Australian Government

AusAID

Concept Paper

PNG Integrated Sexually Transmitted Infection Management and Prevention Program

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1 Introduction

PNG is facing a serious HIV/AIDS epidemic. The prevention and treatment of Sexually Transmitted Infections (STIs) is one of a range of strategies that has been linked to reducing rates of HIV/AIDS transmission. However, because of the urgency and scale of STI transmission the existing capacity of government programs is not sufficient to respond to current STI infection levels. Significant issues, including remoteness, gender, the limited capacity of existing health services, availability to enlist and maintain appropriately skilled staff and the enormity of the need challenge the provision of STI services in PNG

Under the umbrella of the proposed program, the Integrated STI Management and Prevention Program (ISMPP), AusAID proposes to augment PNG National Department of Health (NDoH) STI management and prevention efforts by contracting AusAID accredited non-government organisations (NGOs) to undertake innovative STI management and prevention projects. This approach is intended to build on past program work, increase the capacity of current services and also introduce new approaches to the management and prevention of STIs. NGOs will be contracted through cooperation agreements, which aim to build on and maximise the unique strengths of NGOs particularly in relation to their long-term experience, capacity and linkages with partner organisations and communities.

Based on a set of priorities established in conjunction with NDoH it is intended that a number of projects, across a variety of locations, delivering services to a range of target groups, will be established. Projects should aim to not only address gaps in current service provision but also complement the services currently on offer. In addition, while individual projects may differ considerably in service scope each will require:

- A target-community focus
- Commitment to capacity building and skills transfer
- Commitment to sustainability and development
- Willingness to implement the full range of STI prevention messages, including the active promotion and distribution of condoms (either directly or through collaborative arrangements where necessary)
- Commitment to working within current NDoH STI management and treatment guidelines
- Exploration of innovative approaches to STI management and prevention
- Research fundamental to project design.

AusAID will separately contract a key research partner to support and coordinate research arrangements.

This concept has been approved in-principle by NDoH who would be the counterpart agency for oversight of this initiative. Further, this strategy is in line with the PNG National Strategic Plan on HIV/AIDS. Implementation of this program will be coordinated with AusAID's other support for HIV and Health in PNG.

2 Rationale

2.1 HIV/AIDS – The state of the epidemic

PNG is the fourth country in the Asia-Pacific region to fit the criteria for a generalised epidemic. In November 2004, the National Consensus Workshop estimated that the rate of HIV in the 15-49 year old population was from 0.94% (low scenario), to 1.7% (medium scenario) to 2.5% (high scenario), which translates to 24,528 to 46,744 to 68,966 of people aged 15-49.

2.2 Sexually Transmitted Infections are Linked to HIV Transmission

The presence of some STIs has been clinically linked to an individual's increased chance of contracting HIV.[1] STI management is therefore considered to be an essential component of any HIV prevention program. Recent research demonstrates that treatment of STIs in high-risk groups and communities can reduce the risk of HIV transmission. Moreover, UNAIDS suggests linking STI activities with HIV activities in settings where there is a high prevalence of STIs. A study of STI programs in Tanzania reports that integrated services that reduce STIs using syndromic management are successful in the developing country context.

It is recognised however that STI interventions are known to be complex and there are many aspects of the PNG situation that may hinder the success of any program. These include:

- Poor recognition amongst the general population as to the symptoms of STIs, and in particular, the implications of untreated infection
- Low status of women, which is directly related to a women's right to consensual and safer sex
- Lack of community confidence in the health system and reluctance to seek treatment
- High rates of "transactional sex", ie trading sex for money, goods or favour
- Concurrent and multiple sexual partners
- Rapid reinfection rates
- Presence of asymptomatic STIs
- Mobile population – difficulties with treatment, tracing and compliance
- Difficulties in drug procurement and distribution
- Poor compliance with medication and/or incorrect use of drugs
- Poor acceptance and/or low availability of condoms
- Inconsistent or low target group commitment to prevention.

Within this context caution is warranted and it is important that the expectations of all stakeholders be realistic.

[1] Grosskurth et al, 2000, for more detail see background in Appendix 1 and references in Appendix 4).

2.3 High Rates of Sexually Transmitted Infections in PNG

PNG has a high prevalence of STIs in both rural and urban areas. The World Health Organization (WHO) statistics covering the decade of the 1990s, show that PNG has the second highest prevalence of syphilis and the highest prevalence of genital Chlamydia, trichomoniasis and gonorrhoea in the Asia Pacific Region. Many provinces in PNG report alarmingly high related morbidity due to the complications of untreated or inadequately treated STIs. These include pelvic inflammatory disease, ectopic pregnancy, male and female infertility and congenital syphilis.

UNAIDS report there is a high prevalence of STIs in both high-risk and low-risk groups. UNAIDS, in their PNG Epidemiology Fact Sheet – 2004 Update, report the following rates of STIs in PNG:

- Syphilis – 4% in highland's populations, 32% in sex workers, 7.1% of antenatal screening.
- Chlamydia – up to 26% in highland's populations, 31% in sex workers.
- Gonorrhoea – 15% in highland's populations, 36% in sex workers.
- Trichomoniasis – 28.75% in sex workers.

While data is limited these figures indicate that STI prevalence rates in PNG are extremely high.

2.4 STIs and Risk Behaviours

Recent data indicates that significant risk factors associated with STI transmission are: the early age of girls' first sexual encounter, the number of sexual partners, low rates of condom use and the trading of sex.

Sentinel behavioural surveillance supported by the National HIV/AIDS Support Program (NHASP) at one of PNG's STI clinics[2] showed the following results:-

- 6% of males and 10% of females stated they had sexual intercourse prior to 15 years of age
- 89% of males and 98% of females state they had sexual intercourse prior to 20 years of age
- 79% had one or more non-regular sexual partner in the last 3 months.
- 88% of males and 42% of females reported they did not use a condom with last non-regular partner.

In another sample of 132 people, 20% sold sex for money or other favours, and of this group 67% were females and 33% were males.

National AIDS Council Secretariat (NACS) findings in 2004 from three selected sero-surveillance sites found that the number of people who had more than one sexual contact in the last 12 months was high (41%, 50% and 71%). In addition the number of people who never used condoms was very high (52%, 53% and 75%).

[2] The study covered 169 people of which 128 were males, 41 females, 37% married, 42% single and 14% widowed or divorced.

2.5 PNG Government Calls for Action on STIs

The PNG Government recognises the importance of targeting STIs as part of dealing with the HIV epidemic. The PNG National Strategic Plan on HIV/AIDS (PNG NSP) calls for a dramatic reduction in the incidence of STIs by 2008. Strategies suggested to obtain this goal include the training of district level health workers in syndromic management of STIs, the construction of STI clinics, increased capacity of health workers through ongoing training and efficient supply of treatment medications.

The National Health Plan (2001-2010), together with the Medium Term Development Strategy, establishes a high level policy and strategic framework for health. The Medium Term Expenditure Framework 2004-2006 (MTEF) operationalises the policy framework by identifying costed sector priorities and linking these to government and development partner resource allocation. The MTEF's top priorities include HIV/AIDS/STIs.

2.6 Constraints in the capacity of the Health System to respond

Over 70% of PNG's population lives in rural areas where STI clinical services are very limited. A functional and expenditure review of rural health services, conducted in 2001 by the Public Sector Reform Management Unit (PSRMU), stated that there was a slow breakdown and collapse overall of the health system in rural areas. It is thought that the decline of the rural health system in combination with the emergence of HIV/AIDS suggests that the health of rural people could worsen.

Of particular concern is the likely impact of HIV/AIDS on an already overburdened health system. The PNG National Health Plan 2001-2010, states "70% of the hospital beds in the country could be occupied by AIDS patients in 2010. For every 5% increase in HIV prevalence in PNG, the total national spending on health will need to increase by 40%, at a 10% HIV prevalence rate, tuberculosis will rise 50-fold to 30% of the population"[3]. The entire health sector is under pressure with approximately only 3.5 percent of GDP devoted to health.

While NDOH are working closely with AusAID and other development partners to implement wide-ranging reforms, they have limited capacity, including restricted human resource services, to deal with the epidemic. Also its capacity to conduct monitoring and surveillance of all STIs including HIV/AIDS is constrained, resulting in limited STI prevalence data.

2.7 AusAID Support for HIV/AIDS and STIs PNG

AusAID support for HIV/AIDS prevention and treatment strategies represents the majority of both national and development partner support. The Australian funded $60 million National HIV/AIDS Support Program (NHASP), which began in October 2000 and was due to end in October 2005, has been extended to October 2006. Activities focus on education and awareness, counselling and care, clinical services, surveillance and strengthening the capacity of the National AIDS Council Secretariat (NACS) and other program partners.

Prior to NHASP AusAID supported the construction of twelve STI clinics at both provincial and district level in six provinces (Eastern Highlands, Morobe, East New Britain, Southern Highlands, Western Highlands and National Capital District). A

[3] The PNG National Health Plan 2001-2010 ,NDoH, 2000, pp. 123-124).

2002 review of this project found that access to appropriate STI services were greatly improved and additional benefits included an increased profile of STIs and increases in opportunities for community education. Construction of a further six clinics in Gulf, Sandaun and Western Provinces commenced in late 2005. An additional 29 clinics in fourteen provinces have been earmarked for future establishment.

AusAID is committed to supporting HIV/AIDS programs in PNG beyond NHASP. It is currently drafting a HIV/AIDS strategy that will outline Australian priorities for future support for HIV/AIDS in PNG. This is expected to be completed early in 2006.

AusAID is conscious that ISMPP will be limited in scope and that the issue of STI management and prevention will also need to be considered as part of design and implementation of future AusAID Health and HIV support. Appropriate linkages will be developed between all support for STI management and prevention.

2.8 Working with NGOs

It is proposed that this program be implemented by NGOs who are fully accredited through the AusAID NGO Cooperation Program (ANCP). These NGOs have gone through an accreditation process which determined that they are professional, well-managed community organisations, capable of delivering quality development outcomes.

NGOs offer a number of benefits as a mechanism to complement GoPNG efforts to manage STIs.:

- NGOs have demonstrated innovative approaches to both prevention and treatment of STIs
- Most NGOs already have established partnerships in PNG. This offers the opportunity to strengthen local capacity as well as to expand the number of STI services available in the country
- NGOs have a proven track record of providing cost-effective STI management programs, particularly in more remote areas,
- Because of the community-based they have a greater capacity to connect with and gain the confidence of local communities and are thus, more likely to have success in accessing hard-to-reach populations.
- NGOs have international linkages that enable information, lessons learned and resources to be broadly shared

(For further background please refer to Appendix 1.)

During the design of ISMPP it will be important to continue to ensure that the Program is consistent with AusAID's other support to NGOs in PNG. AusAID's approach to working with NGOs will be set out in an upcoming Civil Society Strategy.

3 The Proposed Program

3.1 Program Goal

The Program will operate within the framework of PNG's HIV/AIDS National Strategic Plan (NSP) and and in line with the Health Medium Term Expenditure Framework, within a broader AusAID strategy for Australian support for HIV/AIDS in PNG that is currently being developed.

Program goal: To reduce the rate of increase of HIV prevalence.

Program purpose: To reduce the prevalence of STIs through the provision and use of integrated sexual health services.

Program Objectives:

1. Increase access to and use of STI management and prevention services by the target communities, including appropriate groups of which vulnerable populations such as youth and women are a part.
2. Determine and disseminate the elements of effective and innovative PNG specific STI services to showcase opportunities to improve STI services nationally.

These objectives are in line with two main NSP objectives:

- Objective 2, which aims to facilitate and sustain behaviour change to minimise HIV and STI transmission in specific populations and to increase awareness of prevention in the general population, and
- Objective 4, which aims to improve social and behavioural change research in PNG so that it complements epidemiological and other information and informs the development of strategies for behaviour change.

Specific project strategies and outcomes, which support these objectives, will be developed by implementing organisations. However the broad national outcomes the program is expected to contribute to are:

1. Reduced prevalence of STIs in the area where the programs are operating.
2. Evidence that the targeted population in the program areas is practicing safer sex.
3. Innovative STI management programs tested and the lessons learned disseminated to government and other agencies involved in HIV/AIDS prevention and treatment programs.
4. Health staff in the program areas are able to deliver quality STI services and undertake appropriate surveillance activities.

3.2 Proposed Strategy

AusAID proposes to engage approximately five fully accredited NGOs to design and deliver innovative and effective programs that reduce STI prevalence. The final number of NGOs to be contracted will be determined following Technical Assessment Panel (TAP) discussions. To be selected NGOs will need to demonstrate significant experience in developing countries in the delivery of innovative, effective and appropriate STI management and prevention programs.

After agreement with the GOPNG, AusAID will call for fully accredited NGOs to present statements of their capacity to engage in the program. Selected organisations will then be supported to develop detailed design proposals. Once design proposals are appraised and approved, agreements will be signed for the implementation of the designs.

The program is estimated to cost $5 million annually over a five year period, with possible extensions. This amount should be thought of as a ceiling only and programs should reflect need and appropriate scale rather than a budget target. Flexibility will be incorporated into the program through an annual planning process. This will detail key activities and inputs for the year. This mechanism will enable flexibility in implementation, which is essential in the changing environment of PNG.

3.3 Context of the Program

The relationship between sexual health and HIV is very complex in PNG. It is recognised that programs that adopt a comprehensive pattern of intervention and incorporate a development approach are likely to be more successful.

3.3.1 A comprehensive sexual health approach

While the purpose of this program is to reduce STI prevalence, it is recognised that this can best be achieved through a broader sexual health approach. Factors such as sexual violence and gender, high rates of non-consensual sex and sexual assault, trauma in childbirth and infertility as a result of undetected or untreated STIs must be considered.

The terms STI management and prevention has been adopted for this program. STI management and prevention includes: detection and treatment services that are augmented by education, prevention (including condom distribution), information, counselling services and contact tracing.

Understandably, there is difficulty in getting people to visit STI specific services – the most obvious reason being ‘shame’ and the fear of being seen. The more successful existing HIV/AIDS clinics generally offer a range of services, for example TB, STI and reproductive health services. They do this primarily to alleviate client concerns. Given this, there is a strong argument for the delivery of STI services as one aspect of a broader based health service – be it limited to sexual and reproductive health or broader still.

This does not however mean that all services need to cover all aspects of a comprehensive program. For example a program may have as its prime focus youth sexual and reproductive health education with no clinical component, however, program designers also need to be aware of the importance of articulating into other services so as to facilitate access to a range of interventions.

3.3.2 Development approach

PNG can be a very difficult environment in which to achieve sustainable outcomes. Programs that focus on longer-term sustainable change will be prioritised. Adopting an integrated development approach heightens the likelihood of recognising social and cultural complexities including the drivers of the epidemic.

3.3.3 Capacity Building

There is a strong need for capacity support and strengthening within the infrastructure of the health provision sector. Caution is warranted so as to avoid further stressing existing services. For this reason it is important that, wherever feasible, new services complement pre-existing services, policies and practices.

A focus on local capacity building will help ensure that skills, experience and infrastructure across the sector are systematically strengthened and become rooted in the local health system beyond the life of this program.

3.4 Capacity Criteria

The process for AusAID accreditation of NGOs assesses design, implementation and management capacity. As accredited NGOs can be assumed to have these capacities, the following criteria focus on specific capacities related to this program. NGOs considering involvement in the program will need to demonstrate the following capacities and experience in their capacity statement and in any interview with the Technical Assessment Panel.

SELECTION CRITERIA	WEIGHTING (%)
1. SEXUAL HEALTH PROFICIENCY - Demonstrated knowledge of key trends in the prevention and management of STIs internationally and in PNG - Knowledge of the relevant policies, protocols, and guidelines for delivery in the ISMPP in PNG - Demonstrated experience in providing STI management and prevention services in resource poor settings - Demonstrated experience promoting a comprehensive prevention approach, including the promotion and distribution of condoms.	**40**
2. PROJECT APPROACH - Demonstrated understanding of the ISMPP Concept through an indicative description of the proposed approach to be explored during the Design Phase. - Demonstrated commitment to the inclusion of research and information sharing as integrated components of health delivery programs.	**20**
3. TARGET GROUPS AND REMOTE AREAS - Demonstrated capacity and approach to working with marginalised groups - Demonstrated capacity to work in a range of remote and difficult locations.	**20**

4. PARTNERSHIPS, CAPACITY BUILDING and SUSTAINABILITY - Demonstrated ability to form and support effective partnerships - Demonstrated ability to network with and, as appropriate, integrate service components with existing services. - Nature of existing relationships with PNG partner organisations or networks - Demonstrated ability to build the organisation-wide capacity of local partners. - Demonstrated sensitivity to and application of strategies that will help sustain the work of the project beyond its fully funded duration.	**20**

3.5 Design Parameters

In undertaking program design NGOs will be expected to work within the following parameters, which AusAID will refer to when assessing design proposals:

3.5.1 Scope of Activities

The scope of activities to be funded through this program is flexible so that NGOs can work to their strengths and capitalise on opportunities in the locations where they are working. That said, activities should:

- Have a primary focus on the management and prevention of STIs.
- Provide appropriate referrals for other services
- Where necessary and appropriate, provide additional services, for example voluntary counselling and testing for HIV, rape crisis support and wider sexual health services. While ARV treatment and hospital and home-based care will not be funded under this program, linkages with ARV providers and support for people living with HIV are likely to be appropriate.
- Demonstrate innovative ways in dealing with the constraints inherent to the delivery of STI services in PNG. Some of these constraints include:
  - Limited laboratory services
  - Issues related to the procurement of drugs
  - Security and confidentiality issues
  - Populations in areas that are geographically rugged and isolated
  - Highly complex cultural, spiritual and social environments
- Identify risks and articulate appropriate ways to manage them.
- Articulate the process of expansion (if anticipated) in the types of service and geographic area.

3.5.2 Nature of the Services Offered

Issues to be considered in determining the nature of service to be offered include:

- The nature and capacity of existing services

- Local health sector capacity
- Community interest and support
- Logistics such as transport and access to supplies
- Staff skills and availability
- Security and
- Partnership opportunities.

Services offered across a range of variables, not limited to but inclusive of location and target group, are required. In particular, there is a need to ensure a mix of rural and remote, urban, mobile, fixed or multi-sited or out-post service delivery models. This approach enables 'best fit' services across the needs and desires of all stakeholders. It is also consistent with the stipulated 'lessons-learnt' approach, one objective of the program being the need to research a number of service delivery models in order to determine a range of 'best-practice' models.

3.5.3 Partnerships with PNG Organisations

Links with PNG organisations (including FBOs and NGOs) with experience in STI management and health service delivery are encouraged and proposals that include partnerships with PNG organisations will be well regarded. PNG Government or private sector organisations may also be appropriate partners for implementation of this Program.

In locations where there are no established local partners, it may be necessary for accredited NGOs to work alone, while at the same time seeking to support the establishment of local partner organisations which are compatible with organisations/services already established in PNG

3.5.4 Access to Technical Expertise

NGOs will need to demonstrate how they will access high calibre international expertise and experience and how this will be used in the program in conjunction with the roles of local staff

3.5.5 Sensitivity to the Environment

Programs will only be considered favourably if they:

- Take a target-audience sensitive approach to the design, delivery and management of the service
- Demonstrate sensitivity to the cultural, social, spiritual, economic and political environment both at regional, community and individual levels
- Reflect diversity within and between provinces.

3.5.6 Target Populations

It is difficult to determine appropriate target groups in PNG as STI prevalence is often high throughout communities and not isolated to particular groups. Selected NGOs will need to determine appropriate target populations during the design phase. This will require assessment of particular populations at risk or vulnerable.

Due to the problem of youth not accessing services we would, in particular, encourage investigation into the needs of this group. A gendered approach is critical to the success of any sexual health intervention in PNG, so a focus on projects that look to meet the different needs of men and women is of paramount importance. It is recognised that a comprehensive gendered approach cannot be implemented successfully unless the attitudes and practices of men are challenged and ultimately modified. In particular it needs to be recognised that interventions that target men with 'disposable income', those who are in a position to negotiate transactional sex and who belong to certain industry enclaves will need to be engaged.

AusAID acknowledges that any one project should not necessarily attempt to address STI issues for all population groups.

3.5.7 Location of the services offered

Discussions with NDoH and other current service providers have identified the following priority locations where STI prevalence is high and/or treatment is limited:

- Urban Port Moresby and Lae,
- Settlements in Port Moresby. Lae, Goroka and M t Hagen
- Western Highlands Province, particularly Wahgi Valley eg Banz
- Morobe Province – particularly Markham Valley
- East New Brittain – particularly Gazelle Peninsula eg Geligela resettlement area
- Southern Highlands Province – particularly Moro area

While establishing services in these areas is viewed as a priority, proposals that target other sites *will not* be automatically rejected. Rather, proposals that demonstrate an obvious synergy between the nature of the proposed activity, the location that is proposed and the groups being targeted will be considered.

AusAID reserves the right to make the final decision on locations where design proposals will be prepared. The following process will be followed to determine and allocate locations:

- NGOs will be asked to indicate in an annex to their capacity statements locations where they would be interested to develop a proposal during the design phase. This information will not be used as a basis for initial selection of NGOS, but will form a basis for subsequent discussions about allocation of locations.
- After NGOs have been selected and prior to the design period AusAID will consult with NGOs and GOPNG about proposed locations to develop proposals.
- AusAID will invite NGOs to prepare design proposals for specific locations. AusAID's location allocation decision will be based on consultations, information about selected NGOs' capacity to operate in particular locations, presence of supportive NDoH provincial counterparts, potential for integration with existing services and the ability to form viable partnerships with pre-existing PNG NGOs, INGOs and FBOs.

For a list of currently known providers and services per region see Appendix 2.

3.5.8 A Harmonised or Integrated Approach

Programs will be considered favourably when they:

- Work within PNG government policies, protocols and systems.
  - Policies and protocols include:
    - Compliance with existing pharmaceutical laws of PNG
    - Use of existing treatment protocols
    - Involvement in nationwide studies as appropriate

  - Fit with existing NDoH Systems
    - compliance with existing PNG government health structures and systems (including diagnosis, testing, treatment, contract tracing, surveillance and procurement protocols).
    - Project design should demonstrate a plan to compliment existing NDoH services wherever possible.
- Link and harmonise with existing government and/or non-government services and align with existing structures where possible. That is, where possible existing health services and/or local FBOs/NGOs should be partners in the project or at least engaged to provide input into the program as their capacity enables. If the capacity of existing services is very low, development of a complementary system will be required. In particular, programs that recognise the need to work with the existing staff skill base in a way that compliments, rather then detracts from, the existing system will be given priority.
- Include, where feasible and appropriate, institutional capacity building of existing health services (both government and non-government). This could involve training and the eventual transfer to appropriate PNG agencies of infrastructure and resources developed as part of the program.
- Include a Monitoring & Evaluation (M&E) framework that is based on the national HIV/AIDS M&E framework including surveillance.
- Programs should be of an appropriate scale to avoid the risk of high funding levels undermining any existing services.

While the emphasis is on working with PNG policies, protocols and systems, alternative approaches may be of interest to GoPNG and AusAID. For example, while syndromic management of STIs is the approach approved by NDOH, subject to agreement, it may be possible for NGOs to investigate alternative approaches to STI treatment. If this is not possible as an initial activity it may be something that can be addressed in later years of Program implementation.

3.5.9 Participation of Local Communities

Programs will only be considered favourably if the proposal:

- Looks to involve target populations in the final project design and project monitoring and evaluation.

- Looks to determine final target populations in partnership with the local community and to finalise project design in partnership with the target group where possible.
- Is sensitive to the impact of any proposed project on local service provision. In particular, while NGOs are encouraged to use local human resources, they should avoid over burdening existing services by competing for valuable staff.
- Prioritises the development of productive relationships with government and other service providers in the area.
- Emphasises ways of building the capacity of PNG non-government organisations to respond to STI and HIV/AIDS.

3.5.10 Research Component

Research will be a central component of all projects established under the program which will be supported by a key research partner contracted to AusAID.

The NSP's 4th objective is to improve social and behavioural change research in PNG so that it complements epidemiological and other information and informs the development of strategies for behaviour change. In line with this stated objective one of the objectives of this program is to:

> Determine and disseminate the elements of effective and innovative PNG specific STI services to showcase opportunities to improve STI services nationally

The actual type of research to be conducted will not be finalised until the Design Phase. Where appropriate however research could be one or all of Clinical, Social and Operational/Action Research. The Key Research Partner should buy-in additional research capacity if needed to accomplish its role.

The proposed roles of the Key Research Partner would include:

- Involvement in the in-country briefing of the selected NGOs as the beginning of the Design Phase
- Working with the individual NGOs during the Design Phase to determine the nature of research to be proposed under each project
- Preparation of an ISMPP Research Plan for AusAID
- Ensuring that research component of the ISMPP is consistent with NDoH current data collection protocols and is able to be articulated into current NDoH Information Systems
- Implementation or co-implementation of actual research with program NGOs
- Any training needed for the implementation of the research component of the ISMPP
- Design and Preparation of all support materials relating to the collection of research
- Coordination of research across the program as a whole
- Interim and final ISMPP Research Reports

The Key Research Partner will need to recognise that different NGOs will require different levels of support as determined by the nature of the research to be undertaken, their current capacity to do so and any existing research partner links that they may have. In the case where an NGO is well established in the field of research or they have a pre-existing research partner the role of the Key Research Partner may be one of Coordination only.

The Key Research Partner will need to implement and coordinate the research component of the ISMPP in a manner that is consistent with the underlying ISMPP tenets of capacity building and sustainability. For example it is anticipated that they will work with PNG based research partners where the nature of the research component calls for it and the opportunity exists. It is also anticipated that they will use the opportunity to build the general research capacity of PNG.

The Key Research Partner for the program will be determined prior to Design Phase. The Key Research Partner will play a significant role in the final design of individual projects and the coordination of research across ISMPP. Research conducted as part of ISMPP should be well coordinated with AusAID's support for HIV research as part of our new HIV program currently being developed.

Consistent with the Selection Criteria all Capacity Statements should demonstrate a commitment to the inclusion of research as an integrated component of health program delivery.

Further consideration of research arrangements will be needed in the Project Design. This will include, but is not limited to:

- Information about how lessons learned and innovations will be tracked and disseminated to the community in which it functions, counterparts, other STI/HIV services, NDoH and any other interested parties within PNG.
- An indication of how best practice modes will be developed, with local differences between settings taken into consideration.
- Consideration of ethical clearances requirements from the Medical Research Advisory Committee of Papua New Guinea.

3.6 Monitoring and Evaluation

Effective monitoring and evaluation will be of critical importance to the success of this program. Activities will provide an important source of learning about the delivery of sexual health services in PNG. This combined with the need to monitor the progress of each project will mean that monitoring and evaluation must form an integral part of each NGO's design proposal.

Ultimately the M&E of these projects may be articulated into a set of national monitoring and evaluation activities and, moreover, be linked to research that is expected to form part of AusAID's program of support for HIV/AIDS in PNG. At this stage however this M&E Framework is still in the development stage. Given this, the selected NGOs should establish their own M&E components as part of the project design.

3.7 Phasing and Duration of the Program

It is expected that designs will be funded for a five year period under the NGO cooperation agreements for AusAID accredited NGOs. Only fully accredited NGOs are eligible to apply directly for funding. Consortia with New Zealand, PNG and International NGOs are strongly encouraged.

Funding will be made on an annual basis subject to AusAID acceptance of Annual Plans and acquittal of previous funding.

Reporting requirements will be further developed during the design period and will be commensurate with the scale of funding provided.

A mid-term review will be undertaken by AusAID at the beginning of the third year. This will determine if projects are to proceed or if there are to be any changes in direction.

Extension of the program beyond this period may be considered in the future.

3.8 Program Management

More detail on management arrangements and lines of communication will need to be developed as the design for this program proceeds and as AusAID's design for wider HIV support proceeds. It will be important that management arrangements facilitate engagement among GOPNG, AusAID, NGOs and the key research partner aimed at improving shared understanding of effective approaches to STI management and prevention. It is also important that management arrangements are not burdensome on GoPNG and AusAID

While it is envisaged that this program will be managed as part of AusAID's Health Program at Post, it will also need to be well coordinated with work under AusAID's new HIV support program. It is proposed that the Program Management Team will be supported and coordinated by a Post-based AusAID Activity Manager.

A Program Management Team will manage the program with the following proposed representatives:

- AusAID post
- All NGO service providers (including where applicable an additional local counterpart eg member of local committee, youth peer educator, NDoH clinician from local partner clinic)
- The chosen key research partner
- An Independent Research Institution
- NDoH.

There may be an option for selected NGOs to have a significant role in the management arrangements for the Program. For instance NGOs could participate in peer reviews of each other's design proposals and a charter group could be formed comprised of selected NGOs (similar to Church Partnership Program Charter Group) to ensure program coordination and help with administration.

4 Next Steps

The design process will consist of the following steps;

1. Initial circulation of proposed approach to NDoH, NACS and possible NGOs/INGOs/PNG NGOs (Completed).
2. Development of draft Concept Paper to be approved by NDoH (Completed).
3. Finalize the Concept Paper; including input from PNG based consultations and final GOPNG approval (Completed).
4. Draft Cooperation Agreement guidelines in consultation with AusAID Community Programs and Contracts areas in preparation for Request for Capacity Statements (Completed).

5. Invite AusAID accredited NGOs to submit a Capacity Statement. As part of this stage there will be a Pre-capacity Statement briefing for all interested and eligible NGOs.
6. Technical Assessment Panel (TAP) shortlisting and selection of NGOs to be invited to go forward to Design Phase
7. Allocation of locations for NGO to prepare design proposals
8. Following signing of Cooperation Agreements and Exchange of Letters/Service Order successful NGOs to proceed to Design Phase
9. Selected organisations to embark on an AusAID funded feasibility and design mission in PNG. It is likely that this mission will be for 6-8 weeks and will include briefings from NDoH, AusAID Post and the Key Research Partner.
10. Following the in-country design mission NGOs will be given a further 4-6 weeks to complete their proposals after which they will be required to submit fully costed project design proposals for consideration by AusAID and NDoH.
11. Following agreement and issue of Exchange of Letters/Service Orders, NGOs may proceed to Implementation Phase.

5 Risk Management

In a complex environment such as PNG there are inherent risks in any program. These are compounded, in this case, by factors that specifically relate to the provision of services in the sensitive area of sexual health. Program risks will be further investigated during program design and selected NGOs will be expected to put forward a risk management strategy as part of their final design proposals. Some of the risks that may need to be considered include, but are not limited to:

- An inability to establish a program that people access. This could be due to a number of interrelated and complex issues such as the stigma attached to STIs, an unsupportive environment, inappropriate design, etc
- A failure to recognise the damage that could be done by establishing competitive services
- Provision of new services undermining existing service delivery capacity
- A new service delivery structure develops which undermines existing systems
- NGOs investigate and develop alternative approaches that are not supported by GoPNG
- Risk that Program will not be well linked and coordinated with other AusAID support for health and HIV, including the health SWAp and the design of new HIV support.
- Risk that Australian NGOs will not have the capacity on the ground and/or appropriate local partners will not be available
- Risk that NGOs would not be prepared to work outside the area of their current operation
- Risk that NGO funding through this program could be out of proportion with GOPNG funding in particular provinces leading to undermining of GOPNG service delivery
- The research component of the program is poorly coordinated
- The program is not managed adequately

- Procurement and distribution difficulties
- The required expertise is not employed
- Community support is not forthcoming
- A secure working environment is not achieved
- Projects are not sustainable in the long term

Where foreseen such issues have been covered in this paper and attempts will be made to minimise potential pitfalls. It is however recognised that this will be the subject of on-going monitoring and negotiation between all key parties throughout the duration of the program.

6 Appendices

6.1 Appendix 1: Background

6.1.1 Background Information on HIV/AIDS

Sexually Transmitted Infections are Linked to HIV Transmission

The presence of STI in an individual increases that individual's chance of contracting HIV (Grosskurth et al, 2000). UNAIDS state "strong evidence supports several biological mechanisms through which STIs facilitate HIV transmission by increasing both HIV infectiousness and HIV susceptibility" (UNAIDS, 2004, pp. 7). Research by Steen (2002, 2003) demonstrates that treatment of STIs in high risk groups and communities, can also reduce the risk of HIV transmission. This finding has been backed up by earlier studies by Laga et al (1994) and Grosskurth et al (1995). Therefore the high prevalence and poor treatment record of STIs in PNG is of great concern given the HIV/AIDS generalised epidemic. UNAIDS suggests linking STI activities with HIV activities is indicated in settings where there is a high prevalence of STIs. A study of STI programs in Tanzania reports that integrated services which reduce STIs using syndromic management are successful in the developing country context (Grosskurth et al, 2000).

In a review of existing evidence in 2000 a UNAIDS and WHO consultation concluded that STI management is an essential component of HIV prevention (UNAIDS/WHO, 2000).

Sexually Transmitted Infections and models of service/best practice

- Innovative services are likely to offer additional benefits, for example there is thought to be many benefits to the integration of reproductive health and HIV prevention services (Alan Guttmacher Institute, 2004).

- Berer (2004) called upon international donors, health services and NGOs to ensure that appropriate HIV/AIDS programs to be included in all sexual and reproductive health services, that is health mainstreaming of HIV/AIDS programs. This point is backed up by Askew and Berer (2003, pp. 51) stating that "sexual and reproductive health programmes can make an important contribution to HIV prevention and treatment, and that STI control is important both for sexual and reproductive health and HIV/AIDS control'.

- The United States of America Centre for Disease Control (CDC) believe that STI prevention and care services should consist of a comprehensive public health services, including the following elements:
    - Reinforce primary prevention – promotion of risk reduction behaviours.
    - Improve STI health seeking behaviours
    - Strengthen quality STI services
    - Increase services for vulnerable populations
    - Offer integrated services to youth.

CDC endorses the use of syndromic management, and innovative approaches to STI management, stating they are an essential part of HIV/AIDS prevention activities (CDC, 2004).

6.1.2 Sexually Transmitted Infections in PNG

STIs were not a significant health problem in the pre-contact period (Hughes, 1997). At first contact, between 1900 – 45, STIs were controlled by incarceration, as patients were thought to be unlikely to seek or accept treatment (Hughes, 1997). In the later colonial period, STIs were treated, as drugs such as sulphonamides and penicillin became available and by 1970 were not seen as a major health problem. However despite a comprehensive approach to STIs in the 1974-1978 National Health Plan, STIs have steady increased since 1975 (Hughes, 1997).

Incidence and Prevalence Information

World Health Organisation (WHO) Data

Since the 1970s, PNG has had a high prevalence of STIs in both rural and urban areas. WHO statistics, covering the decade of the 1990s, show that PNG has the second highest prevalence of syphilis and the highest prevalence of genital chlamydia, trachomatis and gonorrhoea in the Asia Pacific region. Many provinces in PNG report alarmingly high related morbidity due to the complications of untreated or inadequately treated STIs. These include pelvic inflammatory disease, ectopic pregnancy, male and female infertility and congenital syphilis.

UNAIDS Data

UNAIDS report there is a high prevalence of STIs in both high-risk and low-risk groups. UNAIDS, in their PNG Epidemiology Fact Sheet – 2004 Update report the following rates of STIs in PNG:-

- Syphilis – 4% in highland's populations, 32% in sex workers, 7.1% of antenatal screening.
- Chlamydia – up to 26% in highland's populations, 31% in sex workers.
- Gonorrhoea – 15% in highland's populations, 36% in sex workers.
- Trichomoniasis – 28.75% in sex workers.

Regional figures were not available in this report. These prevalence rates were also quoted in the 2000 Consensus report by WHO, although trichomoniasis was reported to be 45-50% of both the low and high risk populations. The numbers of genital ulcers and genital discharges, are also reported in this report by region, please see annex I for details (WHO, 2000).

National Department of Health Data

The PNG National Department of Health (NDoH) have limited data on STI prevalence. This is evident in the 2003 Annual Health Sector Review, which did not report STI rate in the disease control section (NDoH, 2003). At the November 2004 consensus workshop, it was clear that NDoH lacks the resources to conduct monitoring and surveillance of all STIs including HIV/AIDS. Dr Esorom Daoni, the STI senior medical officer of the Disease Control Branch within NDoH, reported a lack of resources for STI monitoring and surveillance. He stated that there was a under reporting and there was no recent data. The National Health and HIV/AIDS support program (NHASP) (2004b) also report that to date STI data collection has been very poor. There are two systems for data collection; the first syndromic diagnosis based, is data from health centres and hospital out patients departments. These are reported through the provincial health information office to the National Health Information System (NHIS). The second is based on aetiological diagnosis from provincial STI clinics and is planned to be reported monthly, directly to the STI/HIV section of NDoH. Therefore two different sets of data, which cannot be reported together have been collected. NHASP (2004b, pp. 19) report that "neither Provincial

Health Officers nor NDoH have had access to a set of complete data on which to base their strategic responses". NDoH have recently made a commitment to collect STI data from all health institutions, using syndromic diagnostic criteria, and so this may improve in the future. Dr Daoni did report the following key points:-

- STIs are most common in the 25 to 34 year old age group, followed by the 15-24 year old group and the older than 35 year old group respectively.

PNG Institute of Medical Research (IMR) STI Research Findings

The Porgera Valley, Enga Province

From a study of 436 people in the Porgera valley the following serological data was reported:

- "overall STI prevalence rates were 23% (in males) and 40% (in females)"
- "2.6% HIVab+ rate in mine-site workers, 5% HIVab+ in adult male volunteers, 1% HIVab+ in adult female volunteers"

Table 1: STIs in 436 people, Porgera Valley

STI	Female %	Male %
Trichomoniasis	37	16
Chlamydia	10	5
Syphilis (ab)	8	1
Gonorrhea	8	8

(PNG IMR, 2004, pp.14-15).

Sex Workers in Lae - 2004

A study of 51 sex workers, with an average age of 26, ranging from 15 to 46, were found to have a total of 81 STDs, representing an average of 1.4 for each female sex worker. The women were volunteers.

Table 2: STIs in 51 Lae Sex Workers

STI	Female %
Trichomoniasis	46
Chlamydia	40
Syphilis (ab)	47
Gonorrhoea	24
HIV	4

(Hammer, 2004)

Lae Total Study - 2004

A sample of 367 people including the above 51 sex workers, 236 from West Taraka, and 80 from Kamkumung. These two sites are Lae settlements.

Table 3: STI Rates of 367 Lae People

STI	Female %	Male %	Average %
Trichomoniasis	26.9	22.1	25.4
Chlamydia	23.3	12.1	20.3
Syphilis (ab)	26.0	21.1	24.2
Gonorrhoea	14.1	17.7	15.1
HIVab+	2.2	2.2	2.2

(Hammer, 2004)

Asaro Valley, Eastern Highlands Province

A randomly selected sample of 201 women from the Asaro Valley showed the following prevalence rates:

Table 4: STI Rates of 201 Asaro Valley Women

STI	Number/Total	Percentage
Trichomoniasis	92/198	46.5
Chlamydia	53/201	26.4
Syphilis	8/201	4.0
Gonorrhoea	3/201	1.5
Any of the above	117/198	59.1

(Passey et al, 1998a, pp. 122).

Passey et al (1998b) noted in this sample population the WHO algorithm had extremely low sensitivity for detecting either vaginal or cervical infection because relatively few women reported vaginal discharge. In this same data collection activity which was conducted in 1995, 62 of 254 men tested positive for Chlamydia (Tiwara et al, 1996, pp. 237).

In a study published in 2002, with data collected between June 1998 and January 1999 high STI rates amongst sex workers was found. From a total of 407 sex workers, 201 in Port Moresby and 2000 in Lae, the overall prevalence rates of HIV, syphilis, genital chlamydial infection, gonorrhea, and trichomoniasis was 10%, 32%, 31%, 36% and 33%, respectively.

<u>Other Research</u>

Frank and Duke (2000) determined that congenital syphilis was responsible for 22% of all neonatal deaths, mostly due to low birth weight. In their sample of 5385 women, 7.1% had syphilis, and they reported that antenatal screening at the time was inadequate covering less than 30% of the Eastern Highlands Province.

Behavioural Information

NHASP Findings

Sentinel behavioural surveillance at the STI clinic of 169 people of which 128 were males and 41 females, with 37% married, 42% single and 14% widowed or divorced showed the following results:-

- 6% of males and 10% of females stated they had sexual intercourse prior to 15 years of age.
- 89% of males and 98% of females state they had sexual intercourse prior to 20 years of age.
- 79% had one or more non-regular sexual partner in the last 3 months.
- 88% of males and 42% of females reported they did not use a condom with last non-regular partner.
- 58% of females used condoms with their non-regular partners.
- Out of 132 people, 20% sold sex for money or other favours, and of this group 67% were females and 33% were males (NHASP, 2004b).

NACS Findings

Dr Joachim Pantumari presented some behavioural findings at the November 2004 Consensus Workshop held in Port Moresby. These findings came from three selected serosurveillance sites Port Moresby, STI attendees, Angau/Lae pregnant mothers and Mt Hagen STI attendees. Generally the number of people that had more than one sexual contact in the last 12 months was high (41%, 50% and 71% respectively). In addition the number of people that never used condoms was very high (52%, 75% and 53% respectively) (Pantumari, 2004).

IMR Findings

The Institute of Medical Research (IMR) is attempting to map and explain the overlapping epidemics of HIV and STIs in PNG. They plan to visit 10 provinces during this study.. It is hoped that at least initial results from this study will be available before selected NGOs move to the Design Phase of this program.

Other Research

Wardlow (2002) found in the Tari Basin that many men were returning with STIs and that there was an emergence of a form of prostitution due to women being frustrated and angry that their culture seemed to no longer value them as persons. Overall Wardlow stated that the following characteristics that were common to all of PNG were:

- Men seeking wage labour are away from their communities sometimes for extended periods of time, and are therefore not able to perform their customary roles, such as pursing justice. A man being absent also increases the likelihood of extramarital partners for both men and women.
- It is likely that the meaning and functions of bride wealth have changed. In the past women were the desired items for which people gave pigs and money, but now money is the desired item for which people give women.

This both of the issues, male absence and partial commoditization of bride wealth, women feel they can no longer depend on kin to fulfil their customary obligations to them.

Additional research in the Tari Basin by Hughes reported that many people regarding STIs as a nuisance rather than a serious health risk, and that those infected were primarily concerned about the risk of infertility rather than the immediate effects of the infections (Hughes, 2002).

Summary

It is clear that although there is not a great deal of data available the STI prevalence rates are extremely high in PNG.

The great majority of PNG's population lives in rural areas but STI clinical services are greatly limited. There have been many constraints that have restricted the community's access to sexual health services, but by far the most significant of these has been the lack of services in the rural periphery.

6.1.3 The current position of the Health System

The current structure of the PNG Health system is:

Table 5: Overview of the structure of the PNG Health System

Health Sector Level	Role
National Department of Health	Policies, standards, some services
Provincial Hospitals	Service delivery – province/district level
Provincial Departments of Health	Service delivery – province/district
Local level Government	Aid post staff
Church Health Services	Mainly rural health services, most funding comes from government.
Other NGOs	Increasing presence

Key indicators of the health of Papua New Guineans indicate there are many health concerns.

Table 6: Key PNG Health Indicators

Indicator	Number	Year	Source
Life Expectancy	55.5	2000	UN estimate
Life Expectancy	57.6	2005	UN projection
Infant Mortality	70 per 1,000 live births	2002	UNICEF
Maternal Mortality	300 per 100,000 live births	2002 – No national data, estimates derived from model	WHO, UNICEF, UNFPA

TB cases	542.578 per 100,000	2002	WHO
Malaria	1688.26 per 100,000	2000	WHO

(UNSTATS, 2004)

Seventy five percent of deaths in infancy occur in the 1st month of life, the causes of these deaths include – pneumonia, diarrhoea, malaria and meningitis. In regards to adults six of the top ten cause of death are potentially preventable at the aid post level: pneumonia, malaria, diarrhoea, TB, measles and anaemia. An additional three causes are manageable by well-trained staff at health centre level: obstetric complications, meningitis and typhoid related diseases.

Many of the factors affecting the health of Papua New Guineans are influenced by factors outside the health service; income levels, education (especially girls), water supply & sanitation, law & order, roads, agriculture and nutrition. Factors within the health system include; efficiency of resource allocations & use, organisational, financial & management fragmentation, technical, administration & managerial competence, and low consumer & community demand for service.

A functional and expenditure review of rural health services, conducted in 2001 by the public sector reform management unit (PSRMU), painted a grim picture (PSRMU, 2001). The report stated that there was a slow breakdown and collapse of the health system in rural areas. The report stated that aid posts were closing down with health centres ceasing to function effectively, resulting in most services being based in urban areas (PSRMU, 2001). These findings were supported by the 2004 World Bank (WB) report which stated that "current outcome and output indicators are low and there are signs of recent deteriorations in health services" (WB, 2004, pp. viii). Further support comes from a 25 year study conducted by PNG IMR which concluded that the decline of the rural health system in combination with the emergence of HIV/AIDS suggests that the health of rural people could worsen (Vail, 2002).

The entire health sector is under a pressure with approximately only 3.5 percent of GDP devoted to health (CIE, 2002, pp.41). The 2005 budget shows no real great increase. In 2004 the budget was 96,873 thousand Kina and in 2005 it is 111,364 thousand Kina. Of the 111, 364 thousand Kina 190 thousand Kina (0.17%) will be dedicated to SIT/AIDS within the disease control unit. Funding to NACS was 567.9 in 2003, 706.7 in 2004 and has been increased to 1,500 in 2005 (all figures in Thousands of Kina). These budget allocations are inadequate to provide a holistic approach. Primary care facilities are not capable of meeting current needs, and if expected increases in HIV/AIDS prevalence continue to rise exponentially the health system will be unable to cope (NAHSP, 2003 and PSRMU, 2001). The PNG National Health Plan 2001-2010, states "70% of the hospital beds in the country could be occupied by AIDS patients in 2010. For every 5% increase in HIV prevalence in PNG, the total national spending on health will need to increase by 40%, at a 10% HIV prevalence rate, tuberculosis will rise 50-fold to 30% of the population" (NDoH, 2000, pp. 123-124).

Currently, NDoH are leading various health sector reform activities including; linking health priorities with budgets, national-provincial performance agreements, improved policy coherence with donors by participating in a sector wide approach program (SWAP), increasing emphasis on building PNG capacity and improving staff performance. The SWAP is aiming at a single sector policy & expenditure program

and adoption of common approaches across the sectors. NDoH have made good progress, especially compared to other national government departments (PSRMU, 2001, pp. 9). AusAID is assisting with the SWAP and funding the Health Services Support Program (HSSP) and the National HIV/AIDS support program (NHASP). HSSP is providing health sector support at the provincial level, and other projects include the Women's and Children's health project, the Pharmaceutical upgrade project and the central public health laboratory project.

6.1.4 Recent AusAID Activities

AusAID support for HIV/AIDS prevention and treatment strategies accounts for 95% of funds spend in this area. The Australian funded, five-year $60 million NHASP began in October 2000. Activities focus on education and awareness, counselling and care, clinical services, surveillance and strengthening the capacity of the National AIDS Council Secretariat (NACS) and other program partners. Specific projects are outlined below.

Sexual Health HIV/AIDS Prevention and Care Project - The Foundation Program

The foundation program constructed twelve STI clinics in 1996/1997. Clinics were provided at both provincial and district level in six provinces covered by the project, as listed below:

Eastern Highlands Province

Goroka Base Hospital – 'Michael Alpers Clinic' (existing clinic upgrade)

Kainantu Health Centre – 'White Haus Clinic' (new district level clinic)

Morobe Province

Angau Hospital – 'Friends Clinic', Lae (existing clinic upgrade)

Finschhafen Health Centre, Braun Memorial Hospital (new district level clinic)

East New Britain Province

Butuwin Health Centre, Rabaul (existing clinic upgrade)

Southern Highlands Province

Mendi Hospital (new provincial level clinic)

Ialibu Health Centre – 'Greg Clinic' (new district level clinic)

Tari Health Centre (new district level clinic)

Western Highlands Province

Mt Hagen Base Hospital – 'Tininga Clinic' (new provincial level clinic)

Baiyer River Health Centre – 'Tinsely Clinic' (new district level clinic)

Kudjup Health Centre (new district level clinic)

National Capital District

Port Moresby General Hospital (new provincial level clinic)

The report titled *Review of the Sexual Health HIV/AIDS Prevention and Care Project (Foundation Project) STI Clinics*, commissioned by AusAID and conducted by the Sector Monitoring Review Group (SMRG) was completed in February 2002.

This review stated that access to appropriate STI services were greatly improved and additional benefits included an increased profile of STIs and increases in opportunities for community education.

STI Clinic Construction Project

As a follow up to the Foundation Project it has been agreed that up to an additional 38 clinics be established in fourteen provinces of PNG in at least two phases. A Subsidiary Arrangement for the construction of 38 Clinics was signed in June 2004. The first phase will include six additional clinics being constructed by late 2005. The proposed clinic sites for the first phase are:

Gulf Province

Kerema – Provincial Clinic

Kikori – District Clinic

Sandaun Province

Vanimo – Provincial Clinic

Western Province

Daru – Provincial Clinic

Kiunga – District Clinic

Morehead – Minor Clinic

Under the terms of this Subsidiary Arrangement:

- NDOH are responsible for the direct tendering and contracting for the clinics (with technical advice from HSSP).
- NDOH will sign Memorandums of understanding (MOUs) with relevant hospital, provincial or district authorities for the staffing and management of clinics prior to contracting for construction of each clinic. These MOUs are to be signed before construction contracts are awarded.
- Implementation of further phases of clinic construction are subject to satisfactory assessment of clinic impact, effectiveness, affordability and value-for-money. If the outcome of ongoing assessments are favourable the further 32 clinics will be constructed, most likely in a number of phases. These clinics are listed in Appendix I.

The Integrated STI Management and Prevention Program is distinct from the STI Clinic Construction Project, however collaboration with this project will be encouraged.

National HIV/AIDS Support Program (NHASP) Activities

Education, Advocacy and Behaviour Change

Sexual health promotion, HIV/AIDS and STI materials and training packages are being developed for use by program partners.

Monitoring, Surveillance and Evaluation

NHASP is currently strengthening public health surveillance of HIV/AIDS and other STIs and related behaviour change through improvement to case definitions, data collection, reporting, analysis, and feedback mechanisms including sentinel surveillance sites.

Specific outputs outlined in the Jan 2004 – June 2005 NHASP Annual Plan are:

- Sentinel HIV and STI surveillance sites established and maintained.
- Improved data collection systems for the reporting of STIs
- Sentinel behavioural surveillance at selected sites established and maintained.
- Capacity of NDoH and NACS to improve the feedback mechanisms for HIV/AIDS and STI surveillance data strengthened.

Clinical Services and Laboratory Strengthening

Generally NHASP has been tasked with the objective to improve the quality and delivery of STI and HIV/AIDS services through enhanced diagnosis, clinical management and community care. This objective hopes to achieve the following nine outcomes:-

1. Support for improved management of STI/HIV/ADS programs at national/provincial levels.
2. Support for of STI services in provinces and districts upgraded.
3. Improved quality of clinical care for management of STI/HIV/AIDS, in conjunction with NDoH.
4. STI and HIV service delivery in rural health services strengthened in collaboration with NDoH.
5. Services at PMGH STI clinic strengthened in preparation for the proposed establishment of the National Centre for Sexual Health.
6. Capacity of STI clinic workers to diagnose and manage STI's and HIV/AIDS and promote sexual health improved in conjunction with NDoH.
7. Improved capacity of general health care workers to manage STI's and HIV/AIDS and promote sexual health in conjunction with NDoH.
8. Management of laboratory services to improve STI/HIV diagnosis strengthened.
9. The capacity of laboratory services to diagnose STI's and HIV strengthened.

(NHASP Annual Plan January 2004-June 2005, pp.70-77)

6.1.5 Further activities are required to address STIs in PNG

From an assessment of the background provided thus far it is clear the issue of STIs in PNG is enormous.

Although there is ongoing commitment from the PNG health service, FBOs, donors and others to address this issue, there is a need for additional external inputs. External inputs are needed for a number of reasons.

- The large numbers of STIs presents an enormous potential value of prevention and treatment of STIs, on HIV/AIDS transmission.
- Given the urgency and scale of this issue, the current capacity of existing programs is insufficient. For example, the rate of the role out of the 38 STI clinics has been slow for a variety of reasons, and the existing health services are greatly limited. NHASP (2004, pp. 21) reports in many centres there is currently inadequate room and equipment for examination of patients.
- The complexity of the problem - the challenges to the provision of STI services include remoteness, gender issues, structure of existing health services, availability of skilled staff and the enormity of the need.

In order to build on past program work, and introduce new approaches it is thought that there are likely to be benefits from gaining the specialized experience and assistance that some international organisations possess. For example there are some INGOs that have been able to engage youth complex social environments.

Rapid service delivery is the focus of this program, however it is hoped that INGOs which take a capacity building approach will be able to provide innovative and targeted approaches that will have on going benefits for existing projects.

6.1.6 The Challenging Environment

PNG is a diverse developing country. In June 2004 World Bank (WB) Poverty Assessment in PNG "there are indications that poverty levels have increased sharply in recent years and are unlikely to climb down in the immediate future" (WB, 2004, pp. vii). The WB also state that education levels are not high and that gap in soco-economic indicators between the urban and rural population are widening. The limitations of the health system can be understood in light of this general picture.

Given limitations of the health system, especially in regards to STIs, any organisation embarking on work in PNG are likely to encounter various constraints.

Because it is hoped that the programs may be able to be replicated in other areas in PNG, it is important not only to note these constraints, but to determine appropriate local based solutions as far as possible.

Some of the specific constraints that are likely to be encountered include:-

- Limited laboratory services.
- Procurement issues in regards to drugs and equipment.
- Security in some areas.
- Geographically rugged and isolated.
- The reality of the highly complex cultural, spiritual and social environment. For example there is at least 860 distinct languages, which linked with geographical isolation have resulted in "unique cultural forms, including those of a religious and sexual nature" (Jenkins and Passey, 1998, pp. 231).

6.2 Appendix 2: Current PNG STI Services[4]

Province	Site	Agency	Comments
NCD	Port Moresby General Hosp.	Govt	Major clinic – STI, HIV, ARV, VCT services – under upgrade to Nat. Ctr for Sexual Health
	Stop Aids (Anglicare)	Church/ NGO	VCT, Developing STI centre
	Save the Children "Poro Sapot", Boroko	NGO	Targeting female sex workers (FSW) and men who have sex with men (MSW). Prevention, support and clinical services (STI & VCT)
Morobe	Angau General Hospital	Govt	STI and limited VCT – not functioning well – Hospital accessing funds to build new purpose designed clinic to be owned by Hosp – not Prov. Hlth Office
	Braun Dist Hospital - Finschhafen	Church	STI and limited VCT
	ADRA urban centre	Church	Building in progress – drop in centre, VCT – may expand to STI in future
	PNGFHA - Lae	NGO	SRH including some STI
Oro	Popondetta Gen Hospital	Gov	Limited STI service from joint disease control room
Madang	Madang Gen Hosp	Gov	STI clinic – limited VCT
	Bethany Centre	Church	Drop in centre – VCT – no STI or clinical service
East Sepik	Wewak Gen Hosp	Gov	STI room in shared Dis Contrl clinic Limited STI service
	Maprik Dist Hosp	Gov	STI service from Disease Control clinic
	Centre of Hope	Church	VCT, general urban clinic including some STI
Eastern Highlands	Goroka Base Hospital	Gov	STI clinic, VCT
	Kainantu Dist Hosp	Gov	STI clinic, VCT
Simbu	Kundiawa Gen Hosp	Gov	STI (part of Dis. Cont), limited VCT
Western Highlands	Mt Hagen Gen Hosp. Tininga Clinic	Gov	STI Clinic, HIV, VCT

[4] Information supplied by Dr Greg Law, NHASP, PNG

	Nazarene Hosp (Dist)	Church	STI clinic, HIV, VCT
	Tinsley Dist Hosp	Church	STI clinic, limited VCT
	Rebiamul Urban Clinic	Church	VCT, general clinic incl some STIs
	Shalom Centre	Church	VCT – no STI service
Southern Highlands	Mendi General Hospital	Gov	STI Clinic – VCT, HIV
	Ialibu District Hospital	Gov	STI Clinic
	Tari District Hospital	Gov	STI Clinic
Manus	Lorengau Gen Hosp	Gov	Limited STI service from Dis. Cont.
East New Britain	Butuwin Urban HC	Gov	STI clinic – very limited service
	PNGFHA - Butuwin	NGO	Refers STIs to HC
NewIreland	Kavieng Gen Hosp	Gov	Very limited STI service
Milne Bay	Alotau Gen Hosp	Gov	STI Clinic – part of Disease Control

Private Ventures

In addition to the above the major mining companies are also developing STI/HIV services as part of their existing health care facilities – these are located in Tabubil (OK Tedi), Lihir (Lihir Mines), and Porgera (Porgera Joint Venture).

6.3 Appendix 3: STI Clinic Construction Project - Phase Two Clinics

The additional 32 clinics, in phase two are:

Central Province

Bereina – Minor Clinic

Kwikla – Minor Clinic

East Sepik Province

Wewak – Provincial Clinic

Angoram – District Clinic

Maprik – District Clinic

Enga Province

Wabag – Provincial Clinic

Laiagam – District Clinic

Wapenamanda – District Clinic

Gulf Province

Baimuru – Minor Clinic*

Madang Province

Madang – Provincial Clinic

Bogia – Minor Clinic

Gusap – District Clinic

Miak – District Clinic

Manus Province

Lorengau – Provincial Clinic

Milne Bay Province

Alotau – Provincial Clinic

Losuia – District Clinic

New Ireland Province

Kavieng – Provincial Clinic

Namatani – District Clinic

North Solomons Province

Buka – District Clinic

Arawa – District Clinic

Buin – District Clinic

Oro Province

Popondetta – Provincial Clinic

Oro Bay – District Clinic

*These three clinics were planned for the first phase of construction, therefore the detailed plans for these clinics can be found in the phase one reports by James Cubitt Architects

Kokoda – Minor Clinic

Sandaum Province

Aitape – District Clinic*

Simbu Province

Kundiawa – Provincial Clinic

Kerowagi – District Clinic

Gumine – District Clinic

West New Britain Province

Kimbe – Provincial Clinic

Bialla – District Clinic

Kandrian – Minor Clinic

Western Province

Balimo – District Clinic*

6.4 Appendix 4: Suggested Reading

Alan Guttmacher Institute (2004) Press Release: New Analysis calls for increased integration of Reproductive Health and HIV Prevention Services, 10th November 2004.

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