

Report on the
**Review of ACP and COMATAA
re HIV/AIDS in Papua New Guinea**



inspired by the communities & staff

written up by the Review Team

7 March 2009



Acknowledgements

We, the Review Team, would like to acknowledge those who contributed substantially to the review mission and the preparation of this final document . . . which we hope is not the final event resulting from this Review of ACP and COMATAA in the PNG.

- The communities and the People who inspired and educated us
- The facilitators of ACP and COMATAA who gave us their time and knowledge
- The government and NGO staff at all levels level who informed and guided us
- Jessica of WHO and Regina of Unicef who organized, facilitated and cared for us
- The Representatives and staff of WHO and Unicef who made this happen

We would also like to acknowledge that the mission and this document are judged by us to be constrained due to limitations of time, organization, logistical support and preparation.

Sincerely,

The Review Team of
Rabia Morea
John Kaupa Kamasua
Bobby Zachariah
Uncle Ken Kampe

Peoples' Summary¹

We want good things. We don't want AIDS. We must learn to solve these new problems. We already have knowledge and skills, but interventions like COMATAA on a periodic basis, and follow-up is helpful. It's a good program. This process has helped us to realize our strengths and resources available in the community. We don't really need money, but we need moral support . . . and some material assistance. We need to continue talking and discussing, and some small support for actions. All communities should come together to solve this problem. We the mothers have realized that alcohol consumption and noise have gone down. Therefore, we are happy mothers. Earlier I was totally discriminated by my own family and neighbors due to my HIV status and my profession. But after ACP came, I'm totally accepted and I now earn my income by selling vegetables. Before ACP it was hard to find our youth together for good things like this. A young man living with me now tells me where he is at night. Before ACP he didn't pay attention to me. Now when the youth talk we respect them. We were looking for ways to tackle these things. When ACP came, it helped us to put all of this together. ACP was established and it helped us to make decisions in our life and organize activities. We found it very interesting. One thing I noticed in myself is changing my attitude and thinking. Many nurses would now like to resign from the hospital and work on HIV/AIDS in the communities. We are very much impressed with ACP, because it has helped us realize our potential. Our community is now stronger. We have plans, a five year plan with ACP.

Review Team Summary

During 25 February-5 March 2009, a review of the AIDS Competency [ACP] and Community Mapping and Theatre Against AIDS [COMATAA] programs was conducted, involving 11 communities in 5 provinces and representatives of government agencies and NGOs at community through national levels. The summary results are shown below.

Conclusions

Both **ACP and COMATAA are effective approaches in combating HIV/AIDS** through local empowerment and should be continued and expanded. Consideration should be given to integrating or merging ACP and COMATAA.

ACP and esp. COMATAA are limited by: [a] insufficient follow-up and support; [b] inadequate incorporation into provincial and national plans and budgets; [c] insufficient number and strength of links to government agencies [e.g. education, law & justice] and NGOs/FBOs; [d] too few opportunities for exchange and mutual reinforcement; and [e] constraints on Facilitators [e.g. very limited travel budget, resources].

ACP and COMATAA [less so] are in a good position for expansion and further contributions, including: [a] existing pool of 62 ACP experienced trainers/facilitators; [b] track record and acceptance by a significant number of communities, districts, provinces, government agencies, and NGOs and FBOs; and [c] they directly address needs identified by the Independent Review Group on HIV/AIDS in 2008.

Several issues require further investigation, including:

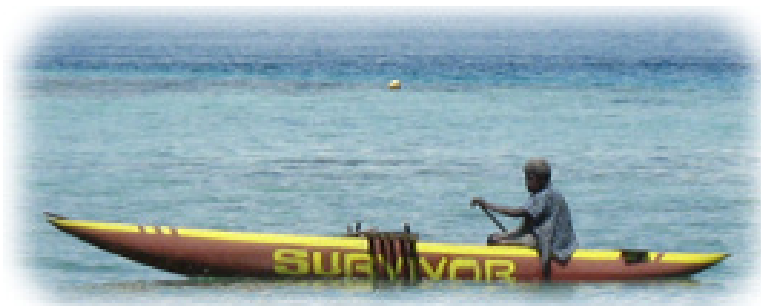
- more comprehensive and in-depth analysis of the nature of the factors limiting ACP/COMATAA
- deeper understanding of the COMATAA processes
- examination and detailing of the methods and resources for supporting ACP/COMATAA, including: staffing, funding, transfer of resources to new sites, and interfacing with government, NGO/FBO, and traditional community responses

¹ Direct quotes from community members.

- conceptualization and outlining of an overall approach and structure for the continuation, expansion, and integration of ACP/COMATAA into the existing and planned government, NGO/FBO, and community responses to HIV/AIDS.

Recommendations

1. Both **ACP and COMATAA** are effective approaches in combating HIV/AIDS through local empowerment and **should be continued and expanded**. Consideration should be given to integrating or merging ACP and COMATAA.
2. The **factors limiting the efficiency and effectiveness of ACP and COMATAA must be addressed**, including:
 - improve and sustain follow-up and support
 - integrate ACP/COMATAA into government systems
 - develop systematic linkages among government agencies, NGOs, and communities
 - increase opportunities for exchange and mutual reinforcement at national and regional levels
 - improve support for Facilitators, and their integration into the national system
 - better define the roles of NACS, PAC, and DAC in supporting ACP/COMATAA
3. **Contract a team to analyze & make specific recommendations** on:
 - the factors limiting the efficiency and effectiveness of ACP and COMATAA
 - options for integrating ACP & COMATAA and other efforts into a larger system
 - draft an overall plan for scaling up ACP/COMATAA
4. **Establish a National Facilitation Team** to effect support and facilitate the further development of community and organizational responses to HIV/AIDS in all provinces.



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Review of ACP and COMATAA re HIV/AIDS in Papua New Guinea

1. Introduction: Background, Objectives, and Methodology

1.1 Background on ACP and COMATAA re HIV/AIDS

Since the global AIDS epidemic began in 1987, Papua New Guinea has implemented various strategies and programmes to slow the spread of HIV/AIDS and mitigate its impacts. However, such efforts have made little impact to reverse the trend. One reason has been insufficient local involvement.

The AIDS Competence Process (ACP) is one community based approach used in Papua New Guinea and other areas to increase self-reliance and respond to HIV/AIDS based on local strengths. It was first introduced in PNG in 2006, and conducted through a local host (NGO) tasked to introduce and scale up the approach in selected communities (settlements) in high HIV prevalence provinces.

Similar to the ACP, Community Mapping and Theatre Against AIDS (COMATAA) is a primary prevention methodology emphasizing community discussion, analysis, ownership and response to HIV/AIDS. COMATAA has been coordinated through Provincial AIDS Councils and implemented by local NGO/CBOS. This training-of-trainers approach was first introduced in 2005 in two provinces, and later expanded to three more – the total includes: Port Moresby, Mount Hagen, Goroka, Lae and Bougainville

We are very much impressed with ACP, because it has helped us realize our potential.
[Sohano mothers]

While the achievements and levels of momentum have been variable and at times disappointing, these approaches appear to contribute significantly to the response to HIV/AIDS. Funding support has come from The UN Humanitarian Trust Fund, implemented in collaboration with WHO and UNICEF. See Annex 1 for the quoted words of the people interviewed.



1.2 The Review

Objectives

1. To analyze each program's strengths and/or weaknesses, which will then inform future strategic program decisions.
2. To identify omissions that may undermine the cooperation, coordination, and communication process within and outside the national response.

Content

Processes:

- project implementation & documentation
- existing & potential program linkages
- community confidence in ACP/COMATAA
- local processes, participation and learning
- 'implementers and facilitators' way of thinking and working
- overall management and efficiency

Results:

- networking and cross-community knowledge sharing
- changes in health, social and other behaviors
- effectiveness of ongoing HIV/AIDS programs
- sense of participation and ownership, and extent of local decision making and activities
- impact on lives and related issues
- sustainability of processes and achievements, e.g. health, social, local empowerment
- overall effectiveness

We have already established a good structure, and it's in place, but we don't get enough support.
[HRC of Buka PAC]

Strengths & weaknesses:

- the common elements of success
- challenges for ACP/COMATAA

The time and place

During 25 February-3 March 2009, a total of 11 communities (8 ACP and 3 COMATAA) were visited in 4 provinces and the NCD:

- NCD: Korobosea [COMATAA], ATS [ACP]
- Mt. Hagen: Walis [ACP], PIS Pond [ACP]
- Goroka: Pis Wara [ACP], Genoka [ACP]; Banana Block [ACP]
- Bougainville: Rumba [COMATAA], Pok Pok [COMATAA], Sohano [ACP]
- Lae: Tent City [ACP], Saw Dust [ACP]

Methodology

1. Desk reviews of ACP and COMATAA documents, community work plans, records, etc.
2. Review & discussion of the review plan among Review Team [RT] and donors, managers, implementers, etc. [Responsible Parties – RPs]
3. Travel to selected communities to learn and observe outcomes and share, etc.
4. Interviews, discussions, consultations, and other participatory processes with implementers, communities, facilitation teams, government officials, etc. to gain understanding
5. Review findings among RT and discuss with RPs
6. Prepare draft & final reports and submit to RPs

Expected outcomes

1. Improved understanding of local situation/s and what's important and/or difficult about ACP and COMATAA, including the overall context and the hearts & minds of the People
2. The responses of communities, key individuals, NGOs/FBOs, government agencies, and responsible UN agencies
3. Conclusions and recommendations regarding implementation of ACP and COMATAA in the existing and future context.
4. . . . and, of course, a readable and informative report
5. Importantly, sharing of this with the People in the communities



2. ACP and COMATAA Processes [as previously documented]

2.1 The AIDS Competence Process [ACP]

The heart & soul of ACP:

- Commodities (money, medicine, manuals, guidelines, condoms, syringes, equipment, structures, systems etc.) are important and necessary. But they cannot replace people, communities, and local partnership.
- The real fight against HIV/AIDS has to be fought at the community where people live, work, and relate to each other.
- Social vaccine = local ownership of the HIV/AIDS problem and response by AIDS-competent people and communities
- AIDS competence needs to spread faster than the virus!

The journey towards AIDS Competence

We are bound by a common vision: a world where AIDS Competence spreads faster than the virus.

Common vision

In an AIDS Competent society, we as people in families, in communities, in organisations and in policy making act from strength

- to acknowledge the reality of HIV and AIDS
- to build our capacity to respond
- to reduce our vulnerability and risk
- to allow everyone to live to their full potential and
- to share our experience with others

People change themselves (you cannot change them)

Progress happens when people own the issue of AIDS. Communities have the capacity to identify opportunities and threats. They do respond, take charge, expand, transfer, learn from each other, care and change.

That capacity, however, remains to be revealed and nurtured. This is what the Constellation does around the world.

Looking for strengths

We stimulate AIDS Competence by looking for peoples' strengths and seeking to learn from their experiences. Our starting point is that we are all human. AIDS concerns us all. We all have something to learn; we all have something to share.

Stimulating and connecting local responses

We stimulate AIDS Competence by looking for peoples' strengths and seeking to learn from their experiences. Our starting point is that we are all human. AIDS concerns us all. We all have something to learn; we all have something to share.

To any network or organisation, the Constellation proposes to stimulate the development of a Facilitation Team.

This Facilitation Team:

- builds on the strengths of the communities the network or organisation works with
- works as a SALT team (S: Stimulate, A: Appreciate, L: Learn, T: Transfer)
- offers a set of tools for these communities to develop their AIDS Competence

Our way-of working: SALT

S stands for Stimulate, Support
A stands for Appreciate, Action
L stands for Learn, Listen
T stands for Transfer, Team

Facilitation Team members **S**timulate further action through their appreciative questions, **S**upport each other in the **A**ppreciation of individual and community strengths, exchange their perspectives about what they have **L**earned from each visit, and prepare to **T**ransfer lessons learned to their own context.

Our tools

Building the dream

What is your dream? The first step for a community towards AIDS Competence is to build a community vision or dream.

Self-assessment

How competent is our community towards HIV/AIDS?

Communities need to discuss HIV/AIDS in order to own the problem. The Self Assessment opens up the dialogue. Communities assess their own strengths, decide on their own actions, and measure their own change.

Measuring change

How do I know I progressed? When our community progresses toward HIV/AIDS, we want to measure this progress.

Sharing lessons learned

How can we share our good practices and learn from others?

The Constellation supports knowledge fairs, joyful learning events where communities exchange lessons learned from experience.

Building new knowledge

What are the common principles to win the battle against HIV/AIDS?

The Constellation offers support to the development of knowledge assets, which summarize common principles for action based on experiences and available resources for those who wish to adapt those principles to their own context.

Assessment of AIDS Competence:

Level 5 [the highest] : Our response to AIDS is part of our daily life. We know our own HIV status and act from strength.

Level 4: We regularly discuss AIDS, and have a common program of action to respond.

Level 3: We publicly recognize that HIV/AIDS is affecting us as a group/community and take occasional action.

Level 2: We know enough about HIV/AIDS to respond when something happens.

Level 1: We know that HIV and AIDS exist.

See the Self-assessment Framework in Annex 2

2.2 Community Mapping And Theatre Against AIDS [COMATAA]

The District Response Initiative [DRI] is implemented through COmmunity Mapping And Theatre Against AIDS [COMATAA], a comprehensive and tailor-made package, process and intervention aimed to involve and empower communities to own and lead the fight against HIV/AIDS, with the following features.

1. Advocacy seminars for political leaders for commitment and support.
2. Advocacy seminar for district leaders for multi-sectoral collaboration, coordination and support to HIV/AIDS programme
3. Capacity building for facilitators of DRI, including: National, District, and Ward Facilitators
4. Mobilization of communities for COMATAA
5. Communities carrying out own situational analysis and development of own plans.
6. Implementation, supervision, monitoring and evaluation of village HIV/AIDS action plan by communities, soliciting support services, coordination and management.

COMATAA is designed to promote AIDS competence at individual, community and district level through empowering communities, and different groups in communities, to assess and analyze their own situations in relation to risks, vulnerability and impact of HIV/AIDS, reach consensus and develop and implement their own VAP.

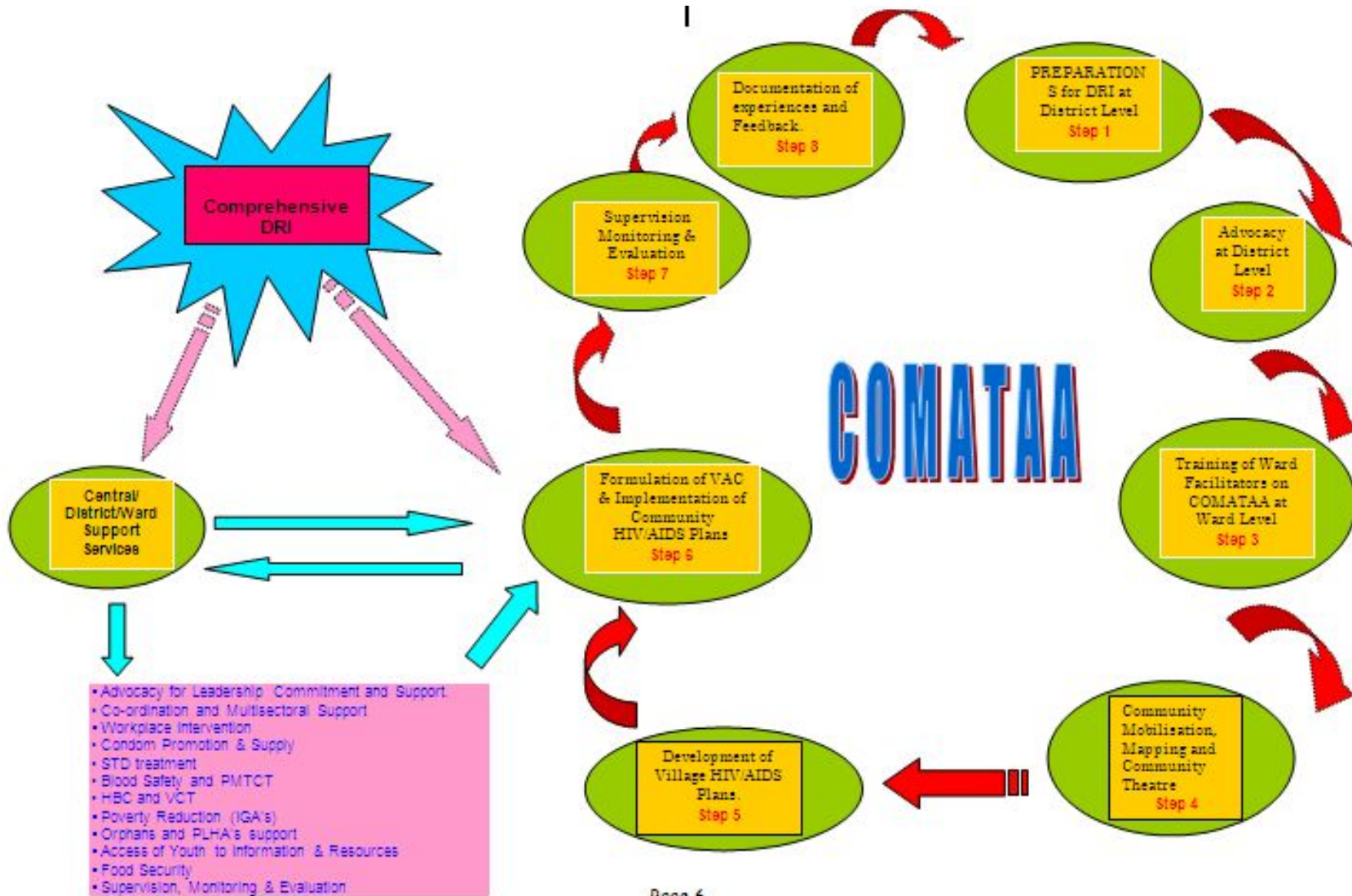
[from COMATAA document]

Key elements of the District Response Initiative include:

- DRI Management, Coordination and Resource Mobilization
- Management Mechanisms which avoid institutional problems
- Coordination system comprising of all stakeholders and partners
- Implementation Mechanisms which intensify the response to HIV/AIDS prevention, control, care and support activities.

See diagram on following page.





3. Findings regarding ACP and COMATAA

Review Team comment on ACP and COMATAA: ACP and COMATAA are similar in many respects. Where ACP embodies an overall philosophy, principles and strategies for working with communities in numerous situations [and HIV/AIDS in particular], COMATAA has built on these to develop methodologies for dealing with specific issues of HIV/AIDS, particularly community mapping and theatre. These philosophies, strategies and working tools are very much in line with the [current and empowering] Participatory Learning & Action [PLA] developed and expanded over the past 20 years.

The ACP and COMATAA approaches to empowerment and action in the face of HIV/AIDS are discussed together under a number of separate but related and often interdependent headings to facilitate analysis of the composite parts. The communities inspired and educated us, and the Review Team recorded this.

Note: Due to the many limitations placed on the Review Team, the findings in this report are indicative, rather than definitive.

A few paragraphs on the review of COMATAA. The Review Team had little success in obtaining documents on COMATAA, including those describing the process, activities, progress, results, context, etc. We expect that such lack of documentation would also make the work of facilitators very difficult in assisting with program implementation. At the same time, discussions and interviews with community members, NGOs and government officials revealed a similar inability to articulate exactly what COMATAA is and how it works. Given this deficiency in basic understanding of the program and its implementation, the Review Team can not make definitive statements about COMATAA. However, on a few occasions it was indicated that COMATAA used awareness, mobilization and empowerment approaches similar to ACP, but no details were forthcoming. Exacerbating this situation is the fact that COMATAA lacked what ACP had – an external organization providing full support in all areas [training, follow-up, documentation, etc.]

On the other side of the coin, it was consistently reported in the three sites visited that COMATAA was appreciated by community members and led to local theatre, even though theatre was no longer being performed as before [although they would like to bring it back]. In two sites, it was reported that theatre was now employed only when critical situations arise. Moreover, it had evolved into the enactment of a brief scene illustrating the situation, followed by community discussion and analysis [see photo at right]. In one case, COMATAA led to the establishment of a pre-school [later discontinued due to lack of funding for teachers wages].

This is about as much as can be said with certainty about COMATAA. The Review Team is not in a position to provide deeper analysis without basic data. Thus, ACP and COMATAA findings will be presented and discussed under each topic area of the Findings.

We only use theater here when critical situations arise. When there is a big fight. We use it to resolve differences.

[William Takikus, Facilitator]



3.1 ACP and COMATAA Processes

3.1.1 Implementation and way of thinking and working

- What happened and how well? ACP and COMATAA were initially well-implemented in all sites visited, but enthusiasm later began to decrease in half of those. Most ACP communities are still active, while most COMATAA are not. Facilitators maintain participatory and positive thinking and actions even when support is lacking.
- Why? The two approaches are good and meet local needs. Consistent support [e.g. follow-up visits, bringing people to together to exchange] resulted in sustained local actions for most ACP sites.



3.1.2 Documentation of processes & results

- What happened and how well? ACP documents are very good and useful. COMATAA appears to have very few supporting documents at all stages; the Review Team had no access to any except the Facilitators Training Manual. ACP has been well documented and included in DoH, PAC, and NSP plans.
- Why? The ACP documentation has been due to the works of supporting organizations and national partners. The reason for the lack of COMATAA documentation was not found.

3.1.3 Existing and potential linkages w/ government, NGOs, FBO's, communities

- What happened and how well? COMATAA has/had some links with government, churches, NGOs, and other communities, but too few. ACP maintains good links with many, with 17 NGOs, 5 PACS, 4 DoHs, 2 clinics and hospitals, and 1 CBO receiving training in ACP. Both would like to expand their links.
- Why? The quality of links has depended on the attention and energy of specific organizations and persons, and their desire to support, deepen contacts and scale up.

3.1.4 Community confidence & acceptance

- What happened and how well? There has been a high level of acceptance of & confidence in for both methods. COMATAA seems to be more interesting to youth.



Before ACP, the emphasis was on PAC and we were confused. We were sitting on the sidelines for quite a while. Now we have decided to take the lead and link up with other partners. It is not possible for us alone to collect all the information. We only need to complement what others are doing. We want everybody's involvement. Before that everyone was doing things on their own. We are the lead agency and must link to others. The community can definitely continue to support these efforts. We are training youth in proposal writing, so they can have the capacity and as an incentive for them. We discourage people just asking for money. They raise some of their own funds through their own work.

[Director, Bougainville Provincial DoH]

- Why? Both are well suited to local cultural adaptation, mobilization, empowerment, vision, planning and action, especially ACP.

3.1.5 Local learning and participation

- What happened and how well? Initial participation and learning was good in both methods [including HIV and other issues], but decreased later for all 3 COMATAA, and 2 of the 8 ACP sites visited. However, it appears that participation and learning can be readily activated in all with external support.
- Why? Both methods are effective in addressing community interests, flexible in different cultures, and based on the promotion of learning leading to action.

3.1.6 Use of ACP and COMATAA to address other life issues

- What happened and how well? Both ACP and COMATAA are much used to address other issues, e.g. alcohol & drug abuse, lack of education, risky sexual & social behaviors, desire for youth activities, hygiene issues, and environmental concerns. All communities learned ways to seek outside assistance in dealing with these areas.
- Why? Both are empowering processes based on culturally appropriate methods of discussion, decision making, planning, and action regarding community issues.

All communities should come together to solve this problem.
[Pok Pok Chief]



3.1.7 Overall management

- What happened and how well? Management of the program in many areas/sites [especially ACP] has been good. In others, [especially COMATAA] the management has been less effective. However, overall management directed at integrating the various organizations involved [e.g. government, NGOs, UN] has not been very systematic. Communities noted that they lacked sufficient training in HIV/AIDS management.
- Why? The quality of management has depended on the organizations and especially the commitment of persons involved, as well as the quality of follow-up and support.

3.1.8 Overall efficiency of the ACP and COMATAA

The participation of People [community members and facilitators] has been the main input in both the ACP and COMATAA processes. For this low-cost but often labor intensive input of resources, the output has been substantial – awareness, empowerment, plans and actions regarding both HIV/AIDS and related social and other issues. Communities have taken ownership and used their own resources, while seeking and accessing additional outside resources & services.

3.2 Results & Impacts:

An overall view of the communities visited shows good initial success, with activity decreasing over time in half of the sites. Expansion to 10 new sites came from 3 communities.

Province/ Town	Site/Community	Initial success	Current activity	Expansion: new sites
NCD	Korobosea – COMATAA	Good	Low	2
	ATS – ACP	Good	High	planned
Lae	Saw Dust – ACP	Good	Low	0
	Tent City - ACP	Good	Low	0
Bougain- ville	Rumba- COMATAA	Good	Low	0
	Pok Pok – COMATAA	Good	Low	0
	Sohano – ACP	Good	High	0
Mt.Hagen	Walis – ACP	Good	High	4
Goroka	Pis Wara – ACP	Good	Medium	0
	Genoka – ACP	Good	High	4
	Banana Block – ACP	Good	High	0
Total	11 sites: 8 ACP, 3 COMATAA	Good	Low-high	10

3.2.1 Community level response to HIV/AIDS

- What happened and how well? All communities have identified and acknowledged risk behaviors and taken preventive measures, e.g. requests for information and documents on HIV/AIDS, changed sexual & social practices, use of condoms, reduced alcohol and drug abuse, cessation of multiple partners, reduced criminality, income generation, improved family communications, and employment seeking [to avoid risk behaviors]. In addition, stigma has been reduced and several communities have adopted community and home-based care for HIV+ persons.
- Why? Attitude and behavior changes due to the ACP and COMATAA experiences, aided by the energy and guidance of local leaders and facilitators. Community members have acquired new competence and status. For example, mothers have increased knowledge of HIV/AIDS and skills in discussing issues with the youth. ACP and functional literacy contributed to youth seeking employment.

ACP was established and it helped us to make decisions in our life and organize activities. We found it very interesting.

3.2.2 Accessing health systems and services (e.g. blood testing, ART & STI)

- What happened and how well? Communities report improved individual health practices [e.g. hygiene, desire for information] and access to more health services [e.g. VCT sites, ART]. However, services are not always readily available or accessible.



- Why? Reduced stigma and increased local acceptance resulting from ACP & COMATAA, aided by the efforts of local leaders and facilitators.

3.2.3 Local networking & sharing

- What happened and how well? Networking & sharing among communities, NGOs/FBOs and government agencies ranges from good to poor; overall, it is better in ACP than COMATAA. In some sites, ACP led to the establishment of local CBOs. Nevertheless, networking with government agencies remains a challenge in some places.
- Why? Community organization skills have been enhanced and/or built, and the desire for mutual support and action, especially on the part of committed individuals.

We have been discussing about a monthly newsletter on AIDS and other issues.

[Pok Pok Community]

3.2.4 Reach and coverage of results & processes

- What happened and how well? Coverage of ACP and COMATAA processes and results in individual communities ranges from approximately 25% to 75%. In some communities, ACP has been transferred to 2-4 new sites.
- Why? The key factors have been time, facilitation/support, concern for people in other communities, interest of nearby communities and energetic and committed individuals.

3.2.5 Ownership of the process and decision making

- What happened and how well? There has been a high degree of local ownership and decision making for both ACP and COMATAA in all communities, generally facilitated by local leaders, women, youth and church groups. There has been active participation by large numbers. Both women and youth have been making increasing input into community decision making.
- Why? ACP makes use of the existing leadership structure and local 'champions' [proponents of ACP and COMATAA]. People now have more confidence in their own decision making. At the same time, the support of churches and motivated volunteers has been important.

I saw the process [ACP] and I took on the process and we developed an action plan. Then we went to three or four new sites. Now we have six sites working with ACP.

Ben, Deputy
Lord Mayor
of Lae City

3.2.6 Sustainability [of the heart, process, and activities], and interface with and support of other programs and organizations

- What happened and how well? The heart and process, but not all activities are sustained in ACP communities; less so for COMATAA. In two PACs, ACP is now included in the provincial health plan. The concepts and the processes of ACP and COMATAA have been adopted by inter-church and other groups, especially women's. However, there is still insufficient interface with other HIV/AIDS efforts. However, in some



places, ACP is now included in LLG or provincial plans. In most sites, support is the key to sustainability.

- Why? An approach based on community needs and strengths in line with the local leadership structure has been important. The ease of adaptation to local culture and conditions, the needs of women and youth, and input of key committed persons, and linkages with VCT, ART and NGOs/FBOs has made the difference.

3.2.7 Overall effectiveness of ACP and COMATAA

ACP and COMATAA both were effective in addressing HIV/AIDS as well as other local issues [e.g. establishment of a pre-school] through local mobilization and empowerment. ACP and COMATAA can be an effective complement to general HIV/AIDS awareness programs. The inherent practicality of the approaches [stimulating action], resulting behavior change, and support of facilitators, leaders and organizations have been instrumental in this effectiveness. ACP appears to be more effective than COMATAA in sustaining community action in the long run. At the same time, in some cases [especially with COMATAA] there is too little support and follow-up from outside.

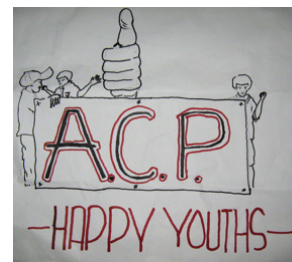
3.3 Strengths & Weaknesses

3.3.1 Common elements of success

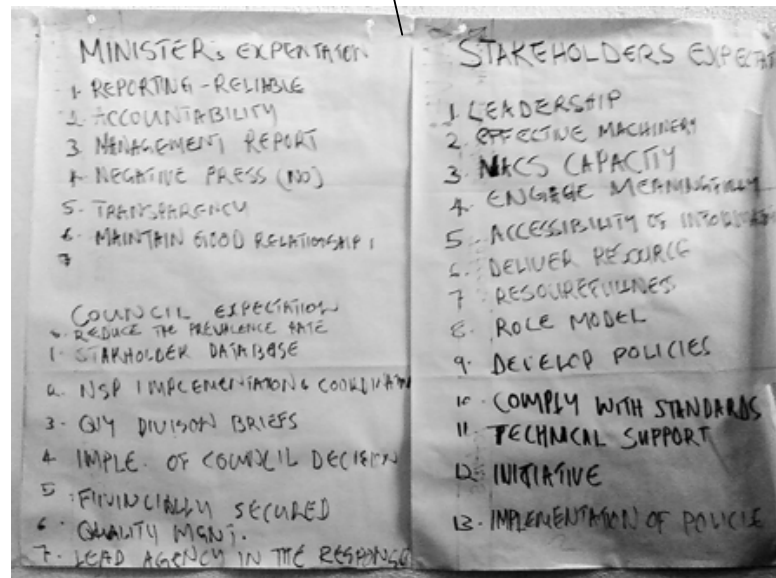
- participatory & empowering nature of ACP and COMATAA
- commitment of local leaders, NGOs & FBOs, and government agencies
- ownership by the community
- strong and continuing facilitation, follow-up & support
- trained country support team
- strong focus on local issues, including HIV/AIDS and others defined by the community

3.3.2 Challenges for ACP & COMATAA

- providing sufficient follow-up and support, particularly for COMATAA, and including small scale resources, staff, travel and visits
- gaining genuine involvement of PACS and PDoHs
- instituting effective programming of activities at district level, and overall management at national level
- identification and retention of key persons involved



These “Expectations” posted outside the NACS show the differences in views among the various levels of persons involved in HIV/AIDS efforts.



ATS/ORO Community ACP Story

ACP process started two years back with a SALT visit. This then progressed on to a 'dream building' followed by use of a 'Self Assessment' tool. This helped the community to see where they stand in their journey to AIDS Competence. The community has prepared a master plan for action for the year 2009-13 called Settlement Rehabilitation and Improvement Plan (SRAIP) with clear Vision, Mission statement and Objectives spelt out.



The women reported how the men in the community have now changed and now regularly attend church. The women are now safe to walk around in the community, even at night, more than 30 people have gone for blood testing, and resources within and outside the community have been identified for future growth. They want to work to remove the fear and stigma towards HIV positive people. They are eager to transfer their experiences to nearby communities.

The community noted the following reasons for success: regular follow-up by the Salvation Army and the Constellation team, awareness of strengths based on the ACP process, connection with key services like VCT, ART center, hospital, etc.

4. Conclusions and Recommendations

Important note: These conclusions are derived from the communities. They were grouped and supplemented by the Review Team.

4.1 Conclusions

- 1) Both **ACP and COMATAA are effective approaches in combating HIV/AIDS** through local empowerment and should be continued and expanded. Consideration should be given to integrating or merging ACP and COMATAA.
- 2) **ACP and COMATAA are limited by:** [a] insufficient follow-up and support; [b] inadequate incorporation into LLG, provincial and national plans and budgets; [c] insufficient number and strength of links to government agencies [e.g. education, law and justice] and NGOs/FBOs; [d] too few opportunities for exchange and mutual reinforcement; and [e] constraints on Facilitators [e.g. limited travel budget, resources].
- 3) **ACP and COMATAA [less so] are in a good position for expansion** and further contributions, including: [a] existing pool of 62 ACP experienced trainers/facilitators; [b] track record and acceptance by a significant number of communities, districts, provinces, government agencies, and NGOs and FBOs; and [c] they directly address needs identified by the Independent Review Group on HIV/AIDS in 2008 – Focus Area 6: Family and Community Support. See Annex 3.
- 4) **Several issues were beyond the scope of the Review Team and require further investigation:**
 - more comprehensive and in-depth analysis of the nature of the factors limiting ACP/COMATAA
 - deeper understanding of the COMATAA processes
 - examination and detailing of the methods and resources for supporting ACP/COMATAA, including: staffing, funding, phased scaling up to new sites, and interfacing with government, NGO/FBO, and traditional community responses
 - conceptualization and outlining of an overall approach and structure for the continuation, expansion, and integration of ACP/COMATAA into the existing and planned government, NGO/FBO, and community responses to HIV/AIDS.

Note: In both the Conclusions and Recommendations that follow, we must recognize and plan for the institutional limitations placed on government agencies and bodies such as PAC, e.g. slow response and start-up times, difficulty in implementing the variety of approaches required to meet individual community needs and contexts, problems in budget allocation and disbursement. In light of this, greater authority and flexibility must be given to the PACs, including their ability to coordinate and facilitate the work of NGOs, FBOs, and CBOs. This should include methodologies to reduce the “fixation on funding” to the detriment of local initiative.



4.2 What next?

Hmmm . . . this is both easy and tough. Easy to offer simplistic ideas and tough to propose practical recommendations which fit both the resources and constraints placed on the people who will take action, e.g. the inherent bureaucracy of governments and international organizations, the lifestyles and resources of the communities. Well, let's give it a try.

4.2.1 Recommendations

Maintain your support and consider . . .

1. Both **ACP and COMATAA** are effective approaches in combating HIV/AIDS through local empowerment and **should be continued and expanded**. Consideration should be given to integrating or merging ACP and COMATAA.

We recommend that UNICEF/WHO meet with NACS to discuss this and make decisions on:

- *Introduction and transfer of ACP/COMATAA to all provinces by 2010.*
- *Involvement of national ACP coaches in this discussion and planning to find ways how this can be done*
- *Allocation of funding for this program for a period of two years*
- *Overall management of the programs, including reporting and monitoring guidelines*
- *Involvement and coordination of NGOs/FBOs and communities [See list of potential NGO partners in Annex 4]*
- *An annual evaluation at the end of years one and two to learn from the implementation, address challenges and discuss ways forward*
- *Documentation of the basic ACP/COMATAA approaches, processes, implementation progress, monitoring & evaluation, and lessons learned*

2. The **factors limiting the efficiency and effectiveness of ACP and COMATAA must be addressed**, including:

- improve and sustain follow-up and support to communities and NGO's implementing the programme, e.g. more frequent monitoring, small scale funds [travel, seed money]

We recommend that a budget be made available to every PAC through NACS to support the ACP/COMATAA Facilitators and program implementation via partners.

- integrate ACP/COMATAA into district, provincial and national systems, with supporting structures

We recommend that this be done in a flexible manner, decentralizing decision making and budget allocation authority to PAC, DAC, partners and community levels in accordance with jointly developed guidelines.

- develop more systematic linkages and networks among government agencies [e.g. education, health, community



development], NGOs, FBOs, and communities [e.g. inter-community exchanges, visits and training].

We recommend that NACS and PACs work closely with these departments to find ways of fulfilling the needs expressed by the communities to comprehensively address the existing and projected HIV/AIDS situations.

- increase opportunities for exchange and mutual reinforcement at national and regional levels, e.g. workshops, seminars, knowledge fairs, newsletter.

We recommend that the PACs create opportunities for sharing between the communities, NGOs and the related departments by bringing them together once quarterly to share ideas, learn, formulate further action plans, document the progress and iron out difficulties.

- better support for Facilitators, and their integration into the national HIV/AIDS prevention, treatment & care system.
- more clearly define the roles of NACS, PAC, and DAC in supporting and strengthening ACP/COMATAA

We recommend that this be included in the TOR for the team proposed under recommendation 3 below.

3. Contract a team of national consultants and key representatives of ACP, COMATAA, government, NGOs/FBOs and communities **to analyze & make specific recommendations** on:

- the factors limiting the efficiency and effectiveness of ACP and COMATAA, and ways to integrate these into the national response
- options for integrating ACP & COMATAA and other efforts into a larger yet flexible system under the auspices of the government, including responsible parties at various levels
- draft an overall plan for scaling up on a national level in coordination with other efforts. This plan should include clear definition of the roles of NACS, PAC, and DAC in supporting and strengthening ACP/COMATAA, training and upgrading requirements for the program staff for the next five years, mechanisms for the coordination of implementing partners and communities, outline of the methods of integrating and funding ACP/COMATAA for the next five years.
- Propose a system for monitoring and evaluation, which involves all parties at all levels, including the identifications of quantitative and qualitative indicators of progress and outcomes, e.g. behavior change, access to services, care for HIV+ persons, planning and implementation of local initiatives.

We recommend that NACS and WHO/Unicef further elaborate the TOR and contract the team within the next 3 months.

4. Establish a National Facilitation Team (NFT) to provide support and facilitate the further development of community and organizational responses to HIV/AIDS in all provinces. This team would provide on-site mentoring, assist in addressing local challenges, facilitate local planning, provide local feedback to provincial and national levels, and help to connect the various players involved. This team should include

'champions' from: communities and CBOs [including HIV+ persons], NGOs and FBOs, and concerned government agencies.

We recommend that the PNG ACP National facilitators be consulted and review the following documents: "Zambia National Facilitation Team: A case study of a human capacity development initiative" by Alison Rader, et al, and "A Short Note on HIV/AIDS Competence" by the Salvation Army. At present, The Constellation for AIDS Competence is in the process of preparing a document outlining the process and guidelines for rolling out NFT's in countries that are interested to do so. When available, this document should be reviewed as well.

We can't wait to find the best model. If something is working, like ACP, we should go with it. Lives are being lost.



Annexes

1. Quotes from the People
2. Self Assessment Framework for AIDS Competence
3. Excerpts From the Independent Review Group on HIV/AIDS, Aug-Sep 2008
4. Current and Potential NGO partners in HIV/AIDS

Quotes from the People in the Communities

Korobosea, NCD - COMATAA

- *The church is ready to host a school, but we need some assistance* [Pastor]

Rumba Community - COMATAA

- *We only use theater here when critical situations arise. When there is a big fight. We use it to resolve differences.* [William, Facilitator]
- *The government doesn't help. The only help comes from Unicef . . . and that is very little . . . only for travel.* [William]
- *We already have knowledge and skills, but interventions like COMATAA on a periodic basis, and follow-up is helpful.* [Village Chief]
- *Let's assume we're all HIV+; then we can go [to the clinic] and check and see that we're negative.* [William]
- [Speaking about COMATAA] *It's a good program.* [Village Chief]
- *If you're throwing away COMATAA, then keep the COM.* [William]

Pok Pok Community - COMATAA

- *The water has been rising more every year. At high tide it now comes into the community.* [Village Chief]
- [Speaking about HIV/AIDS] *All communities should come together to solve this problem.* [Village Chief]
- *The missionaries tamed us.* [Village Chief]
- *We want good things. We don't want AIDS.* [Village Chief]
- *White men have created the problems, and white men must solve them.* [Community member]
- *We must learn to solve these new problems.* [Village Chief]
- *We need support, because this deadly virus comes from outside.* [Village Chief]
- *We don't really need money, but we need moral support . . . and some material assistance.* [Pastor]
- *We need to continue talking and discussing, and some small support for actions.* [Pastor]
- *We have been discussing about a monthly newsletter on AIDS and other issues.* [Community member]

Dept. of Health, Bougainville

- *We work with our development partners. Only through this partnership . . . can we see the way forward.* [Director, DoH]
- *If you don't work together with partners, you are doomed.* [Director, DoH]
- *If we don't deal with these issues [e.g. confidentiality] , we can drive people away.* [Director, DoH]
- *Roselyn [the facilitator] is impressive.* [Director, DoH]
- *We see ACP as the way forward. There is no other way out. We have conducted community engagement, SALT visits.* [Director, DoH]
- *Youths came and approached us [about ACP] . . . about 22-26 youths every night.* [Director, DoH]
- *Capacity building is very important. Then they can take ownership and stand alone. The only way people can take ownership is by ACP.* [Director, DoH]
- *Without ACP . . . that is the missing link.* [Director, DoH]
- *Before ACP, the emphasis was on PAC and we were confused. We were sitting on the sidelines for quite a while. Now we have decided to take the lead and link up with other partners. It is not possible for us alone to collect all the information. We only need to complement what others are doing. We want everybody's involvement. Before that everyone was doing things on their own. We are the lead agency and must link to others.*

The community can definitely continue to support these efforts. We are training in proposal writing, so they can have the capacity and as an incentive for them. We discourage people just asking for money. They raise some of their own funds through their own work.

[Director, DoH]

- *Awareness is just the leaves and flowers of the tree.* [Roselyn]
- *If you have the resource people, no problem.* [Director, DoH]
- *There is a very bad precedent in paying the people in the communities to do things.* [Director, DoH]
- *ACP must come before ART.* [Director, DoH]

Sohano Community - ACP

- *We the mothers have realized that alcohol consumption and noise have gone down. Therefore, we are happy mothers. Before ACP it was hard to find our youth together for good things like this.* [Mother]
- *We were looking for ways to tackle these things. When ACP came, it helped us to put all of this together.* [Mother]
- *ACP was established and it helped us to make decisions in our life and organize activities. We found it very interesting. One thing I noticed in myself is changing my attitude and thinking.* [Youth]
- *A young man living with me now tells me where he is at night. Before ACP he didn't pay attention to me. Now when the youth talk we respect them.* [Mother]
- *Many nurses would now like to resign from the hospital and work on HIV/AIDS in the communities.* [Mother]
- *We are very much impressed with ACP, because it has helped us realize our potential.* [Mother]

Bougainville Provincial AIDS Council

- *Both [ACP and COMATAA] can be sustained, but it depends on us.* [Chief of PAC]
- *COMATAA depends on the facilitators. Last year in Arawa we had plans but no action.* [Chief of PAC]
- *We don't have a clear picture of COMATAA.* [Chief of PAC]
- *We have already established a good structure, and it's in place, but we don't get enough support.* [Chief of PAC]
- *We need DACs. They can support ACP and other efforts.* [Chief of PAC]

Lae Provincial AIDS Council

- *We are left in the dark . As the coordinating committee, we need to know.* [Provincial Coordinator for HIV/AIDS]
- *ACP and partners said they would support us, but they have not. We need shared responsibility.* [Provincial Coordinator for HIV/AIDS]
- *We want to replicate to other sites in the province.* [Provincial Coordinator for HIV/AIDS]
- *I saw the process [ACP] and I took on the process and we developed an action plan. Then we went to three or four new sites. Now we have six sites working with ACP.* [Deputy Lord Mayor of Lae]
- *Sometimes we find difficulties. We find funding support most difficult . . . if ACP is to continue. The Salvation Army will help with literacy programs. We created a DAC.* [Deputy Lord Mayor of Lae]
- *I don't see any leaders in the city coming up to talk to the people or come down to the communities. HIV/AIDS is killing our people.* [Deputy Lord Mayor of Lae]
- *One week after the [ACP] training we started a program, before forgetting what we learned. We stopped in Four Mile Community, because the focal person was no longer cooperative . . . local leaders have their own expectations and want to get something.* [Facilitator]
- *We love ourself. We love other people. Very few people are doing this. AIDS is here to stay.* [Facilitator]
- *Communities "know" that if outsiders are coming about HIV/AIDS, they are coming with money.* [Provincial Coordinator for HIV/AIDS]

- *We try to guide the conversation away from money to the risk and community strengths. Then they start to realize . . . and that there are trained people in the community who can use their knowledge and we can build on this. [Facilitator]*
- *In implementing ACP, we put in some of our own ideas . . . to be creative. When we're doing ACP it's like we're taking it into people's minds. [Facilitator]*
- *The people come to me as a respected leader. They come with their hearts, not because of AIDS. Then I can introduce HIV/AIDS. They change their attitudes. [Deputy Lord Mayor of Lae]*
- *Many women don't know where to get help. [Facilitator]*
- *Currently we're not able to link up all organizations. For example, Anglicare. But we are trying to do this. [Deputy Lord Mayor of Lae]*
- *We ask other NGOs to come to our sites, but they have other commitments. [Facilitator]*
- *Now HIV/AIDS is a compulsory subject in the schools. We're trying to get them [the students] to establish clubs and integrate with theater, art and other activities. [Provincial Coordinator for HIV/AIDS]*
- *We'd like to have an MoU with WHO, Unicef and Department of Health. We need more opportunities to go to Port Moresby and talk to the big people. We need a workshop to share ideas among us and with others. Funding is a terrific problem. [Provincial Coordinator for HIV/AIDS]*

Tent City Community - ACP

- *Our community is now stronger. We have plans, a five year plan with ACP. It is OK for the facilitator to move on to other communities. [Local leader]*

Presentation of results to stakeholders at DoH

- *One question I have is how do we follow-up on the presentation today?*
- *We can't wait to find the best model. If something is working, like ACP, we should go with it. Lives are being lost.*
- *The presentation was testimonial, not concrete.*
- *We need some behavioral change indicators to measure.*
- *The presentation was very good. It shows how we need to focus more on the communities and put our resources there.*
- *There should be a home for ACP and COMATAA.*

Self Assessment Framework for AIDS Competence

	1 We are aware of the issue	2 We react	3 We act	4 Our performance is satisfying	5 The practice is part of our life-style
1.Acknowledgement and Recognition	We know that HIV and AIDS exist	We know enough about HIV/AIDS in order to respond	We publicly recognise that HIV/AIDS is affecting us as a group/ community	We regularly discuss AIDS, and have a common program of action to respond	Our response to AIDS is part of our daily life. We know our own status and act from strength.
2.Inclusion	We know that some of our families are particularly infected and/or affected	We understand the necessity to include in our response persons and families that are particularly affected	We occasionally include in our response people particularly affected by HIV/AIDS.	Affected persons are systematically involved in all stages of our response	Affected persons and families actively take part in all aspects of society
3.Linking Care with Prevention	We have the basic knowledge for prevention and care	We understand the link between care and prevention	Some of our actions link care with prevention	As a community we systematically link care and prevention activities	Care strengthens our relations and helps us change
4.Access to Treatment	We are aware of the existence of ARVs	We know where and how to access ARVs	ARVs are available for some of us who need them	Some of us are using ARVs	All those in need of ARV drugs are using them effectively
5.Identify and address vulnerability	We understand the concept and are aware of general factors of vulnerability	We have identified our own factors of vulnerability to HIV	Our response includes some specific actions to address our own vulnerability to HIV	We systematically address our own factors of vulnerability	Our actions to address vulnerability to HIV strengthens us in addressing other challenges
6.Learning and transfer	We appreciate the need to learn	We adopt good practice from outside.	We sometimes exchange our view points to draw lessons from our actions	We learn, share and apply what we learn regularly, and seek people with relevant experience to help us.	We continuously learn how we can respond better to HIV/AIDS and share our experiences with others
7.Measuring change	We recognise the need to measure change	We know how to measure change	We occasionally measure our own group's change	We measure our change continuously and can demonstrate measurable improvement.	We invite others to share our experience of change
8.Adapting our Response	We adapt our response following external interventions	We recognise that we need to adapt our response to our results, to lessons learned from others and to scientific progress	We can provide examples of adaptation of our response	We regularly take stock to adapt our response	We see implications for the future and adapt to meet them.
9.Ways of working	We are aware that Aids challenges our ways of working	We seek to mobilise our own strengths	We work as teams to mobilise our own strengths, assess our progress and resolve problems as we recognise them.	We find our own solutions and access advice from others	We systematically seek to improve our ways of working and share our experience with others
10.Mobilising resources	We realise the importance of mobilising our resources	We wait what others avail to us to realise the actions they determine	We take some initiatives based on our own resources	We identify possible sources of support to complement our own strengths	We use our own resources, access other resources to achieve more and have planned for the future.

Annex 3

Excerpts From the Independent Review Group on HIV/AIDS, Aug-Sep 2008

To date , two IRG priorities have been identified within this Focus Area [Family and Community Support]: (i) identifying, strengthening and supporting groups of people living with HIV in each province to run an empowered network; and (ii) meeting of stakeholders with front line experiences of engaging families and communities to share experiences and results and develop appropriate approaches for PNG.

Assessment of progress . . . a national network of organizations of people living with HIV does not yet exist. Igat Hope has . . . not been able to sustain communication or provide continuing support. People living with HIV are . . . rarely otherwise involved in HIV prevention and care. Those who are involved are generally expected to do so as volunteers

Community mobilization . . . activities are limited in scale . . . sharing between activities in search of a PNG model has yet to occur.

. . . teacher training programmes . . . have embraced the NDoE HIV curriculum Translating this educational effort to real support in the community through linkages to PACs, churches, care centres and VCT sites has yet to be accomplished.

The provincial response varies widely. . . . complex geography, lack of road links and limited travel budgets mean that large area of some provinces are devoid of community programmes and services

Future planning *The year 2009 Development Plan Budget includes the following action items in this focus area . . . support for community mobilization, support to NGOs, support in the use of media for development*

A continuing gap in this Focus Area concerns efforts to promote the forms of community solidarity and support that will encourage people to know their HIV status and receive treatment and care.

There should be a clear focus on strengthening grassroots organizations and establishing meaningful partnerships between these organizations, PACs, and counseling and testing and ART sites.

Current and Potential NGO Partners in HIV/AIDS

Following is a list of the 26 current and potential NGO/FBO partners as proposed during interviews and discussions in the field:

ADRA
Anglican Church
Anglicare
Baptist Union
CARE International
Caritas
Catholic AIDS Diocese
Catholic women association
Church of Nazarene
City Mission
Constellation
Council of Elders
ECPNG
Faith Fellowship church
Family Health International [FHI]
Friends Foundation Inc. [FFI]
Hope Worldwide
Igat Hope
National Volunteer Service
Red Cross
Salvation Army
Save the Children
Seventh Day Adventist
St Josephs clinic
Tingim Laip
United Church