Review Of Coverage And Quality Of VCT Services In PNG

August 11th to September 7th 2006

Table of Contents Page

Acknowledgments 5

List of Abbreviations and Acronyms 6

Executive Summary 7
- Background 7
- Methods 7
- Summary of findings 7
- Recommendations 8

Introduction 11

Country Background 11
- Health 12
- The health system in Papua New Guinea 12

Literature Review 13
- VCT in the International Context 13
  - Models of VCT 13
  - Current International Situation 15
  - Recent Developments and Issues 16
  - International Best Practice and Most Recent Trends 17
- HIV and AIDS in Papua New Guinea 17
- Efforts to Address HIV and AIDS in Papua New Guinea 18
  - National Government 18
  - Other Agencies 19
- Background to VCT in Papua New Guinea 20

Aim and Methods of the VCT Service Review 20
- Aim 20
- Methods 20

Summary Profile of Sites and Respondents 21

Findings 21
- National Coverage of VCT Services 21
  - Provincial Counselling Coordinators 21
  - Training and Education 22
  - Activities to Date 23
  - Future Plans 24
  - National Coverage of VCT sites 24

Quality of Services 25
- Organisation of Services 25

Types of Services 25
Accreditation 26

Access to Services 26
Physical Access 27
Geographical Access 27
Access to results of Rapid Tests and Confirmatory Tests 27
Stigma and Discrimination 28
Access for Children 28

Promotion of VCT Services 29

Access and Referral to Other Services 29
Relationship with Health Service Providers 29
Referral System to Hospital 29
Access to Anti-retroviral Therapy 30
Access to PLHA Support Groups 30
Referral to other Services 30
Tracking Referrals 30

Management Systems 31
Policies and Procedures 31

Services Provided 32
Technical Quality 32
Personnel 32
Quality of Counselling 33
Client Perceptions of VCT 33

Supervision and Support of Staff 34

Confidentiality 35

Commodity and Supply Chain Management 35

Infection Control and Hygiene 37

Client Records, Data Collection and Reporting 37

Quality Assurance and Internal Monitoring 38

Successes 38

Challenges 38
Access 38

Provincial Teams and Health Personnel 40

Technical Quality 40
Environment 40
Supervision and Support 41
Confidentiality 42
Commodity and Supply Chain Management 42
Client Records, Data Collection and Reporting 43
Quality Assurance 43

Limitations to the Review 43

Recommendations 44
Access 44
Transport and Communication 44
PEP and Occupational Health and Safety 44
Increase Coverage 44
Infection Control and Hygiene 45
Supervision and Support 45
Client Records, Data Collection and Reporting 45
Access to Educational Resources 46
Commodity and Supply Chain Management 46
Quality Assurance 46
Continuation of the VCT Program 47

Conclusion 47

Appendix 1. 48

References and Documents Reviewed

Appendix 2. 51

People and Programs Visited

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List of Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CBO	Community-Based Organisation
CDC	Centre for Diseases Control
CT	Counselling and Testing
FBO	Faith Based Organisation
HAMP Act	HIV/AIDS Management and Prevention Act
HIV	Human Immunodeficiency Virus
HRC	HIV Response Coordinator
HRSS	High Risk Settings Strategy
ILO	International Labour Organisation
NAC	National AIDS Council
NACS	National AIDS Council Secretariat
NGO	Non-Government Organisation
NHASP	National HIV/AIDS Support Project
NSP	National Strategic Plan
PAC	Provincial AIDS Committee
PCC	Provincial Counselling Coordinator
PLHA	People living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infection/s
TB-DOTS	Tuberculosis Directly Observed Treatment Short-Course
ToT	Training of Trainers
UNAIDS	Joint United Nations Program on HIV/AIDS
UNGASS	United Nations General Assembly
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Executive Summary

Background

The PNG National HIV/AIDS Support Project is now in its sixth and final year having been extended from its original term as a five-year project. As part of the finalisation of the project and in preparation for the future of the program, a review of VCT services was planned for August 2006 to review coverage and quality of existing services and make recommendations based on the current status of services and lessons learned both from PNG and international best practice.

Methods

A literature review was conducted which looked at national documents related to VCT and related services and which also reviewed international approaches to VCT, best practices and future trends. Site visits were conducted to VCT services in public health facilities and FBO-run services in four high prevalence provinces. One-to-one interviews were conducted with program staff comprising managers, counsellors, nurses and community health workers, and focus group discussion with clients.

Summary of Findings

In the short time since the Care and Counselling Unit first began developing VCT services (18 months) the project has achieved a level of coverage of services, with VCT services now established in every province. By May 2006, there were 89 VCT sites with 25 providing HIV screening. Three national trainings have been developed, an Introduction to HIV/AIDS, an Introduction to HIV Counselling and Testing, and very recently, a course in Rapid Testing.

By January 2006, 4622 people had attended the Introduction to HIV training, 568 had attended the Introduction to HIV Counselling and Testing course and 47 had attended the new Rapid Testing for HIV course. 85 people had undergone training of trainers (ToT) in the introduction HIV basic course, and 115 had undergone ToT in the HIV Counselling and Testing course.
By May 2006 300 VCT counsellors (100 male, 180 female and 13 unknown) had been trained across all provinces in public health facilities, FBOs and private sector.

National VCT guidelines have been developed and there is a national standard accreditation process for accrediting new VCT services. A cadre of Provincial Counselling Coordinators has been developed to enable collaboration and liaison between the various stakeholders at provincial level including public health services, FBO–run health services and the private sector.

Current challenges for VCT services include:- multiple issues in access including difficulties for clients in gaining access to services because of lack of transport, lack of money to afford transport, continuing high levels of stigma and discrimination which mitigate against people coming forward for counselling and testing; difficulties for staff to gain access to clients in remote areas due to lack of transport and lack of sufficient numbers of staff and insufficient confirmatory blood testing sites. There are substantial difficulties in maintaining a consistent rupture-free procurement and commodity management system.

Ensuring confidentiality is a significant challenge with staff at all levels of services neglectful of client confidentiality in certain situations, for example, when introducing a member of a PLHA group. Maintenance of client records is in most services done well, in some instances there is evidence of duplication of recording of information which wastes staff time. Reporting of information currently only provides statistical information and no narrative reporting, data is not always disaggregated for sex and age, and reports are not always timely.

Infection control, personal and environmental hygiene practices vary between services, with FBO-run services almost always maintaining higher standards than public health facilities. Occupational health and safety is not addressed in a standard approach; many sites do not have a policy for or access to post-exposure prophylaxis (PEP) for staff occupational exposure. There is a need for the development of a quality assurance system to enable staff of services to monitor and maintain the quality of their services.

Many staff of the services have limited or no access to educational resources that would help them maintain current knowledge on VCT.

Recommendations

National Program and structures

Increased Access

- There needs to be a substantial increase in VCT centres and therefore trained counsellors if PNG is to meet identified targets. The services that are currently providing VCT need to be expanded to include an increase in outreach services. Integration of counselling and testing into HBC services.
- If the current testing regime remains in place then the number of and effectiveness of laboratories and confirmatory sites needs increasing
- To achieve adequate service provision it is essential to develop services at primary health centre level.

PEP and Occupational Health and Safety

- A standard national system of occupational health and safety urgently needs putting into place, including rapid introduction or re-instigation of PEP for occupational exposure. Staff require training in OH&S.

Infection Control and Hygiene

- Systems for infection control should be standardised and staff trained to adhere to standards.
- New sites that are established in the future should ensure that hand-washing facilities exist in every room where testing will take place, and that there are provisions for water supply in the event of a break in normal supply.
- Public health facilities should have sufficient support to maintain environmental hygiene, including employing cleaners to clean the units. Health professionals should not be expected to clean public health facilities.
- Ensuring consistent infection control has obvious implications for commodity procurement and management, e.g. consistent and adequate supplies of gloves, to overcome the culture of 'saving' or 'rationing' in case of a rupture in supply, which seems to exist in some services.
- Nurses who are who are involved in testing procedures should be involved in the design of facilities to ensure adequate provision of measures to ensure infection control and hygiene.

Commodity and Supply Chain Management

- The current systems of procurement and distribution need a thorough review by expert technical advisor/s to try to develop an approach which coordinates the work of the various stakeholders from national level through to local level.
- At provincial level a standardised approach should be developed to enable all services to obtain required commodities (sharps bins); at service level, a more standardised approach to provision of condoms needs to continue to be encouraged so that all service providers give the same messages with regard to correct and consistent use of condoms.
- Since the female condoms cannot fit into the dispensers currently being provided to all the VCT services, a separate container needs to be situated next to the dispenser for easy access.

Quality Assurance

- A national quality assurance task force could be developed, drawing on the experience of staff from existing services, to look at developing at standards of quality and simple systems of measuring quality.

Resources & Personnel

- Services need to be provided with at least two vehicles to provide for multiple needs including transport of clients and providing outreach services.
- PCCs need their own vehicle to perform their multiple community roles rather than having to rely on sharing a vehicle with the HRC.
- Staff of the services need to be supplied with cell phones and satellite phones to enable rapid and easy access to referral and support from colleagues.
- Key staff of the centres and each of the PCCs also needs her/his own computer, with internet access where that is geographically possible.

- Both the engagement of service staff in understanding the importance of supervision, and the development of a routine system of clinical supervision and support comprising regular meetings are needed to enable staff to manage their work and address issues of burnout and conflict.

Site Management

- The system of using registration books for entering client data should be reviewed so that as little paperwork as possible is required of the staff and recording of information is not duplicated.
- Services should begin development of a system of narrative reporting (one that would not overburden already-stretched staff) so that the practices and lessons learned can be captured and so that there is a development of a corporate history of each of the services.
- A system of regular provision of educational resources to each service for the continuing education of staff needs to be established ie listserv facility or a paper-based delivery by hand incorporated into the regular visits by national VCT staff.

Continuation of Program

- There should be a dedicated fulltime position for VCT situated within the Department of Health to ensure that the initiatives in VCT to date are not lost and the current VCT program can be improved and expanded.

Introduction

The PNG National HIV/AIDS Support Project is now in its sixth and final year having been extended from its original term as a five-year project. As part of the finalisation of the project and in preparation for the future, a mini-evaluation or review of VCT services was planned for August 2006. The review is to assess coverage and quality of existing services and make recommendations based on the current status of services and lessons learned both from PNG and international best practice. This report summarises the findings of the review.

Country Background

Papua New Guinea (PNG) covers the eastern half of the island of New Guinea. In 1885 it was divided by its colonists, Germany, and the UK, with Germany occupying the northern portion and the UK occupying the southern portion. In 1902 the southern part was transferred to Australia. Australia also occupied the northern portion during World War 1 and continued to occupy the whole country until PNG's independence in 1975[1].

Papua New Guinea has a parliamentary democracy based on the Australian model and a second tier provincial government system. Its societal structure is clan based. There are four administrative regions and twenty provinces.

The population according to the 2000 census was 5.1 million and growing at an annual rate of 2.3 %[2]; it was estimated to be approximately 5.7 million in 2006[1] it is also estimated that half of the population is under 19 years of age[2]. Average life expectancy is estimated at 53.6 years for women and 52.5 years for men. The infant mortality rate is estimated to be 64 per 100 live births[3].

There are at least 800 different languages spoken, with English being the language of government and Tok Pisin the mostly country-wide common national language. Literacy is estimated to be between 50%[2] to 64%[1] (defined as people aged 15 and over who can read and write) with female literacy (57%) lagging significantly behind male literacy (71%)[1].

Papua New Guinea has considerable natural resources such as mineral deposits of gold, oil and copper; mining accounts for 72% of export earnings annually[2]. 85% of the labour force work in agriculture usually in subsistence farming. Widespread logging of the tropical rainforests has occurred since the 1970s with little regulation despite national policy and plan formulation[4].

In 1995, the Government of Papua New Guinea agreed to adhere to a structural adjustment program in association with the World Bank, IMF, and other major donors and lending agencies in return for budgetary support to overcome the nation's financial problems. In 1998 the World Bank broke off relations but restored these two years later. Since the 1980s GDP per head has fallen consistently with the level of poverty, as measured by social indicators, increasing since independence. Government mismanagement, widespread corruption in public and private sectors, poor communications infrastructure and low levels of education are blamed for this situation.[2, 3], Human rights abuses are well documented[5,] violent crime, gender inequity and violent crimes, especially against women and children, domestically and from police, are pervasive[6].

Papua New Guinea is party to a number of international laws, strategies and conventions including being a signatory to the Millennium Development Declaration (2000), the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1995) and the Convention on the Rights of the Child. In 2003 the government of Papua New Guinea developed a poverty reduction strategy, intended to increase focus on poverty in the Medium Term Development Strategy (MTDS 2003-2007); the strategy also focuses on public sector reform, economic growth, good governance, and law and justice policy[7].

Health

The major causes of morbidity and mortality in all age groups are communicable diseases. While Papua New Guinea has been recognized as polio-free since 2000 and the national target for leprosy of less than 1 case per 10000 people has been achieved, 50% of all deaths are still attributable to communicable diseases

including malaria, pneumonia, tuberculosis, measles and diarrhoeal diseases. Malaria and pneumonia account for one-third of all recorded deaths. uberculosis incidence is rising; fully functioning TB DOTS programs existed in only 8 provinces in 2005[7].

Non-communicable diseases are also increasing in incidence, especially tobacco-and alcohol-related illnesses, diabetes and hypertension. The three cancers with the highest incidence are oral, hepatic and cervical, all cancers with preventable causes.[7]

The Health System in Papua New Guinea

Health services are provided by government, church organizations (substantially supported by government financing in many instances and providing about 50% of the total health services for the country), workplace –based services e.g. mines/other industries, by private practitioners and clinics and by traditional healers. Management responsibilities for services are shared between the national and provincial departments of health; the national government is responsible for running the 19 provincial hospitals and the central hospital in Port Moresby, and provincial and local governments are responsible of managing all other services (primary health services including rural hospitals, primary health sub-centres (clinics and health posts). Primary health services are very fragile with many rural health facilities having closed down and many more not able to offer the range of services for which they were originally built.
WHO WPRO, 2005, states , "… there is a lack of district supervision and support, the existence of parallel systems for provincial hospitals and district health services, a scarcity and misdistribution of financial and human resources, and a lack of timely and reliable information for decision-making." [7]

There are 13 doctors per 100000 population, with most based in Port Moresby, and the nurse-to-population ratio is 55:100 000. It is estimated that an additional 600 nurses, 600 community health workers and 100 midwives are estimated to be needed to fill vacant posts, and current recruitment and training is insufficient to fill these gaps. There is currently a government staffing freeze on nursing. There is a national community health worker training of two years' duration, the revision of this curriculum is currently being completed. There are 14 community health worker training schools and 11 nursing schools. The churches run 6 of the 11 nursing schools and all of the community health worker training. There exists both a Nurses Association of PNG and a Medical Society of PNG.[7]

The National Health Plan 2001-2010 and the Medium-Term Expenditure Framework 2004-2006 have prioritized maternal and child health, immunization, malaria control, HIV/AIDS and water and sanitation programs.[7]

Literature Review

VCT in the International Context

Soon after HIV testing first became available in 1985, voluntary counselling and testing for HIV programs began to be implemented across the world, based on indisputable evidence of the efficacy of VCT in engaging clients in addressing issues of behaviour and behaviour change and of VCT as an effective entry point for clients to care, treatment and support. Since that time VCT has been and is regarded as an essential strategy in prevention and mitigation, as part of a comprehensive approach to HIV and AIDS.[8]

Models of VCT

Most countries have developed a range of models of VCT services based on international lessons learned and responding to local needs and contexts. Models of VCT that have developed worldwide include stand-alone sites, integrated sites, quasi-integrated sites, private sector, mobile VCT units and, more recently, home-based VCT initiatives.

Stand-alone sites, also known as freestanding sites, are generally run by non-government organisations and not usually directly associated with health facilities. They are client-initiated. The benefits of these have been found to be : the opportunity for staff to focus solely on VCT services; more opportunity to maintain a standard of quality provision of service; the sites are often based in areas of high prevalence and so have a greater opportunity to reach clientele; there is a likelihood of attracting clients who would not normally use existing health services, particularly clients from marginalised groups; staffing levels are often better than in health facilities and hours of operation are often more flexible. Drawbacks are that the collaboration between NGO and health facility may not be strong, so referral for other needs can be an issue. Maintaining client confidentiality is difficult because the centre is known in the community as a VCT centre.

Integrated VCT services are services provided through existing, usually public, health facilities. These are often provider-initiated, that is the health provider offers the service as part of the client's care, treatment and support. The two types of provider-initiated counselling and testing (CT) are *diagnostic* CT, that is, the client has presented with symptoms of illness, and CT is offered as part of a diagnostic work-up, and *routine* CT, in such instances as ante-natal care or TB treatment where *all* clients are offered CT as part of routine range of checks. Benefits of this model include – in principle – more and better access for clients to a range of health services including TB management, STI treatment, treatment and care for HIV, referral for other supports e.g. social welfare, potential to reach high volumes of clients who are already attending public health facilities, and the "normalisation" of HIV testing as a routine part of medical care.

Client-initiated VCT can also be accommodated in this model. Challenges can be that staff have multiple roles to fulfil and as a result other services, or VCT services, may suffer - from a lack of manpower and time available to ensure quality.

A *quasi-integrated model*, as its name suggests, is situated within a health facility but is run by an NGO, in partnership with the health facility. Benefits include the potential to cater for both provider and client-initiated VCT, but the success of the model depends to a large extent on how well the partnership functions and whether the roles of health provider and NGO VCT provider are regarded as equally important.

Private sector models may be provided as part of a private clinic or as stand alone. They are usually more expensive than public health services and patronised by those who can afford to use them and who perceive they will receive better service because they are paying more. Challenges include the lack of regulation that usually exists with regard to private health in many countries. Ensuring adherence to national and international standards, and that private practitioners undertake appropriate training, can be difficult.

Mobile VCT services have been increasingly used in areas where there is a lack of health centres or transport for clients to attend services is difficult. Bringing the service to the client can achieve good uptake, but needs substantial community mobilisation to ensure adequate turnout. Costs for running the service are higher than in dedicated centres, maintenance of confidentiality and anonymity presents difficulties, and clients may have other more urgent health concerns that they desire to be addressed.

Home based VCT. Most recently, there has been an increasing focus on incorporating various prevention and mitigation activities into home based care, since, just as VCT is recognised as an effective entry point for *care* and treatment, so provision of care for ill people in their homes is increasingly acknowledged as an effective entry point for *prevention* and treatment. As with mobile VCT maintenance of confidentiality may present difficulties along with ensuring quality of test kits and of technique, clean water for handwashing and travelling to client's homes is time-consuming.

In some resource-poor countries the development of VCT services by multiple agencies such as community-based Organisations (CBOs), Faith-based Organisations (FBOs) NGOs and government health services has meant that there is the potential for duplication of services in some areas while other areas' needs are not met. For example, it may be possible for separate services to exist which provide VCT (private and public), prevention of mother to child transmission (PMTCT) counselling and testing, and telephone counselling with referral for testing to health facilities all in the same catchment area. Collaboration between the service providers to aim at integrating or avoiding

duplication and develop services in underserved communities can successfully be led by local or regional government, if there is sufficient motivation and a supporting policy and strategic framework.

Current International Situation

Over the last twenty five years and currently, even though VCT has been a core element of HIV programs, uptake of VCT services has fallen well short of the numbers of people who should be using the services – it is estimated that less than 10 per cent of people in resource poor settings are aware of their HIV status. As a result, over the years recommendations from international advisory bodies, including the World Health Organisation (WHO) and the Centre for Diseases Control (CDC) and international non-government organisations, have further developed strategies to try to reach a greater number of clients; the models described above are examples of attempts to reach greater numbers of people.

Recent Developments and Issues

In the very recent past, the past two years, specific recommendations by WHO (August 2006) and by Centre for Disease Control (CDC) (September 2006), have focussed on provider initiation of counselling and testing and the concept of "opting-out" of testing.
In traditional voluntary counselling and testing services the client "opts in" for testing, i.e. makes the decision to come for counselling, makes the decision and gives informed consent to have the test after being provided appropriate pre-test counselling. In "opt-out" screening for HIV the client is offered the test for HIV routinely, as part of the services being provided on that occasion of attendance at the health facility and is given the opportunity to "opt out", i.e. decline testing. WHO states "informed consent is assured by offering patients the opportunity to decline the test", CDC states "Opt-out screening.. [is] .. Performing HIV screening after notifying the patient that 1) the test will be performed and 2) the patient may elect to decline or defer testing. Assent is inferred unless the patient declines testing"[9].

There has been significant discussion and debate about the merits and potential drawbacks to opt-out counselling and testing, over the last two years, and some programs have changed the name of VCT to CT (counselling and testing) to emphasise that the elements of counselling and testing are the most important elements. Most recently there have been some unfavourable reactions to the CDC recommendations, particularly from resource-poor settings where testing positive to HIV can have significantly worse impact, confidentiality is not guaranteed and stigma and discrimination are still such a huge problem.
It is important to note that the CDC recommendations, which also recommend that pre-test counselling is not required in some acute health care situations, is specifically written for health facilities in the USA, although it is also worth noting

that CDC recommendations intended for domestic services, can also have an impact on international development assistance policy.

Added to concerns from resource-poor settings that provider initiated routine testing will not be as carefully monitored as opt-in VCT is confusion in some quarters between what is meant by *routine* testing and *mandatory* testing (i.e testing without either client permission or knowledge, or both). WHO makes it clear in its recommendations for provider initiated routine testing as a strategy to expand coverage of testing and counselling, that testing must still be voluntary and that clients still retain the right to decline testing. “In all cases, the 3 C’s – consent, confidentiality and counselling – must be respected”.[10]

International Best Practices and Most Recent Trends.

Internationally, where counselling and testing has been part of a comprehensive approach to HIV/AIDS for some time, trends in some of these well-established services in counselling and testing are tending towards integration of VCT in one form or another, whether this be the integration of VCT into primary health facilities, integration of primary health care (or elements of a broader range of services such as micro-finance) into stand-alone VCT services, integration of onsite rapid testing into workplace VCT programs, integration of VCT into home based care services. In diverse countries models of these types are increasing in number, and demonstrating success in reaching greater numbers of clients. These types of models are increasingly showing that the convenience and accessibility of VCT, especially when accompanied by rapid testing, in the workplace and in the home are significant factors in a positive effect on acceptability and uptake of VCT[11, 12.]

HIV and AIDS in Papua New Guinea

The cumulative total of reported HIV cases in from 1987 to September 2005 was 13465, with proportions through all age ranges of 47% female, 47% male and 6% sex not stated.[13] However, in the age range 15-29 years there is a significant difference between sexes with 30% of identified cases of HIV infection in females while males account for 20% of cases. Annual reported cases of HIV have risen each year since 1987 and UNAIDS[14] estimates that the actual total of HIV cases may be as high as 60,000. From available data 2599 cases (19%) were classified as having an AIDS-defining illness, 9205 (68%) were not classified and 612 (5%) deaths have been reported. Figures for deaths are likely to be considerably inaccurate due to errors/omissions in reporting actual cause of death. No formal system for reporting AIDS-related deaths currently exists. UNICEF[15] estimates that there are 11000 children with HIV in Papua New Guinea, and around 800,000 children affected by HIV and AIDS. Data on HIV have improved over the recent years with 22 second generation surveillance centres having been established in 2005, but reporting still varies widely between provinces.[13]

Papua New Guinea has had a generalised HIV epidemic since 2002. There is considerable variation in prevalence between provinces, with the National Capital District and the five highland provinces reporting significantly higher numbers of diagnoses of HIV; reflecting both socio-economic factors as well as increase in uptake and improvements in testing. Heterosexual transmission remains the main mode of transmission. There is very little information available on men who have sex with men (male homosexuality is illegal) and injecting drug use is not yet seen as a problem. A range of social economic and cultural factors contribute to the growth in HIV in Papua New Guinea; the National AIDS Council Secretariat identifies:-

- Early initiation of sex (15 years for both boys and girls)
- Condom use among young people who engage in casual sex is very low
- High levels of sexual activities including multiple partner relationships
- High illiteracy rate and low knowledge about HIV transmission and prevention in both urban and rural settings
- Lack of employment opportunities for young people especially young women, [girls and women trade sex for goods or money]
- High prevalence of curable STIs in both urban and rural settings. (WHO estimates over 1 million cases a year)
- Rapes including gang rapes and other forms of violence against women are rife
- Stigma and discrimination against PLHA is common and not many people are willing to access the few VCT services established
- Cultural practices that can contribute to the spread HIV among a large number of the 800 different ethnic groups in the country have not been addressed under the national response.[16]

Efforts to address HIV and AIDS in Papua New Guinea

National Government

Although the first case of HIV was diagnosed in 1987 in Papua New Guinea, and the national AIDS Council and National AIDS Council Secretariat (NACS) were established in 1997, political commitment to addressing HIV/AIDS was lacking until the enactment of legislation, the HIV/AIDS Management and Prevention Bill (HAMP Act) in 2003. Since that time, a special Parliamentary Committee on HIV/AIDS was set up in 2004, the NACS was relocated to the office of the Prime Minister to increase political support, a Minister responsible for HIV/AIDS was appointed in 2005 and HIV/AIDS was included as a key strategy in the National Medium Term Development Strategy for 2006-2010.[8] The National HIV and AIDS Strategic Plan 2004-2008 was completed in 2004.[16]

The National Strategic Plan identifies seven focus areas –

- Treatment, counselling , care and support

- Education and prevention
- Epidemiology and surveillance
- Social and behavioural change research
- Leadership, partnership and coordination
- Family and community
- Monitoring and evaluation

The HAMP Act legislates for important aspects of the response to HIV/AIDS including among others, clear statements that:-

- Discrimination against someone who is infected or affected by HIV/AIDS is against the law
- Stigmatisation of someone who is infected or affected by HIV/AIDS is is against the law
- Testing is voluntary and is accompanied by counselling pre and post test
- Privacy and confidentiality of client and patient HIV status is protected by the law and test results are confidential,

and sets out steps for individuals to seek redress of unlawful acts.[17]

Other Agencies

Support for the national response to HIV/AIDS has also received support form many other agencies in recent years; international agencies include the Global Fund for AIDS Tuberculosis and Malaria, WHO, United Nations Development Program (UNDP) United Nations Children's Fund (UNICEF) , the European Union, the International Labour Organisation, UNAIDS and the United Nations Development Fund for Women and AusAID.

International NGOs working in various aspects of HIV/AIDS include: Family Health International, Marie Stopes International, International Planned Parenthood Federation, Save the Children Fund, Young Women's Christian Association, World Vision, Hope Worldwide and VSO (UK).

National groups and NGOs include Appropriate Technologies (Hygiene kits for home care), Help Resources (training materials and programs in gender, human rights and sexual health), Humanity Foundation (HIV awareness within settlements, condom distribution), Anglicare (HIV awareness with secondary schools, workplace education , condom distribution, counselling training, VCT and community care centre). Private sector organisations are also becoming involved in provision of services within the workplace.

There is only one national group for people living with HIV and AIDS, activities so far have been focussed on advocacy, it is still in its infancy.

Many church groups and faith-based organisations are the major providers of HIV services. These include Catholic Health Services, Adventist development

relief Agency, the Anglican Church, United Church, Lutheran Church , the Salvation Army and the Order of Franciscans.[18]

AusAID Funded support

AusAID is the major funder of HIV/AIDS prevention and care programs in From 2000 AusAID has funded a five-year national program in health , governance, education and community development, the National HIV/AIDS project (NHASP). NHASP supports the National AIDS Council to implement the Papua New Guinea National HIV/AIDS Medium Term Plan. NHASP is now coming to the end of its sixth year, having had an extension of one year after the fiver year term was completed.[18]

The development and implementation of VCT has been provided as part of the work of the Counselling and Care Unit in NHASP. Team members work closely with the NAC and some team members of the Counselling and Care Unit are also members of the NAC, resulting in a strong collaboration.[19]

Background to VCT in Papua New Guinea

The development of a national coordinated system of VCT as part of the work of the Counselling and Care Unit of NHASP started in March 2001. Although at this time there were already individuals from health services and organisations who had undergone counselling training, many of these individual had not had the opportunity to use their skills nor was there a national system of training, supervision and coordination in place, nor any non-clinical VCT sites in the country. Of the clinical testing sites that existed (a provincial STI clinics), few offered pre and post test counselling or informed consent. There was a need to develop a standardised infrastructure for VCT, which needed recruitment of personnel to various roles and the development and delivery of training, and a system for assessing and accrediting VCT sites. [19]

Timeline and summary of VCT development

2003	2004	2005	2006 (to Sept)
Development of Counselling and VCT Curricula Training of trainers	Modified curricula	All sectors involved	Total number of counsellors trained = 1194
VCT available only in limited STI clinics	VCT commences in stand alone settings (3) National VCT Statistics collated by NACS/NHASP VCT = 728 People testing positive = 48	Stand alone sites = 9 VCT = 2999 People testing positive = 341	Stand alone sites = 16 VCT = 9110 People testing positive = 432
VCT pre and post test			

guidelines produced and distributed	distributed	distributed	distributed
Rapid HIV test pilot commenced at STI clinics with Determine Rapid HIV Test	Rapid HIV testing introduced to stand alone VCT sites	National Rapid Test training (RTT) facilitated Number of people trained in Rapid HIV testing = 67	RTT to be delivered through on the job training and workbook – workbook being finalised
	National VCT Committee – NACS, NHASP, NDoH, Catholic Health Services	Meetings convened Anglicare included	Meetings convened
	Accreditation process defined by committee	Accreditation commenced Sites accredited = 3	Sites accredited = 18
		PNG National VCT Policy and guidelines developed	To be launched
		VCT Logo developed	To be launched
Anti retroviral (ARV) drug therapy pilot in NCD	ARV's available in NCD, Morobe	ARV's available in NCD, Morobe	ARV's available in NCD, Morobe, Mt Hagen, Goroka, Alatau
	PTMCT commenced by Catholic Church Health services	Commenced in Public Health Sector	

Aim and Methods of the VCT Service Review

Aim

NHASP is in its sixth and final year. Consequently a mini-evaluation assessing the coverage and quality of VCT was planned for 2006. The aim of the review was to consider the types of VCT that are used, their coverage and accessibility and assess the quality of the services, reviewing those that are working successfully and those that need strengthening. This was also an opportunity to compare the status of VCT in PNG to current international practices and trends, and to synthesize some recommendations based on the site visits conducted during the review, in preparation for the next phase of development of VCT services in PNG.

Methods

A literature review was performed of international and national documents relevant to the policy and country background in PNG and to best practice in VCT. Site visits were conducted to VCT services in provinces with varying levels of prevalence of HIV and with very different access, coverage and capacity of services. Visits were selected by the project team as most representative of both well-established VCT services and nascent services. They included a variety of models - stand-alone VCT services, integrated VCT services, counseling only services and services provide through a hospital unit. Interviews were conducted

with program managers, counselors and nursing staff and clients. To complement these interviews were also conducted with individuals in other relevant positions (See below, and appendix 2).

Questionnaires for use in interviews with program managers, health worker and focus groups drawn from international tools for assessing and evaluating voluntary counseling and testing programs were discussed with staff in the Counselling and Care component and adapted to the context.[21, 22.] These (except the focus group guide, due to lack of opportunity) were field tested in Port Moresby at the first site visit and adapted again for the remainder of the site visits.

It had been planned for the summary results of the review to be presented at a stakeholder workshop at the end of the review, but this was not possible as many staff of various departments and organisations were away for the first half of the visit at the Toronto AIDS conference with consequent heavy commitments on their return, and a second medical meeting – the Madang Medical Symposium took place on the final week of the visit with, again, several of the stakeholders involved in that meeting.

Summary Profile of Sites and Respondents

Thirteen programs were visited, seven of which were stand-alone sites, three were integrated sites and three offered counseling but with no onsite testing. Nine individuals were interviewed, five clients (as a focus group) the medical chief of pathology services at a base hospital, the advisor to the National Department of Health on STIs and surveillance, a provincial HIV team manager of the Baptist Union, and a human resources representative of the private sector. (see Appendix 2) There was a mixture of sites visited in regards to accreditation. Some of the sites were accredited before the visit; others were assessed for accreditation during the visit by the NHASP Advisor responsible.

Findings

National Coverage of VCT Services

Provincial Counselling Coordinators

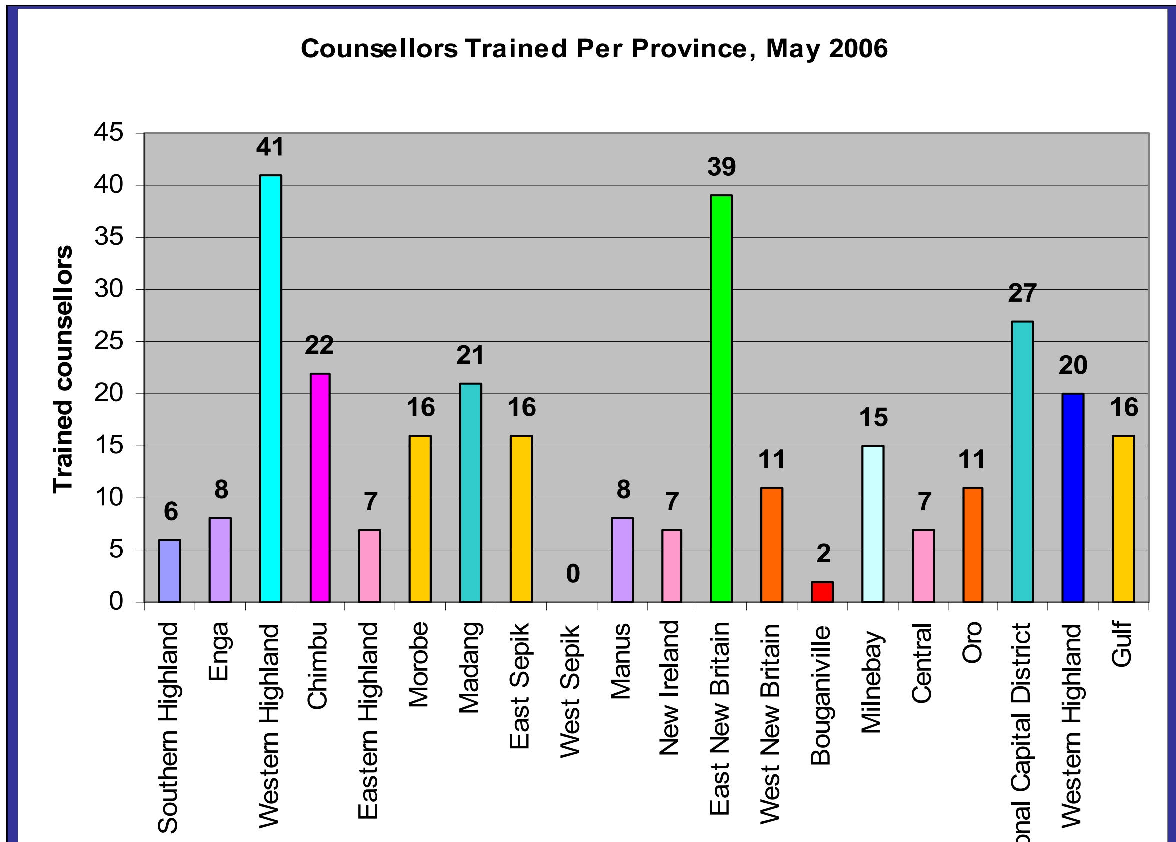
In each province there is a dedicated person in the PAC responsible for the coordination of counselling and care activities. PCCs are well placed to engage with both public sector health and church networks and groups and provide a focal point of liaison between the two.

Training and Education

There has been ongoing development of counselling and VCT training by component two. In 2003 a course had been developed, the 'Introduction to basic HIV and AIDS Counselling'. During the same year two Training of Trainers course were conducted, establishing the first of a national cadre of trainers in counselling for the country. A collaborative review of the training involving the NACS/NHASP coordinating team and the trainers resulted in the separation of basic HIV education from counselling training. This led to the 'Introduction to HIV and AIDS' and the 'Introduction to HIV and AIDS Counselling and VCT' curriculum being developed and facilitated in April 2004 (Introduction to HIV) and November 2004 (Introduction to HIV Counselling and VCT).

The training has been widely taken up with all provinces having trainers trained to facilitate both curricula.

By July 2006, 7786 people had attended the Introduction to HIV basic course training, 1054 had attended the Introduction to HIV counselling and testing course and 67 had attended the new Rapid testing for HIV course. 85 people had undergone training of trainers (ToT) in the introduction HIV basic course, and 115 had undergone ToT in the HIV counselling and testing course.
By May 2006 300 of all the people trained in the Counselling and VCT curricula were being directly utilised (100 male, 180 female and 13 unknown) in the delivery of HIV services and counselling. [20]



To summarise, there are now three distinct training courses in place that contribute to the training of VCT counsellors offered by component two – 'Introduction to HIV and AIDS' and the 'Introduction to HIV and AIDS Counselling and VCT' and a training in rapid testing (the training manual is currently being completed). The Introduction to HIV is a prerequisite to the counselling and VCT training.

Other trainings that are offered either by other components of the NHASP or by other agencies , which have relevance to VCT and address cross-cutting issues include training in prevention of mother to child transmission (PMTCT), training in STI management, the WHO Integrated Management of Adolescent and Adult Illness Acute ART course (which trains prescribers for ART and which includes nurses in the training), the university –based laboratory technician training, and the community health worker training (as mentioned above).

Activities to date

Rapid testing (using Determine Rapid test, with laboratory confirmation) was introduced at the end of 2004, as was the commencement of the accreditation of VCT sites. 12 sites to date have been accredited (August 06), with several others reviewed during the period of this August 2006 review, and awaiting final

accreditation. A national policy and procedure manual and national reporting standards for VCT have been introduced. A national VCT Committee has also been developed which has been instrumental in developing the policy and procedures documents and the procedure for accreditation of sites.

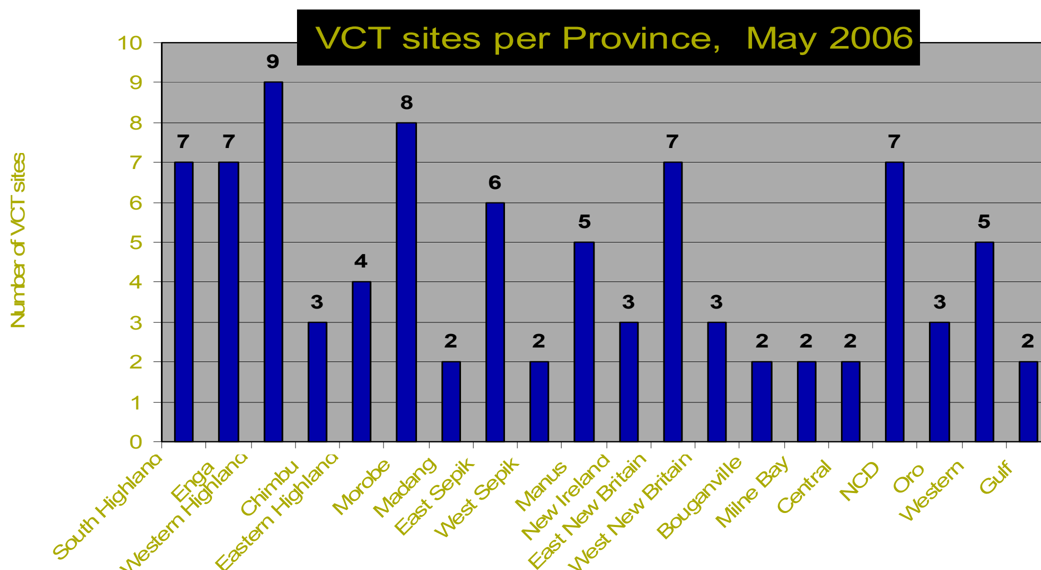
Future Plans

The Papua New Guinea National HIV and AIDS Strategic Plan (NSP) 2004-2008 intends that there should be two VCT sites (1 stand-alone and 1 integrated) in every district by 2010. To achieve this objective strategies include: expansion and promotion of VCT services throughout PNG, improvement of the quality and expansion of the availability of counselling services, capacity-building of health workers in counselling and optimal obstetric care, provision of adequate HIV rapid test kits for all antenatal and family planning clinics in the country.

Key issues for the national government now to address are the integration of HIV/AIDS into the Department of Health's (NDoH) priority focus. Since the inception of the NACS the NDoH had not been as involved in implementation of the plans and strategies for the provision of HIV services including VCT. The current focus on assisting the NDoH to recognise the importance of its responsibility for VCT and current efforts to integrate VCT into the work of the NDoH will go some way to address this. Future plans are for the NACS to retain its responsibility as an advisory body, focussing on coordination of efforts of the public, FBO and private sectors with the implementation of work in HIV/AIDS being the responsibility of the NDoH.

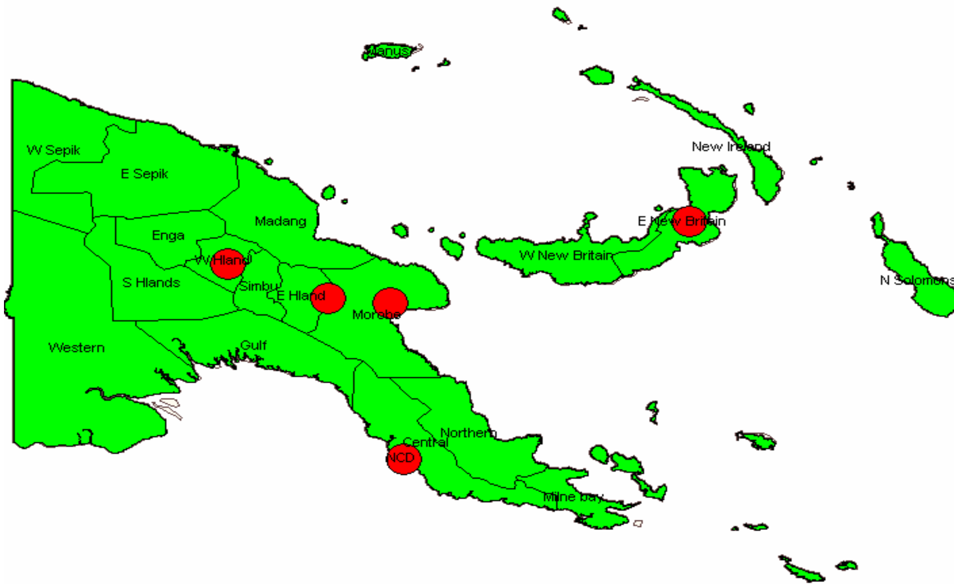
National Coverage of VCT sites

As of May 2006, there were 89 VCT sites available, of which 25 provided HIV screening, under the coordination of the National AIDS Council (NAC).



Five laboratories in the country offered confirmatory testing for HIV, in central Province, Morobe, Eastern Highlands, Western Highlands and East New Britain.

Current HIV Confirmatory Sites



Updated for this report are the VCT statistics for September 2006. 9110 people (2446 male, 3096 female) had been tested at the sites, and 432 of these people tested HIV positive (exact statistics for male and female not known as in several instances sex of client was not reported). What has been reported is 89 were men, 241 were women and 102 gender not identified. This statistic is alarming with the incidence of positive HIV results in women.

Quality of Services

Organisation of Services

Types of services

VCT services are offered by different institutions from the private and public sectors, as well as churches and NGOs. Hospitals, STI Clinics and ante-natal clinics, many run by the Catholic Church, provide services such as counselling &

testing, or counselling only, or testing only. Almost 50 % of the health facilities are run by the Office of Family and Church Affairs (OFCA), especially in remote – rural areas. Stand alone services, integrated services and mobile clinics all exist. The private sector has also been engaged in the provision of services, for example, Ok Tedi mining company conducts confirmatory testing for the local Catholic VCT site and provides resources when needed.

Of the sites visited as part of this review, as mentioned above, seven of which were stand-alone sites, three were integrated sites and three offered counseling but with no onsite testing (of these, one was a university student counseling service, one was a government –run primary health sub-centre [supported by the Catholic church] and one was a FBO primary health clinic). Two sites offered programs in awareness-raising and condom distribution with referral to counseling and testing services at the nearest VCT site. Of the stand alone sites, three concentrated only on VCT services while the others offered multiple services including, variously - pastoral work, community health worker training, respite inpatient care, home based care, clothing provision, some financial aid, drop-in centre, informal PLHA support groups. Two of the integrated sites were STI clinics based in hospital settings and one was a disease control unit within a medical unit in a provincial hospital.

Accreditation

Accreditation of VCT services has been in place as part of the system for expansion of services since 2004. Each site is visited and assessed with a standard questionnaire format and a physical review of the site. Sites must meet basic requirements on availability of trained personnel, adherence to VCT and safety guidelines (including infection prevention) and the physical infrastructure of the service. "Accreditation of VCT requires counsellors to sign the PNG Code of Ethics for HIV Counsellors and lodge a copy with their employer. Provider organisations are expected to ensure counsellors adhere to the national standards, provide organisational support, are not overburdened with too many clients and provide additional training and capacity building opportunities" (NHASP/NACS NHASP 2006, Assessment of the Counselling and Care Training Program).[19]

The review visit is discussed with the program at the time of the visit and explanation given with regard to the follow-up process. Sites then receive a formal letter form the National Counselling and Home Based Care Advisors (NHASP/NACS) informing them either of their approved accreditation or lack of approval with recommendations on needed improvements /changes to facilitate accreditation in the future.

Access to VCT services

Access to VCT services includes physical access, geographical access, access to test results and constraints on access due to stigma and discrimination.

Physical access

Of the sites visited during the review, all seven FBO-run sites had a separate entry or hallway/waiting area for clients where a member of staff would greet them and make them welcome. In one of the stand alone sites, undergoing renovations at the time of the review, there was a possibility that the separate lobby would be unmanned by staff due to the restructuring of the space. On discussion the program acknowledged this and agreed that this would be addressed to ensure that clients would be met and welcomed on entry. Some stand alone VCT centres had provision for offering drinks or a cup of tea to arriving clients.

The two STI clinics had waiting areas for all clients whether for HIV testing or for other STI needs. In one of these, it was possible to look through the outside entrance into the waiting area and view clients. The FBO-run primary health centre had a separate waiting area, the public health primary health sub-centre had a waiting room which had to be shared by all arriving clients – this last site was preparing to move into a new purpose-built two-storey building which had included in the design separate areas including waiting room for clients attending for counselling and testing.

Geographical access

For most of the sites, access to the services was difficult for many clients due to transport costs, including in large towns such as Port Moresby and Mt. Hagen. In remote areas this was compounded by lack of available transport services, poor road access, compounded in the rainy season by flooding, and, in East Sepik, often no road access in parts, with many people having to travel by canoe for at least part of the journey. Travel by road is also unsafe due to the presence of armed robbers in many areas, and, especially for women and girls, the high incidence of opportunistic rape.

Hours of operation were usually business hours but were flexible, especially in the remote services. Most services, with the exception of the university student services centre (which is only open on a Thursday), said that clients who "dropped in" would be seen on the same day where possible. One centre said that the client would have to return on the next day.

Most services expressed the need for more staff and transport for their staff to enable them to provide better outreach services.

Access to results of rapid and confirmatory tests

Those sites which had rapid testing all gave the results of reactivity immediately. One of the STI services which had been used to performing rapid testing and had trained staff to do so, no longer provided testing but took blood for testing which was sent to the laboratory next door and rapid tested there, sent the client away and told them to come back in a week. This centre reported that on occasion the client would return but the results would not available so they would send the client away again and tell them to come back in another week.

Access to confirmatory testing, as mentioned above, is limited to five centres for the country. In the only visit to one of these confirmatory testing labs, it was stated that the laboratory's supply of reagents for CD4 counts had run out and they were waiting for more; the lab's FBC machine has also gone for repair to Port Moresby and the lab did not have the money to pay for its repair so it was not possible to do a total lymphocyte count either.

For clients, the waiting time for receiving the results of the confirmatory tests varies according to how far distant is the VCT service from the confirmatory site. In the programs visited, five stated that the results would be back within a week, five stated that the results took an average of two weeks.

Stigma and discrimination

All sites visited, even in very remote areas, suggested that stigma and discrimination adversely affected client access to services, and said that clients would often come from neighbouring provinces for counselling and testing, rather than go to services locally because of the fear of being identified as having attended a VCT service. Some services in remote areas said that they felt client access was restricted because of the position of their VCT or counselling service, e.g. one stand alone site was next to a factory, clients were reluctant to come to the service for fear of being recognised by members of their extended family or local neighbourhood who were working in the factory, another primary health facility said the clients did not attend the centre because they would be recognised and made the long trip into the nearest town instead. Several programs commented that their clients are treated less well in health facilities than clients with other illnesses.

Access for children

Only one of the services stated that they had specific services for children, this was a counselling service. The STI clinics stated that children would be referred to the paediatric ward in the attached hospital. One service had a statement on services for children in their policy on counselling (see Policies and Procedures in section on Management Systems). All other programs said they had not yet seen any children coming for VCT.

Promotion of VCT services

All visited sites including stand alone VCT services, integrated sites and the individuals engaged in private sector/church work said that they engaged in community awareness programs. This included education available onsite, outreach activities, media spots, school education and testimony from a local person living with HIV. Each site had access for clients to a good range of information leaflets about STIs and VCT services, but several had limited access for clients to other related information, for example, information about nutrition. Several programs said that more awareness in the community was needed to decrease stigma and discrimination, they also suggested that they would like to do more community outreach on awareness and education. Most programs said the demand for services was moderate, but that with increasing access to ART they could see that more people would want to have access to VCT. Those services already providing ART said they could see this was making an impact with more people coming forward for testing.

Access and Referral to other Services

Relationships with health service providers

Most of the programs visited stated that they had excellent collaborative relationships with the local hospital or higher level health service. At the same time, while some programs said that they were sent back information on clients who had tested positive, others said they rarely or never received information back from referrals. One remote program stated that the hospital is happy to use the health centre for beds, for example, when the water is off in the town, but "they get angry with the centre" when the centre refers clients to the hospital.

Referral system to hospital

These referrals seemed to be mainly referrals for sick people, there seemed to be no distinct referral mechanism for referral of pregnant women to PMTCT services (this service is not coordinated by the NHASP counselling and Care component) with the exception of one stand alone service which included it in their range of services. There was also no discernible or direct link between the VCT services and the TB DOTS program that was available. Although the primary health centres said they received clients who had been sick back into their care. There did not seem to be any evidence of active TB case finding for clients who attended for counselling and testing, unless the clients were symptomatic.

For the stand alone sites, referrals for health services were usually made by sending the client with a letter or accompanying the client if s/he was too sick to go alone to the hospital. One program said that they did not send a letter to the hospital, but simply sent the client with instructions on where to go in the hospital to ensure client confidentiality.

Access to Anti-retroviral Treatment (ART)
WHO is conducting a country-wide training in Acute Care for HIV/AIDS (part of the WHO Integrated Management of Adolescent and Adult Illness) as part of the roll-out of ART as mentioned above. Both of the STI clinics had commenced education and treatment for clients. Most centres were aware of this training; clients interviewed in a focus group in a remote area were not aware that ART existed. In one centre there was an expectation that the health facility would provide for the needs of people on ART. The University centre doctor was due to go for training in the Acute Care Course in October. The health extension officer at the hospital which worked closely with the centre in East Sepik was eager to start training, currently the training is being provided to STI clinics and TB clinics in the area.

Access to PLHA support groups

One remote centre had started a very informal support /drop-in group and was aiming to strengthen this – the clients were exclusively women. One of the STI clinics which had been providing client education on ART for the last three month had started to develop a support group out of the training participants. Another stand alone centre held support group meetings and education meetings for clients each week. Yet another stand alone service provided a more informal drop-in approach to provide a space for PLHA to get together, and another multi-service centre was helping clients slowly to become accustomed to the idea of a support group, using the existing prayer groups as an entry point.

Referral to other services

Referral to other services, for example, for help with housing or legal issues, was usually informal; only two of all the programs visited had a written referral directory. Some programs in the remote areas said there just were not many services so a directory was not needed, another said the staff knew everything that was available "off by heart" and did not need it written down, others said they were thinking of developing one. The student service said that it was a mandatory part of their duties at the university to develop one and therefore they had done so.

Tracking referrals

All programs kept a written record or register of client referrals; for tracking the *outcomes* of referrals, several programs stated that they never had any referral back of information from the higher level facility or hospital and relied on the client to come back to their service to tell them what had happened, one said it asked the relatives of the client for follow-up information, one program had developed a system of including the referred client's home in her routine home visiting of all her other clients so that she could keep track of when the person

had come home and not arouse suspicion in the local neighbourhood a about why she was visiting that particular client. Yet another program made sure to do a follow up visit to the client in the hospital and then ask the client to come back to the centre after discharge to ensure follow up in the community. All programs said they would welcome an effective two-way referral system.

Management Systems

Policies and Procedures

Every staff member who had been trained in the national training had received a copy of the national policies on VCT (including the Code of Ethics for HIV Counsellors, the national VCT guidelines and the national policy on privacy and confidentiality) contained in a policy and procedure manual as part of the handouts from the course. There was at least one nationally -trained staff member (trained in the 'Introduction to HIV and AIDS Counselling and VCT' course) in each centre visited except the FBO-run primary health centre which did not provide testing for HIV but referred to the VCT service in the local town.

All centres except one knew of the existence of the policy and procedure manual. All staff spoken to emphasised the importance of client confidentiality but only about half remembered that there was a national policy statement on confidentiality in their centre's policy and procedure manual. At one centre the staff member did not remember until heavily prompted, that a policy and procedure manual existed.

One centre had a specific statement on counselling for children in their policy for counselling; this states that when parents bring their children for counselling and testing that the counsellor if possible will be the same sex as the child, and that the parent is asked to leave the room when a risk assessment is conducted (to enable the child to speak freely, especially in case of parental sexual abuse). At the same time the HAMP Act states that parents can give consent for their child to be tested if the child is under 12.

Workplace policies were not in existence at the centres, or at least the staff members interviewed had no knowledge of any workplace policy. There has been a workplace policy toolkit developed as part of the work the International Labour Organisation activities in PNG; so far this seems mainly to have been taken up by the private sector. Of government departments at national level, the Education Department, Treasury Department, Department of Personnel Management and Defense Force have developed their workplace HIV/AIDS policies.[8] The Department of Health does not yet have a workplace policy on HIV/AIDS and neither does the NAC.

Provision of Post-Exposure Prophylaxis (PEP) for staff, for example, for needle-stick injury, was limited. The Catholic Health Services were providing this service

some time ago, and recently it had been decided that there should be a national standardized approach to make PEP available in areas where ART has already been implemented and so now, the services which were providing PEP in areas that have not yet received ART training and provision are no longer able to have PEP provided.

Services Provided

A summary of the range of services provided by each program visited can be seen in Appendix 2

Technical quality

In most instances there was no opportunity to assess the quality of service provision directly (due to the busy nature of the programs when clients were there and the time constraints of visits), it was obvious from discussion with the staff that they were highly knowledgeable about the types of services they provide and gave the impression of being dedicated and highly motivated to try to maintain high standards. Conflict between staff members (with the potential to destabilise the quality of services because of infighting and professional sabotage) was occurring in one centre which was struggling with organisational change in a remote area.

Personnel

Recruitment, education and training of staff varied according to the type of service. Accreditation demands that all counsellors are trained in the national curricula for Counselling and VCT. Most FBO's have made sure that all their staff in VCT sites (integrated and stand alone) have completed there training. Integrated site counsellors consist mainly of health workers, many of whom had been trained. There is also a standard two-year training for community health workers in place, so there is a level of professional standardisation of staff. Recruitment follows standard procedures, either national procedure for government positions or organisational, for example, internal standard procedures, for example in FBOs.

Quality of Counselling

It was not considered appropriate for the review team to be involved in counselling sessions with clients in the centres. All counsellors had copies of the pre-and post test counselling guidelines easily to hand in the centre.

The provision of the full prevention message within counselling was patchy. Some of the counsellors said they always talked about prevention and correct and consistent condom use, and asked the clients to demonstrate on the model

penis how to put on a condom. Others, from FBOs, said they only talked about condoms if they thought the client was likely to be at risk, or if the client was married. One counsellor said that she asked the male clients if they knew how to put on a condom and if they said yes, she did not use the demonstration model. Some of the counsellors only discussed the male condom, but did not explain in detail about the female condom to female clients, simply gave them a supply, or had a supply available. One counsellor said she always talked about and gave condoms but only to the positive clients. One FBO counsellor did not talk about or have condoms available even though this is a requirement of the national VCT guidelines.

Discussion with selected staff members elicited information about counselling sessions, what sort of issues are raised and how they are managed.
Some of the issues for the staff were – staff felt they needed more training, especially in some of the more technical areas such as ART and acute care, TB management, so that they answer client questions more confidently, and that they thought more training, or follow-up training in advanced counselling skills, would help to better support them in dealing with difficult issues for clients or families. Some staff felt that the quality of their counselling suffered when they had too many clients; the staff of the STI clinics certainly had very busy consultation sessions. Some counsellors talked about rape, having to counsel women who had been raped, both opportunistically, and as part of domestic violence.

Client perceptions of VCT

There was opportunity to conduct only one focus group and this comprised five women in a remote stand alone VCT centre. Some of the key comments made were:-
They felt that local people were reluctant to come to the centre, partly because the centre had a sign outside, so that even though it wasn't on a main road it was obvious to passers-by that those who entered the building were going for counselling and testing. However they felt it was better and more discreet than going to the public hospital. At the same time some of the group said that they thought there was still a great lack of public awareness outside the town as many people were not aware of the existence of the centre (this centre had only been in existence for less than a year). They suggested that a good way to increase awareness would be to engage the priests and pastors in giving talks on HIV within the church as many of the priests and pastors had already had some training on HIV and many were supportive of people with HIV.

Some group members said that coming to the centre was often a first step in the process of counselling and testing and that people often came to achieve better understanding of their risk. All group members made it clear that people would

rarely discuss with anyone else prior to coming for VCT – one member of the group said it was not possible to trust anyone (family/friends etc) in this respect. The group also, however, agreed that when people disclosed their status to family/friends these were generally supportive and that this was an improvement over recent times. One young woman said that this had not been her experience and that in her village, "no-one will look after you, including your family". When asked whether they thought that seeing people go to a centre for VCT would encourage others to use the service, the unanimous response was negative, one member of the group summarised this as "No, people point and say that person has AIDS".

There were some significant misconceptions among the group – two members who disclosed during discussion that they were HIV-positive, had said that a positive result means death, the same two believed that the herbal medicines they were (both) taking would cure them by the end of the year. None of the group had heard of antiretroviral therapy.

Suggestions for improvements to VCT services included greater involvement of the clients as advisors in developing and improving services, and involvement of clients in conducting needs assessment to identify most appropriate combinations of services offered through a VCT service. They felt that this would form part of a strategy to help in addressing stigma and discrimination and emphasised the need for continued and expanded awareness- raising and education of health facility workers to reduce current high levels of stigma and discrimination in the health facilities.

Some group members suggested that there was a great need for VCT services to be developed at district level as many people could not afford the transport to get to the centre in the town. They suggested that the existing system of AID posts (first level health facility) manned by Community health workers, which has fallen into disuse in many areas, urgently needed reviving so as to provide for VCT services at that level.

Supervision and Support for Staff

Only four of the programs had a routine systematised program for support and professional supervision, debriefing and problem-solving for staff, two on a monthly basis, and one on a weekly basis, although this is part of the responsibility of the NAC according to the National VCT Guidelines. Two of these four program meetings seemed to take more the form of a management meeting with the Officer in charge of the services 'facilitating' the discussion. Some centres said they "managed" by informally talking about issues with each other, a remote centre said that they used to have regular meetings as a management team but this had now stopped because everyone was too busy with other commitments and the team was struggling as a result. One FBO counsellor who works alone said she had the priest and other members of her religious

community for spiritual support, but no other regular professional support for debriefing and problem-solving.

Confidentiality

Most of the programs correctly stated that their centre had a policy on confidentiality (as this is contained in the manual provided as part of the training). Two staff at one STI clinic stated they did not have a policy even though four members of the staff had been though the national training. One primary health centre member of staff did not know whether or not there was a policy in the centre – she was new to the centre and has not attended VCT training, the counsellor was way on that day. At the other primary health centre no staff had attended the national training even though they provided onsite and mobile counselling and testing, and so did not have any of the national policies available.

All staff professed to maintain confidentiality but in several centres people were introduced to the review team as "our first person living with HIV' or "this is our advocate for HIV, he is living with HIV himself". Staff seemed to be completely unaware that in so doing they had broken confidentiality.

The staff member at the public primary health sub-centre said that they all maintained confidentiality but everyone knew anyway of someone was positive and that there was one woman who was positive who lived in the district and the whole district knew her status. She went on the say that even though there was a counsellor employed at the centre, everyone went to the local town so that no-one would find out they had gone for counselling. All centres said they had secure systems for maintaining confidentiality of client records and that information as always coded if it needed to be sent out of the centre. All but one of the services maintained a locked filing cabinet; one of the STI clinics maintained a locked room, but this was usually unlocked during the day when clients were being seen and within the room all records were lying open on benches rather than being filed.

Client consent must be voluntary and noted on a signed form. Parents can give consent for a child under twelve year to be tested. All of the centres said they maintained these consent forms with the client records in the secure filing system.

Commodity and Supply Chain Management

Commodities and supplies are funded by and obtained from a variety of sources. Medical equipment, for example, gloves, is obtained from the public health facility medical stores nearest to the centres, NHASP procures condoms for NAC which supplies the PACs to provide condoms to those centres which are FBOs or jointly funded through the provincial government and FBOs, the National department of

Health procures and supplies condoms to public health facilities. Rapid test kits are procured by the Department of health through the Global Fund, and supplies the district health services. The Catholic health Services also procure rapid test kits through the international agency Caritas, and distributes to FBOs. The distribution system for rapid test kits consists of a person carrying the kits with them when they pay a visit to a VCT site. The distribution system for condoms is supposed to be organised by the Department of Health as is the distribution system for medical supplies. There are no evident imprest-based, routine systems, even for supplies form medical stores; all supplies seem to be ordered or requested (in the case of rapid test kits) on an ad hoc basis and an individual then obtains the supplies and provides to the centres. In the case of the STI clinics these seemed to have a system of regular top-up of most supplies, but in one of these it was obvious that the plastic sharps ‘bin’ had been re-used on several occasions.

During the site visits it was evident that ruptures in the system of supply and distribution of all commodities are common. One stand alone FBO site had run out of gloves - the person in charge was unaware that she could obtain these from the medical stores through the Provincial Infectious Diseases Officer. Another centre (a remote FBO) had run out of condoms and said that they had stopped advocating the use of them because they could not supply them. The same centre stated that some time ago they had had rapid test kits but the supply had run out so they had stopped doing rapid tests and now sent the clients to the nearby town. Some centres had not received a supply of test kits recently so were using test kits with expired dates on them. Yet another centre had none of the cardboard sharps containers and was using an obviously recycled plastic detergent bottle which had such an amount of congealed and old blood around its opening that it was obvious that it must have been being used, emptied and re-used, for some days at the least. A simple request to the Infectious Diseases Officer was all that was required to obtain a fresh supply of the standard issue of cardboard sharps bins.

The national condom kit was usually available in most sites except as mentioned above. There was only one centre that had the condoms in a dispenser and correctly attached to a wall in an accessible point in the centre. Another centre had dispensers that were waiting to be put up. The national condom kit only contains male condoms as the package containing female condoms is too big for the current condom kit package and for the dispenser. While all centres that had condoms had supplies of both male and female condoms, this style of packaging does mean that special efforts are needed by the staff to ensure equal access to and availability of female condoms for clients.

Antiretrovirals are procured by the Global Fund and training is conducted in IMAI by WHO.

There is a standard national protocol in place for routine quality control of rapid test kits and confirmatory testing. Quality control for test kits and confirmatory testing is carried out at the five provincial sites already mentioned.

Infection control and hygiene.

Disease prevention and infection control are taught as part of the training for 'Introduction to HIV and AIDS Counselling and VCT' and as part of the newest training in Rapid Testing. In the sites visited there were varying levels of adherence to infection control principles; some sites did not have a hand washing sink in the room allocated for testing, all had access to a sink within the vicinity of the room. One site had decided to address this by ensuring the staff member bring a fresh basin of water into the testing room for each testing procedure.
In some provinces there is a standard issue of reinforced cardboard sharps bin which is available directly from the Infectious Disease Officer. There seemed to be confusion in other provinces about whether these sharps bins were available or not; not all sites visited had access to these bins or were aware of their existence and used plastic detergent bottles, which once full would either be sent to the hospital incinerator (by both public health facilities, and in some instances, by stand alone services which had a good relationship with the local health facility) or were thrown into a pit latrine. Some stand alone sites had a purpose built fenced off pit for the burning of contaminated waste.

A staff member at another site mentioned that although there was a consistent supply of gloves, that staff usually wore the same pair of gloves for three tests and then changed them – in this site the hand washing facilities were down the hallway from the testing room.

The public health facilities were untidy, dirty and rundown. Staff at one facility said there were no cleaners and they were supposed to do their own cleaning of the entire clinic.

Client Records, Data Collection and Reporting

There are standard forms for client consent, guardian consent for minors, client registration with the service, consent for release of test results to others, VCT client referral and VCT monthly summary reports. The national VCT guidelines state that client records must be maintained in a secure filing system.
Client registration books were held by each centre, these were also maintained in a locked system. Most of the centres maintained one book for clients presenting for counselling and testing for HIV and one book for test results. In one of the STI clinics all of the registration data for every client regardless of diagnosis was recorded in one book, making for a cumbersome task of sifting through each month to tally those clients who had attended for HIV counselling and testing. In the other STI clinic one book was used for recording demographic data only,

another book was used for registering clients for testing, a third book was used for test results which were then transferred back into the registration book, and a fourth book was used for a detailed client record form, with substantial duplication between books.

Data is collected on a monthly basis for reporting to the NAC – this data is mainly statistical with very little narrative component at present. Some centres visited had difficulty in sending their monthly reports on time, for others this had become routine. The written reports that were kept had very little information and the content was not immediately clear. There was little or no written institutional history in many of the centres. Most of the information about the work of the centres was ‘known’ by the staff, but not recorded.

Quality Assurance and Internal Monitoring

As yet there is no standard system of quality assurance or of centre- initiated demonstrable self-appraisal of developing, reviewing and maintaining standards. While the centres all stated that they follow the national procedures and guidelines, there is no system for them to check their performance against these procedures and guidelines.

Successes

In a very short period of time, there have been significant successes in several areas of VCT services, including achieving national coverage, with VCT services being available in every province; a cadre of trained counsellors trained to national standards, a cadre of those counsellors becoming trained trainers according to national standards; the development and continual review and revision of a national training manual; the development of an accreditation system for all VCT services; involvement of all sectors - public, private and faith-based; the development of a system of procurement and distribution of essential commodities and the development of national VCT guidelines.

The training has enabled those trained to develop an approach to care based on shared accountability in responding to need. The standardised training and selection procedures for training have both enabled selection of committed personnel who can provide a significant contribution to addressing misconceptions and prejudice. The training itself has helped to increase community awareness of HIV and the need for testing. The role of personnel within the VCT services and in the PACs, in particular the role of PCC, has both enabled professional development of those individuals and created a cadre of role models for the local community[19].

Considerable efforts have been made by the project team to engage and collaborate with relevant local, national and international stakeholders; the

project staff are obviously well-respected by both government and faith-based health sector staff. There is already beginning a strong collaboration between the services in VCT and in community and home based care, due to the close working relationship between project staff responsible for these areas; this sets in place the foundation for the development of home based VCT services.

Challenges.

Access

At an individual level, there are constraints to access to services. Clients have significant difficulty in gaining access to and affording transport to the existing centres both for attending for rapid testing and for returning for results of confirmatory tests, although most sites stated that they had a high level of people returning for results.

Stigma and discrimination also caused a challenge for people to physically gain access to sites if they were built in an area where others would see people entering and leaving the sites.

For the sites visited as part of this review, another significant issue affecting coverage was limited human resources and transport for staff to provide outreach services i.e. - awareness-raising, mobile or home based services.

Views of the staff of services on accessibility included the need to provide more awareness-raising and mobile clinics – to effectively reach remote areas, since they felt that many more clients would use services if the services were brought to them. Clients' views echoed the views of staff, those clients interviewed felt that outreach services would improve awareness, decrease stigma and discrimination and enable reluctant clients to come forward for counselling and testing.

Challenges to accessibility at health facility level included limited numbers of staff in hospital and public health clinics having received the national training, for example, at a blood bank in a provincial hospital neither of the two nurses had had counselling and testing training and consequently did not conduct risk assessment of blood donors. Clients reported continued high levels of stigma and discrimination from health workers to people perceived to be HIV-positive.

Access to other services is an issue in a number of areas – PEP is currently only available in those areas where health workers have been trained in ART prescribing and monitoring; collaboration with other clinical services, for example, PMTCT or the existing TB program was lacking in some areas and present in name only in other areas. Access to ART is and may continue to be an issue, especially where VCT is provided out of health facilities which are now having to

take on significant extra work in ART preparation, education and monitoring, without support of extra human resources to cope with the extra workload.

ART is procured by the Global Fund and the training in ART prescribing is done by WHO (as previously mentioned). There is no real link between these two and the VCT program at national level as yet; although there is good potential for overlap and collaboration as many of the staff at the VCT sites are will be trained in the WHO Acute Clinical Care course also and will take on the prescribing role in ART – the danger here is that the quality of other services may deteriorate because the staff have too many roles to fulfil and will start to prioritise tasks. This is already evident at one of the two STI clinics visited which has ceased to perform rapid testing in favour of providing treatment education and support for ART, so that now clients receive the results of their "rapid tests" performed in the hospital laboratory a week after the test instead of on-the-spot.

Insufficient numbers of confirmatory sites (five in the country) delays access to timely results for people in remote areas.

Nationally, the target identified for people on ART is 10,000 people on treatment by 2010. In a generalised epidemic 20% of HIV positive people would need to be on treatment at any one time. This means that to identify 10,000 people who need treatment , 50,000 HIV positive people would need to be identified. In a situation of 2% prevalence (assuming that the epidemic growth remains at 18% per year and is not affected by other interventions) 2.5 million people would need to be screened in order to identify 50,000 HIV positive people. This requires the development of a strategy for massive HIV screening[19].

Provincial Teams and Health Facility Personnel

Human resources is a significant challenge, there are too few staff at each existing site to be able to provide expanded services or to proved new services (e.g. mobile VCT services) or to manage an increasing workload due to the introduction of ART. This situation is compounded by the current staffing freeze on employment of professional staff, i.e. at health facilities.

The PAC, while potentially an excellent model, and while functioning very effectively in some areas, is in certain other areas not functioning at best capacity, due to dysfunctional relationships either between the HRC and PCC, or between the PAC and VCT services. The PCC is a role central to the effective functioning of the PAC and to the collaboration between public health facility and FBO-run facility. In one area this role was functioning almost exclusively in promoting the importance of the FBO-run services, e.g. by inviting the staff of FBOs to training in preference to the staff of health facilities with the result that key health facility staff such as blood bank nurses have not received urgently–needed training.

Technical Quality

Environment

In the public health facilities and in two of the FBO-run primary health facilities space was an issue for some of the services, with very little room for adequate office space for staff, lack of adequate privacy in waiting rooms, especially in the two STI facilities, due to the facility layout. The FBO-run stand-alone VCT services had been purpose-built or renovated to provide adequate space and were mostly well-designed with private areas and discreet space for waiting areas.

Environmental hygiene was a significant problem in all of the public health facilities, with some having no cleaner allocated to the facilities. Both STI clinics had distinctly worse levels of environmental cleanliness and cleanliness in the testing rooms themselves, than did the sites run by FBOs. While staff made every attempt to make the areas welcoming for clients and provided information, posters and leaflets, the general atmosphere, because of the rundown environment was somewhat depressing.

Not having hand washing facilities in the testing rooms engenders extra work for staff (and the potential for neglecting hand washing) as the staff member who has to go out of the room into a bathroom or other area; whereas one site had addressed this problem by ensuring the staff member brought a fresh bowl of water into the testing room on all occasions of testing, at another site a staff member mentioned that although there was consistent supply of gloves, that staff usually wore the same pair of gloves for three tests and then changed them – in this site the hand washing facilities were also down the hallway from the testing room.

In some instances, both public health and FBO staff were re-using plastic sharps bins or plastic detergent bottles used as sharps bins, by emptying the containers manually. In one instance this was because the staff member really liked the plastic sharps bin (a donation) and thought it was better than the standard issue cardboard sharps bin. A discussion regarding her own personal safety resulted in immediate behaviour change.

While all centres visited had adequate and varied supplies of educational material for clients, both FBOs and public health facilities needed access to resources for continuing education and access to recent professional information, trends and developments for staff. These were lacking in all sites visited.
None of the staff interviewed could report the existence of a policy or protocols for occupational health and safety.

Supervision and Support

Geographical constraints and few personnel at each site make it very difficult to provide professional and clinical supervision and support for the staff involved in VCT. Even those services that had several staff had not yet implemented a system of supervision to enable staff to share concerns and problem-solve. Many of the personnel had identified issues in provision of services, emotional and professional issues which would have benefited from sharing and discussion at supervision sessions, although several of the staff did not initially acknowledge the importance of supervision for themselves.

Confidentiality

In each of the sites visited staff were very knowledgeable about issues of confidentiality, and their role in maintaining client confidentiality, and, at the same time, several of the staff in the areas visited disclosed clients' status to the review team without prompting, and without any apparent realisation that they had broken client confidentiality. This disclosure seemed to be a result of pride in the role of the person with HIV as a community educator, but was misplaced in that each time this occurred it was obvious that the person was uncomfortable with being introduced as a person living with HIV. That some staff did not know of, or had forgotten, the existence of the policy on confidentiality was also a concern.

Gender

Issues of gender were apparent in both staff roles and clients' reports. Many of the services visited had only female counsellors – several expressed the need for gender balance in counsellors but stated that it was difficult to persuade men to be interested in the work. At one centre the all-female staff reported the need for a male counterpart in management as they felt that an all-female staff was contributing to division within the team – their belief was that they needed a male manager, ironically perpetuating the role of the man as "boss" and women as subservient. Both men and women expressed preference for female condoms; some of the (female) focus group members stated that this was because men "don't want to bother using condoms and [if women use female condoms] it makes life easier for them".

Commodity and Supply Chain Management

There are significant challenges at each step of the procurement, and supply chain. These include:- multiple agencies involved in procurement and supply of different commodities; inadequate government health service supply chain mechanisms; regular ruptures in supply and distribution of commodities; ad hoc supply of commodities by individuals and agencies, rather than a routine system; no system of imprest stock monitoring and no system of imprest ordering of supplies from VCT services to relevant (multiple suppliers) .

The current system is reliant on individuals and good will, rather than on a systematic approach. This approach has serious implications for the continuous supply of commodities already being used and implications for the country's ability to provide continuous supply of ART when it is provided throughout the country.

Client Records, Data Collection and Reporting

Currently, most stand alone VCT sites and care centres send monthly statistics to NACS/NHASP. Several integrated sites are also sending statistics (also a requirement of VCT accreditation)[20]. Within this system some of the services, while improving in their reporting over time, do not send reports on time and do not send accurately-reported statistics, e.g. some services count people tested without disaggregating for sex. Statistics are also generally not disaggregated for age, so it is difficult to gain a clear picture of the clients attending the services. In one service client records were 'filed' on a large bench in a locked room – this is an inefficient method of filing which is potentially open to breaking of confidentiality since the room is unlocked for long periods of the working day, and is also a waste of valuable space.

Narrative reporting is generally not done and where it is done it is usually in note form, making it difficult to gain a sense of the service's past achievements and current improvements, the corporate history of services is currently is not being documented.

Quality Assurance

Since there is as yet no standard system of quality assurance or of developing, reviewing and maintaining standards, it is difficult for services to demonstrate their success except with statistical data. A national system of standards against which services would measure and maintain their quality of service has not yet been introduced.

Limitations to the Review

In the time allowed for the review it was only possible to visit services in four of 20 provinces, and in most of those services the main part of review was with program staff; very few clients were available for consultation and interview. Visiting only a few provinces out of the twenty provinces meant that it was difficult to accurately assess the roles and function of the PACs and PCCs. There was also no opportunity to meet and interview members of the national PLHA network, the WHO representative involved in ART training or the Global Fund

representative involved in ART procurement, to discuss issues of collaboration between VCT and ART services.

Visits to the medical and nursing associations and members of university faculty involved in training in medicine and nursing would also have been useful to provide a perspective on how these professionals view VCT services.
No antenatal clinics, PMTCT sites or TB programs were visited to review how these services overlap and collaborate with VCT services

Recommendations

National Program and structures
Increased Access
- There needs to be a substantial increase in VCT centres and therefore trained counsellors if PNG is to meet identified targets. The services that are currently providing VCT need to be expanded to include an increase in outreach services. Integration of counselling and testing into HBC services.
- If the current testing regime remains in place then the number of and effectiveness of laboratories and confirmatory sites needs increasing
- To achieve adequate service provision it is essential to develop services at primary health centre level.

PEP and Occupational Health and Safety
- A standard national system of occupational health and safety urgently needs putting into place, including rapid introduction or re-instigation of PEP for occupational exposure. Staff require training in OH&S.

Infection Control and Hygiene
- Systems for infection control should be standardised and staff trained to adhere to standards.
- New sites that are established in the future should ensure that hand-washing facilities exist in every room where testing will take place, and that there are provisions for water supply in the event of a break in normal supply.
- Public health facilities should have sufficient support to maintain environmental hygiene, including employing cleaners to clean the units. Health professionals should not be expected to clean public health facilities.
- Ensuring consistent infection control has obvious implications for commodity procurement and management, e.g. consistent and adequate supplies of gloves, to overcome the culture of ‘saving’ or ‘rationing’ in case of a rupture in supply, which seems to exist in some services.
- Nurses who are who are involved in testing procedures should be involved in the design of facilities to ensure adequate provision of measures to ensure infection control and hygiene.

Commodity and Supply Chain Management

- The current systems of procurement and distribution need a thorough review by expert technical advisor/s to try to develop an approach which coordinates the work of the various stakeholders from national level through to local level.
- At provincial level a standardised approach should be developed to enable all services to obtain required commodities (sharps bins); at service level, a more standardised approach to provision of condoms needs to continue to be encouraged so that all service providers give the same messages with regard to correct and consistent use of condoms.
- Since the female condoms cannot fit into the dispensers currently being provided to all the VCT services, a separate container needs to be situated next to the dispenser for easy access.
- A more standardised approach to provision of condoms needs to continue to be encouraged to build on the considerable work already done by the Care and Counselling unit to ensure consistent messages with regard to correct and consistent use of condoms, rather than their own personal approaches, e.g. offering demonstration of condom use only if someone asks.

Quality Assurance

- A national quality assurance task force could be developed, drawing on the experience of staff from existing services, to look at developing at standards of quality and simple systems of measuring quality.

Resources & Personnel

- Services need to be provided with at least two vehicles to provide for multiple needs including transport of clients and providing outreach services.
- PCCs need their own vehicle to perform their multiple community roles rather than having to rely on sharing a vehicle with the HRC.
- Staff of the services need to be supplied with cell phones and satellite phones to enable rapid and easy access to referral and support from colleagues.
- Key staff of the centres and each of the PCCs also needs her/his own computer, with internet access where that is geographically possible.
- Both the engagement of service staff in understanding the importance of supervision, and the development of a routine system of clinical supervision and support comprising regular meetings are needed to enable staff to manage their work and address issues of burnout and conflict.

Site Management

- The system of using registration books for entering client data should be reviewed so that as little paperwork as possible is required of the staff and recording of information is not duplicated.
- Services should begin development of a system of narrative reporting (one that would not overburden already-stretched staff) so that the practices and lessons learned can be captured and so that there is a development of a corporate history of each of the services.

- A system of regular provision of educational resources to each service for the continuing education of staff needs to be established ie listserv facility or a paper-based delivery by hand incorporated into the regular visits by national VCT staff.

Continuation of Program

- There should be a dedicated fulltime position for VCT situated within the Department of Health to ensure that the initiatives in VCT to date are not lost and the current VCT program can be improved and expanded.

Conclusion

In a very short space of time the Care and Counselling Unit of NHASP has achieved considerable success in developing a national system of VCT, including establishment of services, training practitioners, training trainers, writing training manuals, developing national VCT guidelines and establishing a close collaboration between public, FBO and private sectors.

To build on this impressive foundation and to enable rapid expansion of services to achieve targets for coverage, it will be necessary to address the many current constraints and needs, including access to services and access of services to clients, improvement of supply chains, developing and providing continuing education and training of staff, implementing a system of support and supervision for staff, and developing a system of quality assurance.

Appendix 1. References and Documents Reviewed

1. CIA World FactBook. 2006.
https://www.cia.gov/cia/publications/factbook/geos/pp.html

2. European Commission. 2005. Papua Newe Guinea. Country Overview. http://ec.europa.eu/comm/development/body/country/pg/home/pg_home_en.htm

3. Food and Agricultural Organisation of the United Nations (FAO). 1997 http://www.fao.org/DOCREP/W7730E/w7730e0a.htm

4. World Bank 2005. Development Challenges and Plans. siteresources.worldbank.org/INTPAPUANEWGUINEA/Resources/III-Development-Challenges-Plans.pdf

5. U.S. Department of State. 2005. Papua New Guinea. Country Reports on Human Rights Practices http://www.state.gov/g/drl/rls/hrrpt/2005/61623.htm

6. Amnesty International. 2006. Papua New Guinea. Violence against women: Not Inevitable, Never Acceptable. http://www.amnesty.org.au/home/spotlights/papua_new_guinea_violence_against_women_not_inevitable,_never_acceptable!

7. World Health Organisation Western Pacific Regional Office. 2005. Papua New Guinea . Demographics, Gender and Poverty. http://www.wpro.who.int/countries/png/health_situation.htm

8. National AIDS Council Secretariat and Department of Health Papua New Guinea. 2005. Monitoring the Declaration of Commitment on HIV/AIDS. Jan 2004-Dec 2005.

9. Centre for Diseases Control (CDC). 2006. Revised Recommendations for HIV testing of Adults, Adolescents and Pregnant Women in Health –Care Settings. September 22nd.

10. World Health Organisation (WHO) and Joint United Nations Program on AIDS (UNAIDS) 2006. WHO and UNAIDS Secretariat Statement on HIV testing and Counselling. August 14th. Geneva

11. Peck R, Fitzgerald DW, Liautuad B, Deschamps MM,Verdier RI, Beualieu, ME, GrandPierre R, Joseph P, Severe P, Noel F, Wright P, Johnson Jr WD, Pape JW. The feasibility, demand , and effect of integrating primary health services with HIV voluntary counselling and testing : evaluation of a 15-year experience in Haiti. *Journal of Acquired Immune Deficiency Syndrome*. 2003, Vol 33(4):470 - 475.

12. Corbett E, Dauya E, Matambo R, Cheung YB, Makamure B, Bassett M, Chandiwana S, Munyati S, Mason P, Butterworth A, Godfrey –Faussett, Hayes R. 2006. Uptake of Workplace HIV Counselling and testing: A Cluster-Randomised Trail in Zimbabwe. PLoS Medicine. www.plosmedicine.org

13. National AIDS Council Secretariat and Department of Health Papua New Guinea. 2005. National AIDS Council Secretariat and Department of Health HIV/AIDS Quarterly Report. September

14. UNAIDS. 2006. Report on the Global AIDS Epidemic. UNAIDS. Geneva

15. United Nations Children's Fund (UNICEF). 2005. Children and HIV/AIDS in New Guinea.

16. National AIDS Council Secretariat and Department of Health Papua New Guinea. National HIV/AIDS Strategic Plan. 2004-2008.

17. National AIDS Council, Ombudsman Commission PNG, AusAID , 2004. National HIV/AIDS Support Project. HIV/AIDS Management and Prevention ACT 2003. A User's Guide.

18. National AIDS Council Secretariat and Department of Health Papua New Guinea, UNAIDS, USAID. 2004. HIV/AIDS Stakeholder Mapping In Papua New Guinea

19. National HIV/AIDS Support Project (NHASP) 2006. Project Report. Assessment of the Counselling and Care Training Program.

20. Walker S. 2006. NHASP. PNG VCT Situation in May 2006. Powerpoint presentation.

21. UNAIDS 2000. Tools for Evaluating HIV Voluntary Counselling and Testing. Geneva.

22. Family Health International, 2004 Monitoring HIV/AIDS Programs. Module 7 Monitoring VCT. http://www.fhi.org/en/HIVAIDS/pub/guide/meprogramguide.htm

Centre for Diseases Control (CDC). 1987. Perspectives in Disease Prevention and Health Promotion. Public Health Service Guidelines for Counseling and Antibody Testing to Prevent HIV Infection and AIDS. August 14, Vol. 36(31);509-515

Family Health International, 2005. Service Delivery Models for HIV Counseling and Testing. http://www.fhi.org/en/HIVAIDS/pub/fact/ctmodels.htm

Forest Trends Organization. 2006. Logging, Legality and Livelihoods in Papua New Guinea: Synthesis of Official Assessments of the Large-Scale Logging Industry. 2006. http://www.forest-trends.org/resources/press/PNG_3-1-06.htm

National HIV/AIDS Support Project (NHASP) 2005. Annual Monitoring and Evaluation Report for year 5.

Appendix 2.

People and Programs Visited

Date	Program	Program Focus/Mission	Program Activities	Person/s interviewed
14th August	Simon of Cyrene Port Moresby	Order of Franciscans, FBO.	Stand- alone VCT centre with onsite rapid testing Health and nutrition education, referral for medical management Funded through government and Catholic Health services	Fr. Jude
16th August	Louis Vangeke Care Centre, Veifa, Central Province	Order of Daughters of Our Lady of the Sacred Heart. FBO	VCT , education, pastoral work, community health worker training school, home based care Funded through government and Catholic Health services	Sr. Gabriella Monumwese, Matilda Kyekue
17th August	St. Joseph's Care Centre of Hope, Goroka, Eastern Highlands	Order of Daughters of Our Lady of the Sacred Heart, FBO	Stand-alone VCT centre, with onsite rapid testing Funded through government and Catholic Health Services	Sr. Catherine Chinou
17th August	Michael Alpers Clinic, Goroka Base Hospital	Public health facility	STI clinic, prevention detection and treatment of STIs, provision of ART Funded through government	Mr. Timothy Yalo
18th August	Student Health Centre,	Student Health Services	Multi services, health clinic and student education on health	Miss Judy Towandong Miss Gayani Jeyarathan

	University of Goroka		Funded through government and University	
21st August	Shalom Care Centre, Mt. Hagen, Western Highlands	Order of Sisters of Notre Dame, FBO	Multi services, VCT centre, education and training centre, respite care centre, home visiting Funded through government and Catholic Health services	Sr. Rose Bernard
21st August	W.R. Carpenter, Kudjip estate, Coffee Plantation	Private enterprise	HIV awareness raising and workplace interventions, Trained CHWs in national Course on Introduction to HIV and replaced AID post orderlies on plantation with trained CHWs, office staff and workers offered counselling (at Shalom Care centre)	Ms. Betty Kaime Human Resources
22nd August	Tininga Clinic, Mt. Hagen Base Hospital	Public health facility	Provincial STI clinic, VCT, ART education and ART provision Funded through government	Mr Kuni Hunpio, RN. Officer in Charge Ms Thelma Nisoroa, Counsellor, (Anglicare StopAIDS secondment)
23rd August	Baptist union of PNG	FBO	Pastors and , lay congregation and youth leaders, condom distribution through family planning services, trained Baptist women's groups (no men) in home based care	Mr. Michael Pagasa, HIV team manager
23rd August	Kiripia Health Sub-Centre, Kiripia Village	Primary Health Centre financed through provincial	Primary health centre - health post level , pre-test counselling and referral for testing to VCT centre in Mt. Hagen, simple management of	Sr. Anna Koro RN

	Western Highlands	government and Catholic Health Services	HIV- related and other illnesses and referral to provincial hospital for more complex needs, 6-bed inpatient ward for all admissions, MCH and family planning services Funded through government	
24th August	Togoba Health Centre Togoba, Mt. Hagen District	Primary Health Centre FBO (Seventh Day Adventist – ADRA)	Multi-service agency in primary health care, MCH, 15 inpatient beds, health education, family planning, community awareness-raising, mobile clinic, pre-test counselling only, referral for testing, simple management of HIV-related and other illnesses, including TB follow-up, referral to provincial hospital for more complex needs, safe water, hygiene, nutrition and sanitation education, own laboratory - for malaria testing Funded through provincial government and Churches Medical Council	Sr. Lenthy Bito
24th August	Mary Mother of Mercy, Counselling and Care Centre, (known as Rebiamul)	VCT services, FBO	Stand-alone VCT centre (with health clinic run by same order next door) VCT services, pre and post-test counselling rapid testing. Health and nutrition education, referral for medical management, PMTCT, Funded through provincial	Ms. Margaret Herman Sr. Marina Madalpin

	Rebiamul, Mt. Hagen		government and Catholic Health Services	
24th August	Pathology laboratory, Mt. Hagen Base Hospital	Pathology laboratory	Pathology Laboratory , - all pathology services, including rapid testing from STI clinic	Dr. Zure Kombati, Chief of Pathology
28th August	Anglicare StopAIDS Care Centre Boroko, Port Moresby	Multi -service agency, FBO	VCT , continued counselling, family planning, facilities for train-the-trainer and peer education, condom distribution, drop-in centre , respite care and family support to those infected/affected by HIV. Community HIV/AIDS awareness and education activities, Home based care Funded through government and Anglican Church	Mr. Timothy Tony RN Ms. Lydia Seta RN
29th August	National department of Health	Clinical STI Advisor and Surveillance, National Department of Health	Advisory role in National Department of Health	Dr. John Milan
31st August	Sepik Centre of Hope, Wewak , East Sepik	VCT services	Multi-service HIV - VCT onsite services, STIs and OIs- simple management , referral for complex management of illness needs day drop-in centre, respite care on discharge from Boram Hosptial for HIV+ clients, , VCT mobile unit, training centre, provision of other	Five female clients of service – focus group

			needs for clients on site – bus fares, clothing, meals	
31st August	Sepik Centre of Hope, Wewak , East Sepik	VCT services	Multi-service HIV - VCT onsite services, STIs and OIs- simple management , referral for complex management of illness needs day drop-in centre, respite care on discharge from Boram Hosptial for HIV+ clients, , VCT mobile unit, training centre, provision of other needs for clients on site – bus fares, clothing, meals	Ms. Paula Paiiye, Program manager and Counsellor
1st September	Sepik Centre of Hope, Wewak , East Sepik	VCT services	Multi-service HIV - VCT onsite services, STIs and OIs- simple management , referral for complex management of illness needs day drop-in centre, respite care on discharge from Boram Hosptial for HIV+ clients, , VCT mobile unit, training centre, provision of other needs for clients on site – bus fares, clothing, meals	Ms. Joanne Yanim, counsellor Sr. Miriam Ponvros, CHW counselling and testing
1st September	Disease Control Unit, Boram Hospital Wewak , East Sepik	Communicable diseases inpatient management , part of medical unit of hospital	Multi services – HIV, STIs and leprosy, HIV testing, counselling , treatment of OIs, TB treatment	Mr. Gilson Lisa, Health Extension Officer