEPFAR PNG will be transitioning out of Madang by the end of COP16. Under COP16 PEPFAR PNG will continue to continue to support the development and implementation of models of service at sites in NCD and monitor the relevance of these learning sites.

## 6.0 Program Support Necessary to Achieve Sustained Epidemic Control

### 6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

PEPFAR PNG identified gaps in the clinical cascade that will assist GoPNG to achieve the 90-90-90 goals and sustain epidemic control. Based on information gathered in the SID, the Investment Profile, discussions with the NDOH and other partners, the team identified the following areas as programmatic gaps and priorities for PEPFAR PNG's 2016 COP: Service accessibility for KPs and GBV Survivors, community outreach, ART Retention, and Lack of Availability of Viral Load Testing.

**Table 6.1.1 Key Programmatic Gap #1: Lack of health services in NCD for survivors of GBV, including women, girls and KP**

Key Systems Barrier	Milestones/Deliverables expected after 1 to 3 years of investment	Proposed COP/ROP16 Activities	Budget Code(s)	Activity Budget Amount (\$)	Associated Implementing Mechanism ID	Reporting frequency for POART
Lack of standardized quality mentoring on GBV sensitization	<ul style="list-style-type: none"> <li>• <b>Uptake of GBV related services increased in NCD (i.e. GEND_GBV and non-MER GBV indicators)</b></li> </ul>	<ul style="list-style-type: none"> <li>• Roll out clinical mentoring on GBV screening tool in PEPFAR priority areas, with GoPNG providing leadership</li> <li>• Provide supportive supervision and mentoring following intensive TA on GBV screening and sensitization</li> <li>• Support the roll-out and implementation of the National Clinical Guidelines: Medical &amp; Psychosocial Care for Survivors of Sexual &amp; GBV</li> </ul>	HVCT  HTXS	\$255,000	17083  17083	<ul style="list-style-type: none"> <li>• <b>12 months</b></li> </ul>
Poor quality of care provided to KP and GBV survivors	<ul style="list-style-type: none"> <li>• <b>Accessibility to high quality KP friendly and GBV related services improved</b></li> <li>• Percentage of staff at HTS and ART sites who have received standardized KP and GBV sensitivity training increased</li> </ul>	<ul style="list-style-type: none"> <li>• Roll out sensitivity training for HCWs with GoPNG providing leadership</li> <li>• Provide supportive supervision of clinical staff who have received GBV and KP friendly training</li> <li>• Tailor care and treatment services addressing risk factors among KP clients</li> <li>• Conduct 'friendliness assessments' in NCD KP clinics</li> </ul>	HTXS  HTXS  HTXS	\$70,000  \$77,500	17083  17083  17083	<ul style="list-style-type: none"> <li>• <b>12 months</b></li> <li>• Semiannual reporting</li> </ul>

Cultural acceptance of GBV	<ul style="list-style-type: none"> <li>• Milestone 1: Model of standardized screening for GBV implemented in all HTS sites and ART clinics to NDoH for formal endorsement</li> <li>• <b>Milestone 2: Standardized GBV screening tool formally endorsed by NDOH</b></li> </ul>	<ul style="list-style-type: none"> <li>• Collaborate with Dept. of Community Development, UNDP, and TWG to strengthen national GBV strategy</li> <li>• Clarify interface of HIV services and GBV at the facility level</li> <li>• Assess regulatory environment and develop an action plan, in collaboration with UNAIDS, and advocate for regulatory/legal changes</li> <li>• Train U.S. embassy staff on gender dynamics</li> <li>• Participate in GBV and KP TWGs</li> </ul>	<p>HVOP</p> <p>HVOP</p> <p>HTXS</p> <p>HVOP</p> <p>HVOP</p> <p>HVOP</p>	<p>\$5,000</p> <p>\$40,000</p> <p>\$209,838</p> <p>\$5,000</p> <p>\$10,000</p> <p>\$14,572</p>	<p>Gender Advisor</p> <p>Gender Advisor</p> <p>17083, 18255 (FHI 360 cannot enforce bullet point 1)</p> <p>Gender Advisor</p> <p>Gender Advisor</p> <p>Gender Advisor</p>	<ul style="list-style-type: none"> <li>• <b>24 months</b></li> <li>• Semiannual reporting</li> <li>•</li> </ul>
Lack of GBV/HIV interventions at the community level	<ul style="list-style-type: none"> <li>• <b>Referrals of GBV survivors to clinical and support services increased</b></li> <li>• Participation of women's groups to address GBV/HIV activities increased</li> </ul>	<ul style="list-style-type: none"> <li>• Mobilize community based women's groups around GBV and HIV related issues</li> <li>• Empower CSOs to address GBV</li> </ul>	<p>HVOP</p> <p>HTXS/HVSI</p> <p>HVOP</p>	<p>\$247,500</p> <p>\$23,000</p> <p>\$45,000</p>	<p>17083</p> <p>18255</p> <p>17597</p>	<ul style="list-style-type: none"> <li>• <b>12 months</b></li> <li>• Semiannual reporting</li> </ul>
Strategic Information - Lack of specific GBV data	<ul style="list-style-type: none"> <li>• <b>Gender disaggregated GBV indicators developed and submitted to NDOH for adoption</b></li> <li>• PEPFAR required and customized GBV indicators regularly reported by 100% (4) of PEPFAR supported sites in NCD that receive TA on GBV s</li> </ul>	<ul style="list-style-type: none"> <li>• Develop standardized GBV indicators together with NDOH and program into HPDB</li> <li>• Provide technical support, mentoring and supportive supervision to roll-out new indicators</li> <li>• Validate indicators</li> </ul>	<p>HVSI</p> <p>HVSI</p> <p>HVSI</p>	<p>\$10,000</p> <p>\$27,459</p> <p>\$10,000</p>	<p>17083, 17091, USAID SI Advisor CDC SI Advisor (3%) Hlth Info Advisor (3%)</p> <p>17083, 17091, USAID SI Advisor, CDC SI Advisor (2%) 17083, USAID SI Advisor, CDC SI Advisor (5%)</p>	<ul style="list-style-type: none"> <li>• <b>24 months</b></li> </ul>
<b>?TOTAL</b>				<b>\$949,869</b>		

\*Milestones and customized indicators in **bold** and **red** will be tracked regularly during POART.

**Table 6.1.2 Key Programmatic Gap #2: Community-based Activities for PLHIV within KP**

Key Systems Barrier	Milestones/Deliverables expected after 1 to 3 years of investment	Proposed COP/ROP16 Activities	Budget Code(s)	Activity Budget Amount (\$)	Associated Implementing Mechanism ID	Reporting frequency for POART
<ul style="list-style-type: none"> <li>Not all KP accessing HIV testing</li> <li>Community groups not reaching all KP with prevention interventions</li> </ul> <p><i>Note: the IBBS will allow for a more accurate census of KP in NCD that will allow us to better understand the gaps</i></p>	<ul style="list-style-type: none"> <li><b>KP as a percentage of those tested increased to at least 50% in NCD PEPFAR DSD sites</b></li> </ul>	<ul style="list-style-type: none"> <li>Provide peer education incentives for reaching KP</li> <li>Implement enhanced peer-to-peer outreach approach</li> <li>Strengthen CBO capacity to implement community prevention efforts</li> <li>Pilot additional KP-friendly prevention and HTS efforts</li> </ul>	HVOP HVOP OHSS HVOP	\$400,000 \$350,000 \$400,000 \$323,637	17083 17083 17083 17083	<ul style="list-style-type: none"> <li><b>12 months</b></li> </ul>
<b>TOTAL</b>				<b>\$1,473,637</b>		

**Table 6.1.2 Key Programmatic Gap #2: Identifying PLHIV within KP**

\*Milestones and customized indicators in **bold** and **red** will be tracked regularly during POART.

Table 6.1.3 Key Programmatic Gap #3: ARV Retention*						
Key Systems Barrier	Milestones/Deliverables expected after 1 to 3 years of investment	Proposed COP/ROP16 Activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Reporting frequency for POART
Poor case management of PLHIV	<ul style="list-style-type: none"> <li>90% of ART clinicians in NCD clinics trained/mentored in Active Case-management of PLHIV</li> <li>50% of NDOH and high burden province (with partner support) program supervisors of HIVQUAL clinics trained/mentored in supportive supervision</li> <li><b>HIVQUAL program established in all ART clinics in NCD and monitored using HIV Patient Database (HPDB)</b></li> <li><b>ART Lost to Follow Up (LTFU) at 12 months for HIVQUAL supported sites in NCD decreased by 20%</b></li> </ul>	<ul style="list-style-type: none"> <li>Implement new training/ mentoring protocol on case-management for clinics</li> <li>Train/mentor clinic staff in 6 sites in NCD in case management and provide supportive supervision</li> <li>Facilitate use of HPDB for HIVQUAL analysis to track loss to follow-up in 10 clinics in NCD</li> <li>Provide TA to 10 sites in NCD to evaluate ART retention rates.</li> </ul>	HTXS	\$100,000	17083, HIV Senior Advisor (4%)	• <b>12 months</b>
			HTXS	\$40,000	17083, 17091, HIV Senior Advisor (5%)	• <b>Semiannual Reporting</b>
			HTXS	\$270,000	17083, 17091, HIV Senior Advisor (6%) Hlth Info Advisor (2%)	• <b>12 months</b>
			HTXS	\$141,334	17091, HIV Senior Advisor (5%) CDC SI Advisor (4%)	• <b>12 months</b>
Few successful community ARV retention models	<ul style="list-style-type: none"> <li><b>Community care &amp; support model rolled out in NCD</b></li> <li><b>Phased roll out of community care &amp; support model in other high-prevalence areas (in the 2nd and 3rd year) initiated</b></li> </ul>	<ul style="list-style-type: none"> <li>Develop and test community ARV models in PEPFAR-supported sites</li> <li>Evaluate cost-effectiveness of community models</li> <li>Participate actively within HIV TWG</li> </ul>	HTXS	\$60,000	17083, HIV Senior Advisor (5%)	• <b>12 months</b>
			HTXS	\$108,175	17920, 17091, 17083, HIV Senior Advisor (10%)	• <b>Semiannual Reporting</b>
Lack of consistent QI management	<ul style="list-style-type: none"> <li><b>National HIVQUAL framework implemented in NCD and selected high burden provinces</b></li> <li><b>NCD QI meetings held quarterly Patient retention on ART improved 20% in all NCD clinics that receive TA on adherence &amp; retention</b></li> </ul>	<ul style="list-style-type: none"> <li>Coordinate HIVQUAL/QI activities in 10 clinics in NCD</li> <li>Provide oversight of HIVQUAL/QI scale up in NCD</li> <li>Evaluate HIVQUAL model in NCD clinics</li> </ul>	HTXS	\$95,000	HIV Senior Advisor, 17920, 17083	• <b>24 months</b>
			HTXS	\$109,435	HIV Senior Advisor (20%), USAID SI Advisor, CDC SI Advisor (5%)	• <b>Semiannual Reporting</b>
					17083, 17091, 17920	
Weak M&E and tracking system	<ul style="list-style-type: none"> <li><b>Complete, timely and accurate HPDB trend data available and used in all NCD clinics for program management, planning and interventions</b></li> </ul>	<ul style="list-style-type: none"> <li>Mentor managers on data literacy and data security issues</li> <li>Establish routine data audits/cleaning</li> <li>Conduct DQA</li> </ul>	HTXS	\$40,000	17083, 17091, CDC SI Advisor (10%),	• <b>12 months</b>
			HTXS	\$28,500	17091, 17083SI (5%) and Health Info Adv. (5%),	• <b>Semiannual Reporting</b>
<b>TOTAL</b>				<b>\$992,444</b>		

\*Milestones and customized indicators in **bold** and **red** will be tracked regularly during POART

Table 6.1.4 Key Programmatic Gap #4: Lack of Ability of Viral Load Testing*						
Key Systems Barrier	Milestones/Deliverables expected after 1 to 3 years of investment	Proposed COP/ROP16 Activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Reporting frequency for POART
Slow roll out of new VL algorithm	<ul style="list-style-type: none"> <li>SOPs on VL monitoring available and used by all clinicians and counselors in NCD at 12 months</li> <li><b>90% of all ART clients in NCD received VL test annually at 36 months</b></li> </ul>	<ul style="list-style-type: none"> <li>VL SOPs and algorithm incorporated into the PNG HIV Care and Treatment Guidelines</li> <li>Develop a strategy to roll out viral load services in NCD and PNG</li> <li>Roll-out plasma-based VL testing at Begabari (Anglicare) and Koki clinics and conduct supportive supervision</li> <li>Conduct national trainings on viral load monitoring, management of treatment failure and enhanced adherence counselling for NCD and other sites</li> <li>Conduct operations research and document lessons learned from the phased roll of viral load services for scale up</li> </ul>	HLAB	\$10,000	17091, 17083, 18248, Lab Advisor (15%)	<ul style="list-style-type: none"> <li><b>24 months</b></li> <li><b>semiannual reporting</b></li> <li><b>12 months</b></li> <li><b>24 months</b></li> </ul>
			HLAB	\$50,000	17083, Lab Advisor (15%)	
			HLAB	\$70,000	17091, 17083, Lab Advisor (10%)	
			HLAB	\$10,000		
			HLAB	\$40,000	17091, 17083, 18249, Lab Advisor (10%)	
			HLAB	\$35,000		
Lack of ART clinic laboratory supportive supervision in NCD	<ul style="list-style-type: none"> <li>Monthly supervisory visits by CPHL to ART sites ensured to verify quality of plasma specimen collection and transport at 12 months</li> <li><b>30% increase in clinics using HIV rapid testing external quality assurance (EQA) system at 12 months</b></li> <li><b>Number of VL tests conducted increased by 20% annually</b></li> </ul>	<ul style="list-style-type: none"> <li>Guide CPHL through ISO accreditation activities</li> <li>Conduct supportive supervision visits at Begabari and Koki clinics</li> <li>Develop and pilot training materials on viral load monitoring, management of treatment failure and enhanced adherence counselling</li> </ul>	HLAB	\$40,000	18249, Lab Advisor (5%) CDC-Thailand	<ul style="list-style-type: none"> <li><b>12 months</b></li> <li><b>semiannual reporting</b></li> </ul>
			HLAB	\$30,000	17083, Lab Advisor (10%)	
			HLAB	\$45,000	17083, 18249, Lab Advisor (5%)	
More oversight needed for VL and HIV rapid testing QA	<ul style="list-style-type: none"> <li>Technical oversight, QA and QMS lab activities in 10 clinics in NCD achieved by 12 months and at 24 months in selected high burden provinces (with partner support)</li> </ul>	<ul style="list-style-type: none"> <li>Coordinate activities and conduct evaluations of QA and QMS lab activities in 10 clinics in NCD.</li> <li>Provide onsite mentoring and coaching support to clinicians at Link PEPAR supported sites to the viral load network to ensure</li> </ul>	HLAB	\$10,000	17083, 18249, Lab Advisor (10%)	
			HLAB	\$35,000	17083, 18249, Lab advisor (10%) USAID SI	



		correct implementation of protocols and tools	HLAB	\$30,000	Advisor, CDC SI Advisor (5%)	
Poor tracking of HIV laboratory specimen transport and reporting	<ul style="list-style-type: none"> <li>• <b>90% of NCD clinic specimens transported to CPHL within six hours by 12 months</b></li> <li>• <b>CPHL Lab MIS implemented by 24 months</b></li> <li>• <b>Lab MIS implemented in selected high burden provincial labs in a coordinated effort with NDOH and all USG partners including DFAT, GF, CHAI and WHO by 36 months</b></li> </ul>	<ul style="list-style-type: none"> <li>• Develop a strategy and national protocol for sample management and timely dissemination of results</li> <li>• Work with NDOH and provincial authorities on developing policies, guidelines and implementation strategy for specimen transportation and reporting</li> <li>• Establish a laboratory MIS</li> <li>•</li> </ul>	HLAB	\$20,000	17091, 17083, 18249, Lab Advisor	<ul style="list-style-type: none"> <li>• <b>12 months</b></li> <li>• <b>semiannual reporting</b></li> </ul>
			HLAB	\$34,000	17091, 17083, 18249, Lab Advisor	
			HLAB	\$5,000	17091, 17083, 18249, Lab Advisor (10%)	
			HLAB	\$25,000	Hlth Info (15%)	
Lack of VL data collection & reporting tools	<ul style="list-style-type: none"> <li>• <b>Routine VL data collection tools developed for incorporation into national HMIS by 12 months.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Assess data collection tools to ensure that they meet all indicators and requirements</li> <li>• Support development, modification or customization of tools if needed</li> <li>• Ensure adopted tools are incorporated in HMIS</li> </ul>	HVSI	\$40,336	17091, 17083, 18249, Lab (5%), Health Info (10%) and USAID SI Advisor, CDC SI Advisor (5%)	<ul style="list-style-type: none"> <li>• <b>12 months</b></li> <li>• <b>quarterly reporting</b></li> </ul>
<b>TOTAL</b>				<b>\$529,336</b>		

\*Milestones and customized indicators in **bold** and **red** will be tracked regularly during POART.

Table 6.2.1 Test and Start						
Key Systems Barrier	Milestones/Deliverables expected after 1 to 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Reporting frequency for POART
Recently adopted ART Guidelines are out of date and start initiation at CD4 ≤500	<ul style="list-style-type: none"> <li>• <b>National guidelines revised to require starting all HIV positive patients on ART regardless of CD4 count by 12 months.</b></li> <li>• <b>Test and Start policy implemented in all PEPFAR DSD and sites receiving TA in NCD by 24 months</b></li> <li>• <b>PLHIV initiated on ART increased by 10% in NCD as a result of Test and Start by 24 months</b></li> </ul>	<ul style="list-style-type: none"> <li>• Facilitate expert meeting to develop next steps to move toward test and start</li> <li>• Support Test and Start at 2 KP facilities in NCD and sites receiving TA provide supportive supervision</li> <li>• Provide technical assistance for phased roll out of test and start</li> <li>• Collate and analyze ART data for gap analysis</li> <li>• Mentor/train NCD Health Supervisors at sites in NCD on test and start</li> </ul>	HTXS  HVCT  HTXS  HVSI  HVCT	\$25,000  \$120,179  \$25,000  \$15,000  \$200,000	17091, HIV Senior Advisor (5%)  17083, HIV Senior Advisor (10%)  17083, Senior HIV Advisor (10%)  17083, Senior HIV (5%)	<ul style="list-style-type: none"> <li>• <b>24 months (- test and start in all clinics NCD clinics)</b></li> <li>• <b>Quarterly status updates</b></li> <li>• <b>Semiannual reporting</b></li> </ul>
<b>TOTAL</b>				<b>\$385,179</b>		

\*Milestones and customized indicators in **bold** and **red** will be tracked regularly during POART.

Table 6.2.2 New and efficient service delivery models*						
Key Systems Barrier	Milestones/Deliverables expected after 1 to 3 years of investment	Proposed COP/ROP:6	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Reporting frequency for POART
Current prescribing practice discourages multi-month ARV prescriptions	<ul style="list-style-type: none"> <li>• <b>Multi-month prescription guidelines developed together with NDOH and implemented in DSD and sites receiving TA</b></li> <li>• <b>policy developed and adopted by 12-month</b></li> </ul>	<ul style="list-style-type: none"> <li>• Provide technical assistance and advocacy on forecasting models and ART procurement for 3-6 month prescription for pilot sites in NCD</li> <li>• Phased roll out of 3-6 month prescription for stable patients (virally suppressed) in clinics in NCD</li> <li>• Develop guidelines based on roll out</li> </ul>	HTXS	\$50,000	17083, 17091, HIV Senior Advisor (5%)	<ul style="list-style-type: none"> <li>• <b>24 months</b></li> <li>• <b>quarterly status updates</b></li> </ul>
			HTXS	\$40,000	17083, HIV Senior Advisor (5%)	
			HTXS	No cost implication	17091, USAID and CDC SI (5%) ((10%)Advisor	
			HOSS	\$30,000	17083, , 17091, HIV Senior	
			HTXS	\$10,000		
<b>TOTAL</b>				<b>\$130,000</b>		

\*Milestones and customized indicators in **bold** and **red** will be tracked regularly during POART.

**Table 6.3 Other Proposed Systems Investments**

Systems Category	Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control	Milestones/Deliverables expected after 1 to 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Reporting frequency for POART
<b>Inst &amp; Org Development</b>							
PEPFAR subcontracted civil society organizations lack capacity	<ul style="list-style-type: none"> <li>Conduct organizational capacity building, based on assessments and action plans in the areas of Governance, Financial Management, Procurement, Project Management and Sustainability</li> </ul>	First and second 90s	<ul style="list-style-type: none"> <li><b>Five CSOs successfully completing NUPAS assessment by 12 months</b></li> </ul>	\$250,000	HXTS, HVOP, HVCT	17083	<ul style="list-style-type: none"> <li><b>24 months semiannual reporting</b></li> </ul>
Activities in Clinical Services in HIV/AIDS Treatment need to improve adherence and KP access to care	<ul style="list-style-type: none"> <li>Build capacity of two DSD clinics in adherence and viral load testing,</li> <li>Conduct KP friendliness assessment of services and adjust services in line with recommendations</li> </ul>	Support will generally impact second and third 90s	<ul style="list-style-type: none"> <li><b>Adherence to ARVs increased by 20% in two DSD sites in NCD (using viral load suppression)</b></li> <li><b>70% of sites complying with recommendations from KP friendliness assessments.</b></li> </ul>	\$200,000	HXTS, HVOP, HVCT	17083, 17920, HIV Senior (3%) and Lab Advisors (3%)	<ul style="list-style-type: none"> <li><b>12 months</b></li> </ul>
Civil Society not well engaged in HIV policy making and advocacy	<ul style="list-style-type: none"> <li>Engage CSO in the development of National HIV strategy.</li> <li>Build capacity of civil society</li> </ul>	Support will generally impact all 3 90s and will support sustained response by ensuring Civil Society voice is heard	<ul style="list-style-type: none"> <li>Civil society engaged in development of National HIV Strategy by 12 months</li> </ul>	\$43,000 \$50,000	HVOP HXTS,	18248 17083	<ul style="list-style-type: none"> <li><b>12 months</b></li> </ul>

	<p>organizations to conduct advocacy campaigns</p> <ul style="list-style-type: none"> <li>In collaboration with UNAIDS and other partners, conduct quarterly civil society meetings to discuss progress on both USG and national HIV/AIDS strategy.</li> </ul>		<ul style="list-style-type: none"> <li><b>At least one advocacy campaign is planned by CSOs to address access to and use of HIV/AIDS services by 12 months</b></li> </ul>		HVOP, HVCT		
<b>TOTAL</b>				\$543,000			
<b>Strategic Information</b>							
HIV KP & GBV SI efforts in PNG given low priority	<ul style="list-style-type: none"> <li>Develop a national plan with milestones for strengthening information systems with case-based surveillance</li> </ul>	Support will generally impact all 3 gos	<ul style="list-style-type: none"> <li><b>NDOH standardized indicators/disaggregates for KP and GBV refined and adopted by PEPFAR PNG by 12 months</b></li> <li><b>IBBS data analyzed and disseminated by 12 months</b></li> <li><b>National plan to strengthen information systems approved by 12 months, implemented by 24 months and annually revised</b></li> </ul>	\$102,233	HVS	17091, 17083, Hlth Info (10%) and USAID SI Advisor, CDC SI Advisor (5%)	<ul style="list-style-type: none"> <li><b>12 months</b></li> <li><b>quarterly progress updates</b></li> </ul>
				\$10,000	HVSI	17091, CDC HQ, CDC SI Advisor (5%),	
				\$10,000	IHVS	17091, 17083, CDC HQ, CDC SI Advisor (5%),	
Health staff with low HIV surveillance skills	<ul style="list-style-type: none"> <li>Develop UPNG capacity through twinning, short-term course enrollment,</li> </ul>	Support will generally impact all 3 gos	<ul style="list-style-type: none"> <li><b>FET fellows graduated and employed in HIV surveillance in all high burden provinces and</b></li> </ul>	\$40,889	HVSI	17091, SI Advisor (30%) CDC SI Advisor (5%)	<ul style="list-style-type: none"> <li><b>12 months</b></li> <li><b>quarterly progress reports</b></li> </ul>

	and further training of the Field Epidemiology Training Program graduates on HIV epidemiology		<p><b>5-7 selected districts by 12 months</b></p> <ul style="list-style-type: none"> <li>• <b>Number of health staff in provinces contributing to HIV surveillance increased by 10% by 12 months</b></li> <li>• <b>Number of provincial HIV/TB projects increased by 10% by 12 months</b></li> </ul>				
Standalone computerized and manual reporting systems do not interact with each other	<ul style="list-style-type: none"> <li>• Increase the data collection capacity of the HIV patient Database (HPDB) to track individuals across all services for HIV, KP and GBV indicators</li> <li>• Phased roll out of revised HPDB</li> <li>• Train on HPDB clinic staff and conduct supportive supervision</li> </ul>	Support will generally impact all 3 gos	<ul style="list-style-type: none"> <li>• HPDB system in the 20 largest ART facilities integrated and utilized for reporting by 24 months.</li> <li>• Data base rolled out in a phased manner in all NCD clinics by 12 months</li> </ul>	\$55,896	HVSI	17091, Hlth Info (15%) and USAID SI Advisor, CDC SI Advisor (5%), 17083	<ul style="list-style-type: none"> <li>• <b>12 months</b></li> <li>• <b>semiannual reporting</b></li> </ul>
Duplicate HIV client entries hinder accurate reporting and follow up.	<ul style="list-style-type: none"> <li>• Implement national UIC or biometrics for community outreach activities adopted by PEPFAR supported projects and service providers</li> </ul>	Support will generally impact all 3 gos	<ul style="list-style-type: none"> <li>• <b>NDOH approved national UIC or biometrics for community outreach activities adopted by PEPFAR DSD NCD clinics by 24 months</b></li> <li>• <b>Phased roll out extended to other NCD ART clinics by 36 months</b></li> </ul>	\$138,259	HVSI	17091, 17083, Hlth Info (15%) and USAID SI Advisor, CDC SI Advisor (5%)	<ul style="list-style-type: none"> <li>• <b>12 months</b></li> <li>• <b>semiannual reporting</b></li> </ul>

	<ul style="list-style-type: none"> <li>• Document rollout for phased scale up</li> <li>• Undertake phased scale up for all clinics in NCD.</li> </ul>						
Weak KP surveillance at HIV clinical sites	<ul style="list-style-type: none"> <li>• Develop KP surveillance tools</li> <li>• Strengthen KP data collection from all KP programs</li> <li>• Conduct KP surveillance training at 4 sites in NCD</li> <li>• Implement KP surveillance at 2 sites in NCD and then phase roll out throughout NCD</li> <li>• Strengthen decision tree tool to gather and report data by risk factor for HIV</li> </ul>	second 90	<ul style="list-style-type: none"> <li>• <b>NDOH KP management information system (KPMIS) implemented in NCD KP sites at 12 months</b></li> <li>• <b>Number of facilities regularly reporting KP related/disaggregated data increased by 20% at 12 months</b></li> <li>• Coordinate with partners in high burden provinces</li> </ul>	\$132,277	HVSI	17091, 17083, Hlth Info (15%) and USAID SI Advisor, CDC SI Advisor (10%)	<ul style="list-style-type: none"> <li>• <b>12 months</b></li> <li>• <b>semiannual reporting</b></li> </ul>
Identification of clinic HIV resistance indicators and client ART failure is weak	<ul style="list-style-type: none"> <li>• Develop and adopt NDOH SOPs and Guidelines for early warning for treatment failure</li> <li>• Provide TA and supportive supervision to NCD</li> </ul>	Third 90	<ul style="list-style-type: none"> <li>• <b>Clinic staff trained in treatment failure in 2 NCD sites; phased scale up to two NCD sites by 12 months</b></li> <li>• <b>EWI rolled out in 2</b></li> </ul>	\$90,889	HVSI	17091, 17083, Hlth Info (5%), Senior HIV (2%), and USAID SI Advisor, CDC	<ul style="list-style-type: none"> <li>• <b>24 months</b></li> <li>• <b>semiannual reporting</b></li> </ul>

	sites to establish NDOH Early Warning system to identify drug failure and prevent drug resistance		<b>clinics in NCD by 12-months</b> <ul style="list-style-type: none"> <li>phased scale up of EWI to all clinics in NCD by 24-months</li> <li>Coordinate with partners in high burden provinces</li> </ul>			SI Advisor (5%)	
KP care and treatment cascade data is incomplete	<ul style="list-style-type: none"> <li>Undertake data collection, disaggregation, and monthly reporting of HTS by KP and/or level of risk for HIV</li> <li>Work with partners to do data validation and cleaning</li> </ul>	Addressing all three 90s	<ul style="list-style-type: none"> <li>KP clinical cascade data at the NCD is available at 24 months and at high burden provinces at 36 months</li> </ul>	\$20,902  \$69,987	HVSI	17091, 17083 Hlth Info Advisor (5%) and USAID SI Advisor, CDC SI Advisor (5%)	
Incomplete HIV/TB co-infection data and low testing rates	<ul style="list-style-type: none"> <li>Implement TB-HIV test tracking within HPDB and develop computerized TB HIV testing database</li> <li>Work on small TB-HIV projects through the FET program</li> </ul>	first and second 90s	<ul style="list-style-type: none"> <li>TB-HIV co-infection data improved by 30% in NCD by 12 months</li> <li>TB-HIV testing in NCD increased by 20%</li> </ul>	\$134,495	HVTB/HVSI	17091, 17083, Senior HIV (5%) , SI (5%) and Hlth Info	
<b>TOTAL</b>				<b>\$785,827</b>			



## 7.0 Staffing Plan

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PEPFAR PNG'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), and Centers for Disease Control and Prevention (CDC).

Each agency uses its unique expertise to provide focused technical assistance (TA) in support of core activities. USAID's TA focuses on building capacity of the GoPNG and civil society to efficiently implement and scale up the CoPCT model for KPs, and to address issues affecting the ability of GBV survivors to access HIV/AIDS services. With core strengths in HIV quality improvement in HIV care and treatment, HIV laboratory strengthening and HIV strategic information, CDC's cost effective TA uses CDC country staff to help build capacity of national and provincial health staff. DOS leads the PEPFAR PNG 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 gender-based violence through the centrally funded Local Capacity Initiative and the CoPCT model clinics.

In FY 2015 USAID's Regional Coordinator for the Pacific managed the USAID/PNG office and was partially supported by PEPFAR PNG. USAID/PNG's Personal Services Contractor Health Advisor was the in-country lead for USAID/PEPFAR PNG's activities and was fully funded by PEPFAR. The Health Advisor was supported by a Locally Engaged Staff HIV/AIDS Development Assistance Specialist focusing on M&E and reporting. As the Regional Coordinator moved to Fiji in April 2016, the position is no longer supporting PEPFAR PNG and will no longer be supported with PEPFAR funds. The Health Advisor reports to the Chief of the Office of Health, USAID/Philippines, Pacific Islands and Mongolia, based in The Philippines. Currently USAID's office in PNG also has an LES Development Assistance Specialist and Administrative Assistant (EFM). USAID/Philippines staff also provides substantial strategic, technical, programmatic, procurement, financial and management support, however, none are funded by PEPFAR PNG. USAID Philippines-based staff is part of the expanded "in-country" PEPFAR PNG team, but are not funded by PEPFAR. To more accurately reflect the total number of staff supporting PEPFAR PNG, USAID continues to include the level of effort of Philippines-based staff in this year's staffing for results; no PEPFAR PNG funds are used to directly support Philippines based staff.

The CDC PNG office is led by a medical epidemiologist that serves as the CDC Country Director and four LES staff: Strategic Information Advisor, Laboratory Advisor, Operations Specialist and an HIV Senior Public Health Specialist. All CDC PNG staff provide expert TA to build local capacity through mentoring and coaching for NCD provincial and national-level government and PEPFAR PNG partners.

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

1. New USAID Gender Advisor LES position focused on supporting PEPFAR PNG's emphasis on GBV. With expertise in gender issues this Gender Advisor will assist with PEPFAR PNG's GBV issues across the team. The Gender Advisor will allow PEPFAR PNG's team to expand efforts related to addressing critical GBV issues that create barriers to accessing HIV/AIDS services.
2. New CDC Health Informatics Advisor position to support PEPFAR PNG team to expand TA on enhancing PNG's surveillance system for KPs and GBV survivors including using real time reporting.

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 16**

Level of Implementation	Core Activities	Near-core Activities
<b>Site Level</b>	<ul style="list-style-type: none"> <li>-Continue to improve the CoPCT model for KPs (cost efficiencies, better identification of KP, test and start, viral load, etc.)</li> <li>- Address GBV survivors in the CoPCT model (develop and track indicators related to GBV, prioritize GBV prevention, make treatment more accessible for GBV survivors)</li> <li>- Pilot multi-month prescriptions for stable clients</li> </ul>	<ul style="list-style-type: none"> <li>- Improve diagnostic and treatment practices related to those with HIV/TB co-infection</li> </ul>
<b>Sub-national Level</b>	<ul style="list-style-type: none"> <li>-Develop SOPs, guidelines and roll out VL referral system in NCD sites</li> <li>- Pilot new models for improving adherence in NCD</li> </ul>	
<b>National Level</b>	<ul style="list-style-type: none"> <li>-Develop processes for forecasting for multi-month prescriptions for ART</li> <li>-Participate in national fora to regularly exchange ideas and lessons learned with the national HIV and KP groups</li> <li>-Provide technical support for the roll out of the new care and treatment guidelines and development of test and start 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.</li> </ul>	<ul style="list-style-type: none"> <li>- Ambassador's HIV/GBV small grant program</li> </ul>

**Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16**

Technical area	Core Activities	Near-core Activities
<b>HTS</b>	<ul style="list-style-type: none"> <li>-Continue to support increased uptake of and yield of HTS in KPs in high burden provinces</li> <li>-Train HTS counselors for KPs</li> </ul>	<ul style="list-style-type: none"> <li>- Support the testing of possible new HTS algorithm</li> </ul>
<b>Care and Treatment</b>	<ul style="list-style-type: none"> <li>-Coordinate of institutionalization of HIVQUAL to all HIV care &amp; treatment sites in NCD</li> <li>- Provide technical assistance to Global Fund for implementation of HIVQUAL in other high burden areas</li> <li>-Coordinate HIV QI policy at NDOH and Provincial Health Authority in NCD</li> <li>-Work with national HIV TWG on future acceptance of test and start guidelines</li> <li>-Roll out viral load testing through referral to reference lab in select service delivery sites in NCD</li> </ul>	
<b>Prevention</b>	<ul style="list-style-type: none"> <li>-Explore robust services for prevention of GBV</li> <li>- Strengthen HIV prevention services for GBV survivors, including PEP</li> </ul>	<ul style="list-style-type: none"> <li>-Increase demand for HIV services through development of new SBCC materials &amp; strengthening implementation enhanced outreach</li> </ul>

### Cross Cutting

<b>Strategic Information</b>	<ul style="list-style-type: none"> <li>-Develop/strengthen and roll out national HMIS indicators for GBV and KP, develop KP MIS &amp; Case-based surveillance system</li> <li>- TA for implementing HIV sentinel surveillance for KPs</li> <li>-Publish results for IBBS for size estimations and prevalence of KPs in select high burden areas</li> </ul>	
<b>Laboratory</b>	<ul style="list-style-type: none"> <li>-Develop SOPs for referral VL testing</li> <li>-Build capacity of lab staff in VL testing</li> <li>- Procure VL testing equipment and reagents</li> </ul>	<ul style="list-style-type: none"> <li>- Strengthen CPHL to achieve ISO15189 accreditation</li> <li>- Build capacity of CPHL related to EQA for HTC sites</li> <li>- Strengthen CPHL supervisory capacity</li> </ul>

## APPENDIX B

### B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
\$US 350,000	\$US 6,250,000	\$US6,600,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated			
		USAID	CDC	DOS	TOTAL
MTCT	Mother to Child Transmission				
HVAB	Abstinence/Be Faithful Prevention				
HVOP	Other Sexual Prevention	1,795,709		45,000	1,840,709
IDUP	Injecting and Non-Injecting Drug Use				
HMBL	Blood Safety				
HMIN	Injection Safety				
CIRC	Male Circumcision				
HVCT	Counseling and Testing	375,179			375,179
HBHC	Adult Care and Support	99,865	30,000		129,865
PDCS	Pediatric Care and Support				
HKID	Orphans and Vulnerable Children				
HTXS	Adult Treatment	708,046	620,873		1,328,919
HTXD	ARV Drugs		78,440		78,440
PDTX	Pediatric Treatment				
HVTB	TB/HIV Care	184,495	212,433		396,928
HLAB	Lab	319,404	166,010		485,414
HVSI	Strategic Information	477,674	303,190		780,864
OHSS	Health Systems Strengthening		161,767		161,767
HVMS	Management and Operations	572,426	449,489		1,021,915
<b>TOTAL</b>		<b>\$4,532,798</b>	<b>\$2,022,202</b>	<b>\$45,000</b>	<b>\$6,600,000</b>

### B.2 Resource Projections

PEPFAR PNG used a combination of target-based and lump sum budgeting for COP 2016. Target-based budgeting was used for USAID's Pre-ART, ART, HTS and prevention targets, using unit expenditures from the most recent available EA results. USAID's lump sum activity budgets were based on related costs not captured by unit expenditures. USAID then updated

these costs to support priority activities planned for COP 2016. CDC's projections were done based on identified priority need areas, prior year budgeted figures and what is further required to be done in COP 2016. All estimates and plans were consolidated in Lump Sum budgeting and appropriately apportioned amongst the activities.

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