



napwha national association of
people with HIV australia

Developing peer services for people with HIV in Papua New Guinea

DECEMBER 2025

Acknowledgement

We pay respect to all Aboriginal and Torres Strait Islander people and recognise their cultural, spiritual, and educational practices, their ongoing connection to Lands, Waters, and Communities, and that sovereignty was never ceded.



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DEVELOPING PEER SERVICES FOR PEOPLE WITH HIV IN PAPUA NEW GUINEA

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Preface

This documentation project, supported by the Fred Gordin INSIGHT Memorial Fund, describes the development of Papua New Guinea's HIV peer counsellor network, together with insights on the work peer counsellors do. Peer counsellors are also called 'expert patient counsellors' or 'peer educators', and are regarded as an important part of the country's response to the HIV epidemic.

The document has been produced for partner organisations operating in Papua New Guinea (PNG), so that there might be a chance to further understand the potential of peer counselling supports in the management of HIV. For organisations in other countries who might wish to support the efforts in PNG, this document provides insights into the inputs and efforts required to establish and maintain a network of peer counsellors who work within clinical settings.

Peer counsellors, peer treatment supporters and peer navigators have been used in many other countries, including Australia, Canada and several African countries. The report reflects on that information and the ways in which the concept has been used and developed in those different contexts. Included is a review of international literature on peer support programs, and the provision of updated information on the HIV/AIDS epidemic in PNG. The document provides guidance on the training needs of the peer counsellors and highlights many of the barriers to accessing and adhering to antiretroviral therapies (ART).

The project team recognises that peer counsellors are not the sole answer to managing the HIV epidemic. However, given the extent of the epidemic in PNG, they are an essential part of the response. Peer service delivery occurs within a fragmented health care system in which there are insufficient numbers of trained doctors, nurses and health care workers, and in which access to health facilities is difficult, complicated by the country's extreme geography and lack of infrastructure.

The intention is for this document to be a valuable global resource that can provide insights into what has happened in the PNG context, together with the hope that the information can be used in other countries where a peer support model has also been trialled, and possibly evaluated.

In order to gain an up to date understanding of peer work in PNG in 2025, the project team consulted six currently working peer counsellors (anonymity protected) and their experiences are presented as case studies in the Appendix to this report. The case studies speak directly to the ways in which HIV peer support occurs in PNG, and provide insights into the complexities of the work undertaken by these amazing people. The project team is deeply grateful to 'Tau', 'Rhonda', 'Pialga', 'Yang', 'Nathaniel' and 'Thomas' for their contributions to this report.

On behalf of the National Association of People living with HIV Australia, in support of the important advocacy organisation IGAT Hope in PNG, and in honour of the globally important reach and work of the late Fred Gordin, we are happy to provide this report to you, dear reader.

Dr John Rule, December 2025

Key Points Summary



HIV/AIDS is a public health problem in PNG

The most recent surveillance data on HIV in Papua New Guinea (PNG) show that the estimated number of new infections has doubled since 2010. There are approximately 30 new infections occurring every day, amounting to an estimated 11,000 new cases in 2024. In June 2025, the PNG Minister for Health, the Hon. Elias Kapavore, declared HIV to be a national crisis.



Many people with HIV are also dealing with TB

HIV/AIDS and tuberculosis, also occurring as a coinfection, are the leading causes of death from infectious diseases in PNG. The data show that people in the country are dying from TB and HIV/AIDS at young ages.



The impacts are serious

Since HIV/AIDS primarily affects individuals in their most productive years, there has been a significant loss of income for affected families and communities. The epidemic has contributed to a reduction in the overall productivity of the workforce, and hindered economic development. The epidemic has also overwhelmed a health care system already constrained by limited resources, insufficient infrastructure and a shortage of trained healthcare workers.



Living with HIV affects all aspects of people's lives

People with HIV suffer social stigmatisation and discrimination and are the target of gossip, harassment and assault, as well as exclusion from family, social and religious gatherings. Their financial wellbeing, physical and mental health, and personal safety are impacted, and many experience homelessness. These and other factors can hinder people from managing HIV infection through the regular taking of antiretroviral medications (ART).



The barriers to ART initiation and adherence are plentiful, and may overlap

Individual factors (e.g. feeling healthy, denying the HIV diagnosis), interpersonal factors (e.g. experiences of stigma and discrimination) and institutional factors (e.g. challenges in providing HIV testing, treatment and care services) can inhibit ART initiation and adherence. Some people with HIV experience simultaneous barriers at multiple levels.



There is evidence that peer support can promote ART adherence

Research shows that peer counsellors can strengthen the healthcare workforce and help existing services to achieve positive health outcomes, especially with respect to sustained ART adherence. Compared to people with HIV not receiving peer support, those receiving peer support experience greater long-term retention in care, improved ART adherence, reduced risk of virologic failure, and better viral suppression.



Peer counsellors in PNG strive to achieve positive outcomes

Outcomes include retaining clients in care; seeing clients achieve greater levels of confidence and self-worth; improvements to their own ways of working, including listening more and talking less; contributing to the reduction of fear and stigma in clinical settings; developing stronger community links; and bringing people with HIV together, including through group work.



Peer counsellors in PNG undertake a variety of tasks to achieve positive outcomes

Key areas of work include problem-solving e.g. managing treatment interruptions; counselling e.g. addressing self-stigma in a variety of ways, including focusing on self-worth; outreach and tracking, including working collaboratively with partners in the health care system; and guiding those on ART, including reinforcing the importance of continuing with treatment even when feeling well.



Peer counsellors in PNG make use of a wide range of skills

Essential skills identified by peer counsellors to achieve desired outcomes include using the self as an example of someone living successfully with HIV; strong communication skills, including the ability to build trust and rapport with clients; explaining things in ways that clients can understand; the ability to display empathy, patience and a non-judgmental approach; and cultivating resilience in the face of challenges.



Peer counsellor training and mentoring improves practice

Peer counsellors in PNG express strong support for ongoing learning and skills development in areas such as mental health, advanced counselling techniques, public speaking and community education. The literature confirms that training and mentoring improves peer service delivery.

Background to the project



Objective and focus

In 2024, the Fred Gordin INSIGHT Memorial Fund Project provided funding to the National Association of People with HIV Australia (NAPWHA) to document the situation facing people with HIV in PNG. The focus would be on people's access to antiretroviral therapy (ART) and to better understanding and addressing barriers to ART adherence and retention in the country's HIV treatment and care programs.

The aim was to highlight the work of Igat Hope Incorporated (IHI), the peak body for people living with HIV in PNG, which has been supported by NAPWHA. In particular, the project focuses on the Expert Patient Counsellors (EPC) initiative, which has recruited, trained and supported people with HIV to carry out health clinic-based counselling and support to patients in collaboration with healthcare workers.

Organisations involved

Established in 2003, IHI is a member-based organisation that was consolidated in 2010 when a new constitution was adopted. IHI has a nationally elected board, with members' roles, responsibilities, and terms outlined in the constitution.

NAPWHA is Australia's peak non-government organisation representing community-based groups of people living with HIV. It has a membership of national networks and state-based organisations, reflecting the diverse make-up of Australia's HIV-positive community.

Collaboration for Health in PNG (CHPNG)

Since 2003, NAPWHA has partnered with Igat Hope to establish and strengthen the capacity of a national, viable and incorporated association to represent people living with HIV throughout PNG (NAPWHA 2020). With the support of NAPWHA, IHI established 22 regional networks of people with HIV at the provincial level. The regional network members are part of the broader IHI membership.

The Collaboration for Health in PNG (CHPNG) was a partnership among PNG government agencies, PNG health services, Igat Hope and Australian NGO agencies. The CHPNG was supported through pharma industry philanthropic donations and wound up its operations in 2025. In partnership with Igat Hope, NAPWHA has contributed to capacity building through community health training, clinical mentorship, advocacy and governance support (NAPWHA 2020). One of the joint projects within CHPNG was the Expert Patient Counsellors (EPC) initiative.

¹ These include Heduru Clinic, Lawes Road Clinic, 9 Mile Urban Clinic, St Therese ART Clinic and Anglicare Clinic



Expert Patient Counsellors (EPC) initiative

Within the context of PNG's response to HIV, there was deemed to be value in building HIV peer capacity to enhance and support the healthcare workforce and to complement the training of health professionals in HIV management (Rule et al 2021). A formal role was created for people living with HIV, namely the opportunity to work as peer counsellors and educators.

In essence, this has meant that people with HIV have been engaged as paid staff in clinical settings, and, as of 2021, 48 peer counsellors and educators were in this role (Rule et al 2021). Igat Hope Peer Counsellors have been trained and placed in clinics in the National Capital District¹, Morobe, Eastern Highlands Province, Western Highlands Province, Jiwaka, Enga, Simbu and Madang Provinces.

Participants in a 'train the trainer' workshop for HIV peer counsellors held in Goroka (Eastern Highlands) in 2019 identified the following as the key roles of Igat Hope Peer Counsellors:

- Problem-solving with those who have been diagnosed with HIV.
- Listening, being a friend, and educating when required.
- Outreach work, especially for those who have been lost to follow up.
- Tracking those who have been lost to follow up.
- Guiding those who are on ART and encouraging them to continue taking their medications (NAPWHA 2019).

These insights into the work of peer counsellors provided a framework for exploring what they did in their daily activities. Interviews conducted by the project team with six of these counsellors in four PNG clinics in 2025. The qualitative data derived from these interviews are discussed as case studies (see Appendix) and key insights are extrapolated and discussed in the body of this report.

HIV in Papua New Guinea

Key data

Papua New Guinea has the most serious HIV burden of the 22 Pacific island countries (WHO 2017; Island Times 2017). Despite attempts and programs to address the issue, rates of infection have trended upward, rather than downward. PNG is not alone in this – Fiji for example, is experiencing the ‘fastest-growing HIV epidemic in the Pacific’, with 1,500 new cases reported in 2024, compared to 415 the year before (Burnet Institute 2025a).

Data from UNAIDS showed that there was a 45 per cent increase in HIV infections in PNG from 2010 to 2021, and that a majority of the new cases are among women in the general population (Pederick 2022). While the epidemic is ‘generalised’ in the sense that the virus has spread widely among the general population (Katu 2024), there are also high rates of infection among marginalised and stigmatised groups, in particular female sex workers, men who have sex with men, and transgender women (Mitchell et al 2021).

Current data on HIV prevalence in PNG are drawn from the 2024 report from UNAIDS (2025) and are summarised in Table 1. The statistics are presented as best estimates (due to the limitations of current surveillance mechanisms), together with the estimated range within each category:

Table 1: HIV prevalence in PNG based on 2024 data

HIV in PNG: 2024 data	Best estimate	Estimated range
Total number of people with HIV infection	120,000	110,000 - 140,000
Adults aged 15 and over with HIV	100,000	93,000 - 120,000
Women aged 15 and over with HIV	64,000	57,000 - 74,000
Men aged 15 and over with HIV	39,000	35,000 - 46,000
Children aged 0 to 14 living with HIV	15,000	12,000 – 17,000
Adults and children newly infected with HIV	11,000	9,400 – 14,000

Source: UNAIDS (2025)

According to the statistics presented in Table 1, an estimated 120,000 people have been infected with HIV in PNG as of 2024, but this number could be as low as 110,000 or as high as 140,000. The figures show that there were 11,000 new HIV infections in 2024, but also that the number could be anywhere from 9,400 to 14,000. Data collection, data reporting and data collation systems are in place, but face major constraints in PNG context; these constraints need to be understood when looking at these figures.

Other key data include (UNAIDS 2025):

- The HIV incidence per 1,000 people of all ages is 1.1, with a range from 0.9 to 1.3
- There were 3,400 adult and child deaths due to AIDS, with a range from 2,900 to 4,200
- The estimated number of people who know their status is 70,000 (59% of estimated total number of people with HIV in PNG)

- The number of people with HIV who are on ART is 5,000 (46% of estimated total)
- The percent change in new HIV infections since 2020 is 84%
- The percent change in AIDS-related deaths since 2020 is 35%
- The total number of people receiving pre-exposure prophylaxis (PrEP) is 604.

These figures indicate that less than half (46%) of all people with HIV are on ART, and that uptake of PrEP is low. Worryingly, there has continued to be a high HIV/AIDS mortality rate, with a 35% increase in AIDS-related deaths since 2020 and an estimated 3,400 adult and children deaths due to AIDS in 2024 – this figure could be as high as 4,200 people.

HIV declared a national crisis

PNG has long had the highest HIV/AIDS incidence and prevalence in the Pacific region, accounting for 95% of the reported HIV/AIDS cases in the region in 2010 (Pham et al 2022). The number of new cases has reached record levels in recent years (Radio New Zealand 2024). In response to this increase in infections, the PNG Minister for Health, the Hon. Elias Kapavore, declared HIV to be a national crisis in June 2025 (UNAIDS Asia Pacific 2025).

The most recent surveillance data reveal that the estimated number of new infections has doubled since 2010, with approximately 30 new infections occurring every day – as presented in Table 1, this amounted to an estimated 11,000 new cases in 2024 (UNAIDS Asia Pacific 2025). Of particular concern is the continued high rate of vertical (mother-to-child) transmission – an estimated seven babies per day. Nearly half of all new cases are among people aged 24 and younger. As the Minister noted in the declaration:

HIV is a disease of inequality. We need to support and empower those most impacted. It is time for all of us to step-up. I personally commit to raising this issue with my fellow ministers and parliamentarians and ensuring the urgent allocation of resources to protect our people – especially the next generation of Papua New Guineans.
(UNAIDS Asia Pacific 2025)

Tuberculosis and TB-HIV coinfection

Tuberculosis and HIV/AIDS are the leading causes of death from infectious diseases in PNG, and this contrasts with ‘the global trend of declining infections and deaths from these diseases’ (Pham et al 2022). The data show that many people in the country are dying from TB and HIV/AIDS at young ages, with the two conditions responsible for 38 per cent of all deaths in the population aged 25 - 34 years (Pham et al 2022).

In addition, TB-HIV coinfections have increased, further complicating the effective implementation of TB and HIV/AIDS programs in PNG (Pham et al 2022). There is a high level of social stigma around TB, and discrimination against people living with HIV. These factors contribute to people’s reluctance to test and seek care, and also to potential under-reporting (Pham et al 2022; Kairi 2023).

HIV and TB interventions and services are integrated into public health services at the local level under the administration of Provincial Health Authorities. A new all-oral treatment regime for patients with drug-resistant TB commenced in PNG in 2025, and it is hoped that, with more patients undertaking the treatment, it could reduce the number of people living with, and transmitting, TB (Burnet Institute 2025b).

Factors contributing to high incidence of HIV

There are strong regional disparities in HIV prevalence in the country. While Port Moresby and other major cities have higher prevalence rates due to factors such as higher population density, increased social interaction and better access to testing facilities, ‘it is in specific provinces, like those in the Highlands

region, where the epidemic's impact is most pronounced' (Katu 2024: 66). Contributing factors include geographical isolation; people frequently moving; limited access to healthcare services; and gender-based violence (Katu 2024).

Studies confirm that there is a link between violence against women and HIV. As summarised by Pederick (2022):

Women and girls' vulnerability to contracting HIV is increased by high rates of rape, sexual abuse, forced marriage, widow inheritance and other harmful practices.

In addition to contributing to higher rates of infection, gendered violence can also be a consequence of HIV infection, and this is explored in the section 'Living with HIV in PNG' below.

Impacts of the epidemic

The impacts of the epidemic on the country and its people have been profound and multi-faceted. Impacts on the healthcare system, the economy and on stigma and discrimination are briefly discussed.

Healthcare system

The HIV/AIDS epidemic has overwhelmed a health care system already constrained by limited resources, insufficient infrastructure and a shortage of trained healthcare workers (Katu 2024: 67). It has increased healthcare costs for the government, forcing it to redirect resources, while still needing to address other pressing health issues.

Public health interventions have been facilitated by the communal living and close-knit communities that characterise the country. Such characteristics can also hinder health promotion initiatives, for example when cultural leaders and influencers do not support the interventions (Katu 2024).

Economic

The epidemic has contributed to a reduction in the overall productivity of the workforce and hindered economic development (Katu 2024). Since HIV/AIDS primarily affects individuals in their most productive years, there has been a significant loss of income for affected families and communities. Costs associated with HIV infection, including treatment, travel to healthcare facilities, and caring for the sick have been burdensome to many families, and this has been compounded by the loss of the income earners in the family (Katu 20224).

Stigma and discrimination

As has been the case in other parts of the world, people with HIV in PNG have been subject to stigma and discrimination (Katu 2024). According to Katu (2024: 67), stigma in PNG is

...often rooted in cultural beliefs and misconceptions about the disease, which can discourage people from getting tested or seeking treatment, thereby perpetuating the cycle of infection.

The impacts of stigma and discrimination on people with HIV are included in the discussion in the following section.

Living with HIV in Papua New Guinea

Impact on all aspects of life

Research carried out in two provinces – Western Highlands and Chimbu – explored the impact of living with HIV, with a focus on the stigma and discrimination that people experienced (Rule & Liriope 2016). Findings from the study (N=80) included:

- The experience of gossip related to HIV status was almost universal.
- A majority of the respondents reported being verbally insulted and/or threatened and two-thirds reported some experience of physical harassment, threat or actual physical assault.
- More than two-thirds of the respondents reported being excluded from social gatherings and activities, half of the respondents reported being excluded from family gatherings, and more than a third reported being excluded from religious activities (Rule & Liriope 2016: 78).

The research identified that some people with HIV ‘felt that they were treated like rubbish’ and that they did not have fair access to work, health services and education. Many felt betrayed, and that their sexuality was despised by others. Unsurprisingly, many took steps to avoid being identified as HIV-positive (Rule & Liriope 2016: 81).

Rule & Liriope (2016) identified some effects and results of stigmatisation, for example:

- **Rejection by family** leads to **no support to attend the clinic** which results in **not adhering to ART treatment**.
- **Gossip amongst the clan** leads to **loss of income and financial support** which results in **having to leave and go to another place**.
- **Community isolation** leads to **denial of HIV status** which contributes to **the risk of ongoing transmission**.

Based on testimony from women in PNG, Pederick (2022) concluded that ‘HIV impacts nearly every aspect of their lives’. There are impacts upon their financial wellbeing, their physical and mental health, and their personal safety. Many women have experiences of homelessness and are subject to severe social stigmatisation and discrimination (Pederick 2022). All of these can impact negatively on ART initiation and adherence, the focus of this study.

ART initiation and adherence

At the institutional level, Katu (2024: 67) writes that there have been persistent challenges in providing HIV testing, treatment and care services in PNG. This includes providing reliable access to ART in all parts of the country and ensuring the ongoing monitoring and management of HIV patients.

Mitchell et al (2021) analysed factors influencing ART initiation and adherence among ‘key populations’ in PNG, namely female sex workers, men who have sex with men, and transgender women. The study found that individual, interpersonal and institutional factors encouraged or inhibited ART initiation and adherence (Mitchell et al 2021).

The research highlighted that treatment uptake and adherence was particularly difficult for participants who experienced barriers in several areas of their lives, for example regarding their relationships with family, community members, health workers and/or employers. Relationship stresses were often combined with problems such as destitution and homelessness (Mitchell et al 2021).

Analysis of the findings from the study (Mitchell et al 2021) showed that enablers for ART initiation and adherence included:

- Awareness of the biomedical benefits of treatment, including the desire to remain healthy to care for children or to have children in the future.
- Personal or peer experiences of the social, familial and health benefits of early treatment and adherence.
- Support provided by family and friends.
- Non-judgmental and supportive HIV service provision.

Factors that inhibited treatment ART initiation and adherence were found to include (Mitchell et al 2021):

- People with HIV perceiving themselves to be in good health and/or denying that they have HIV.
- Alcohol and drug use.
- Lack of family support following a positive diagnosis.
- Anonymity and stigma concerns in HIV care services and, in some cases, negative interactions with healthcare workers.

Participants in a 'train the trainer' workshop for HIV peer counsellors held in Goroka (Eastern Highlands) in 2019 (NAPWHA 2019) identified several barriers to treatment adherence:

- A general reluctance to take medications.
- Fear of being 'found out' and judged.
- Experiences of discrimination from health care workers and members of the community.
- The impact of gender discrimination and violence against women (NAPWHA 2019).

Peer support in the context of HIV

Peer support roles and functions

Peer support is ‘a supportive relationship between people who have a lived experience in common’ (Mental Health Commission of Canada 2021: 7). Beginning in the early 1980s, peer support emerged as a way for people affected by HIV to advocate for better treatment and care and to combat stigma and discrimination (Øgård-Repål et al 2021).

Peer support is often described as falling along a continuum. Towards the one side are the informal types of support amongst friends and acquaintances that often occur in the course of everyday life, while towards the other side are the formal, intentional types of support provided within structured organisational settings (Mental Health Commission of Canada 2021: 14). Formal types of peer support have become an integral part of the response to the epidemic and one of the range of strategies employed by healthcare systems in countries all over the world, including PNG.

Peer supporters may take on a range of roles, including:

- **Role model** – to reinforce the benefits of certain attitudes and behaviours in response to the common diagnosis
- **Resource** – to share coping techniques and experiential knowledge
- **Sounding board** – to discuss the client’s responses to experiences and interactions with other people and systems
- **Trainer** – to normalise practices such as taking medication every day
- **Monitoring behaviours** – generally at a low-key and informal, rather than therapeutic, level (Gussow & Tracy, cited in Marino et al 2007).

A scoping study (N=53 studies) found that research on peer support for people with HIV has grown rapidly in recent years (Øgård-Repål et al 2021). There was little uniformity in the terms used to define ‘peer’ or ‘peer support’, with 13 different labels for peer supporters evident in the literature. The most frequently used labels were ‘peer’, ‘peer counsellor’ and ‘peer navigator’.

The key functions of peer supporters evident in the literature were the provision of assistance in daily management, linkage to care and community resources, and giving social and emotional support (Øgård-Repål et al 2021). The researchers recommended further research to demonstrate the effects that peer support can have on helping people with HIV to better address stigma, mental health and quality of life issues.

Peers can help with ART adherence

Several sources in the literature provide support for the contention that peers can help with ART adherence. The review of the literature discussed above provides evidence that peer support can strengthen the healthcare workforce and help existing services achieve health outcomes such as ART initiation and adherence (Øgård-Repål et al 2021). This study also identified assistance in daily management of HIV as one of the key roles for peer supporters (Øgård-Repål et al 2021), and this crucially includes support and encouragement for adhering to treatment.

A systematic review and meta-analysis of randomised controlled trials (N=20) assessed the effects of peer support for people living with HIV (Berg et al 2021). This study provides moderate to high certainty evidence for ‘greater long-term retention in care, improved ART adherence, reduced risk of virologic failure and better viral suppression’ for people with HIV receiving peer support, compared to those not receiving peer support

(Berg et al 2021). The results of this rigorous study suggest that trained peers are effective in supporting HIV patients to engage with healthcare services and to adhere to treatments. On this basis, the researchers recommended that benefits may flow from the scaling up of peer support programs and that ‘this may be particularly important in low-income countries’ (Berg et al 2021).

As will be explored later in this report, assisting clients to continue with ART so as to maintain an undetectable viral load is a key function and goal of peer counsellors in PNG. Treatment adherence strategies identified in earlier research (NAPWHA 2019) are summarised in the box below.

Treatment adherence strategies used by peer counsellors in PNG

Peer counsellors at a workshop held in Goroka in 2019 identified several strategies that have helped them and their clients achieve greater levels of treatment adherence:

- Open and regular communication with health workers.
- Support groups for people with HIV.
- Phone alarm reminders.
- A daily pill box.
- Promoting positive attitudes to health and pill taking.
- Mobilisation of peers to assist in improving understanding of the importance of adherence.

Source: NAPWHA (2019)

Research conducted in the USA (Marino et al 2007) found that HIV peer support to promote medication adherence is promoted through processes such as:

- **Social acceptance** – being with those who are going through the same thing and feeling accepted within an otherwise isolating disease.
- **Reciprocal support** – finding something through peer support that could not be found anywhere else.
- **Personal growth and empowerment** – gaining strength by being part of the program and developing a change in outlook.

The study also found that there were certain situations in which the obstacles to accepting support were too great for any meaningful change to occur e.g. ‘Certain people were just in denial and nothing you can say is going to change that’ (Marino et al 2007).

Examples of HIV peer training programs

Examples of peer counsellor/support/navigation training programs are summarised below, focusing on three contexts, namely the Asia-Pacific region as a whole; Zimbabwe and 13 other African countries; and Australia.

HIV Counselling Handbook for the Asia-Pacific

The HIV Counselling Handbook for the Asia-Pacific (Unicef 2009) provides a valuable overview of the recommended content for training and practice in HIV counselling. The areas addressed include:

- Orientation to the role of an HIV (peer) counsellor within HIV prevention, treatment, and care initiatives.
- Guidance on practice ethics, including responses to common ethical challenges in HIV counselling.
- The basics on HIV/AIDS, sexually transmitted infections and TB.
- Addressing the special needs of pregnant women, new mothers and their partners; men who have sex with men; sex workers; and drug and alcohol users.

- Working with grief, bereavement and mourning.
- Self-care, including stress management and preventing burnout.
- Assistance to clients in overcoming treatment adherence challenges, including providing ‘treatment adherence counselling’, described in the box below:

Treatment adherence counselling

There is value in providing specific training on counselling that focuses on treatment adherence. The training would include material on:

- How ART works.
- How treatment can fail, including the development of treatment resistance.
- How common challenges to adherence can be overcome.

Challenges to address include clients struggling to work their treatment regimen into a daily routine; clients forgetting to take pills on out-of-town travels; and client sharing their drugs with an uninfected partner or other family members in order to ‘keep them from catching the infection’.

Peer counsellors need additionally to recognise that barriers to adherence can change over time and that clients will require different levels of support as they become accustomed to treatment and as their life circumstances change.

Peer counselling training in Zimbabwe and 13 other African countries

A service delivery-focused peer support model that works within government health departments in the treatment, care and support of children, adolescents and young adults living with HIV has been adopted in Zimbabwe and 13 other African countries (Wogrın et al 2025).

A pilot program was initiated in 2023 in Zimbabwe that sought to integrate competency-based assessment into the training program that was integral to the peer counsellor model. Three days were added to the standard five-day training to conduct a pre-assessment of participants’ counselling skills or competencies (the pre-test for this study). There were also assessments in the middle of, and at the end of the training, with the latter being the post-test for this study (Wogrın et al 2025).

Competencies addressed within the training – and thus the assessment – included, but were not limited to:

- Verbal and non-verbal communication skills
- Empathy, warmth and genuineness
- Rapport building and self-disclosure
- Exploration and normalisation of feelings
- Promotion of realistic hope for change
- Giving appropriate feedback (Wogrın et al 2025).

The pilot study was successful – results showed that integrating competency assessment into the training of peer counsellors is feasible and effective as a means to strengthen counselling skills (Wogrın et al 2025). The approach helped trainers identify specific challenges faced by peer counsellors – such as a natural tendency to want to ‘fix the problem’ – and to identify areas requiring further skills development. Wogrın et al (2025) conclude that a competency-based approach provides peers with ‘a framework for observing themselves as well as their clients’.

Peer navigation training in Australia

NAPWHA developed the HIV Peer Navigation Training Program as a training certification based on Australian and international standards (NAPWHA 2025). The training program is delivered online and serves as the foundation preparation for people with HIV who ‘use their lived experience, interpersonal skills and workplace training to support other people with HIV to access the complex system of services and supports available in their local area’ (NAPWHA 2025). In Australia, they are called ‘peer navigators’.

There are four modules – HIV core knowledge; self-work; client work; and organisational work. Participants work as solo learners but relate to a mentor who provides them with opportunities to reflect on their learning and the issues it raises for them. Occasionally, the learners are brought together in interactive webinars in which they can share and jointly reflect on their learning experience. The training draws on a peer health navigation program for people with HIV developed in Canada, which is summarised in the box below:

CATIE Practice Guidelines in peer health navigation for people living with HIV

Organisations are expected to develop appropriate training for their HIV peer health navigators. Trainers would make use of culturally safe and appropriate methods, and apply materials, information, knowledge and skills relevant to the local context.

Training might include:

- Assessing the knowledge and skills of new peer health navigators as part of the training process, including testing them on the competencies necessary for their positions.
- Using a range of training materials and methods e.g. fact sheets and readings; homework assignments; audio recordings of experienced peer workers supporting clients; and videos that depict potential scenarios navigators may face in their work.
- Having content that includes:
 - Orientation to the program, agency and organisational culture
 - Basic training on HIV prevention and treatments
 - Basic training on other sexually transmitted infections and hepatitis C
 - Basic training on substance use
 - Basic training on mental health and trauma
 - Peer counselling techniques
 - De-escalation skills training
 - Self-care training
- Evaluating the training on an ongoing basis.

Key insights from the case studies

As described earlier in this report, interviews were conducted with six peer counsellors (expert patient counsellors; peer educators) in four clinical settings in PNG in order to provide up-to-date insights on the nature of their work. The information from these interviews is presented as case studies in the Appendix of this report. Key insights from these case studies are summarised below.

The varied backgrounds and life stories of the peer counsellors mirror the complex lives of the people they are supporting. They are men and women of varying ages. They have rural and urban backgrounds, and several have experienced disruption and relocation. They have found ways to survive in the face of challenging economic conditions. Some have HIV and TB co-infection. Through their own personal experiences, they understand the importance of HIV treatment, and are driven by a desire to help other people living with HIV. Through their work, they have become respected citizens in their communities.

The interviewees provided valuable insights into how the broad roles adopted by peer counsellors – problem-solving; counselling (listening, being a friend, educating); outreach and tracking; and guiding those on ART – take shape within their own work. Drawing on their responses, examples of practice in the PNG context are summarised in Table 2.

Table 2: Peer counsellor roles and examples of practice in the field

Peer counsellor role	Examples of practice in the PNG context
Problem-solving	<ul style="list-style-type: none"> Managing treatment interruptions Addressing the practical, including financial, difficulties that may interfere with treatment continuity Managing disclosure, such as with partners, with family, in work settings Developing strategies to maintain confidentiality and deal with stigma Addressing family rejection issues, including the practical ramifications Helping to resolve conflicts between clients and health workers
Counselling (listening, being a friend, educating)	<ul style="list-style-type: none"> Helping to create a welcoming and accepting care environment Sharing their own experiences and showing empathy for the client's experiences Using local languages Addressing self-stigma in a variety of ways, including focusing on self-worth Sharing health messages with clients Facilitating peer-led group sessions

Outreach and tracking those lost to follow-up

- Working collaboratively with partners in the health care system, including coordinating with other facilities when clients are transferred
- Visiting nearby settlements to follow up clients
- Building relationships with families to encourage re-engagement
- Interventions such as calling clients who miss appointments, using knowledge of clients' families and whereabouts to find them, and accompanying clients on the bus to the clinic

Guiding those on ART

- Explaining how ART suppresses the virus and how adherence to treatment promotes good health
- Helping clients to understand U=U (Undetectable = Untransmittable)
- Providing practical tips, such as setting phone reminders for doses
- Reinforcing the importance of staying on ART even when feeling well and healthy
- Supporting clients that are experiencing treatment side effects to stay on ART
- Encouraging disclosure to a trusted family member in order to have stronger informal support

The description given by one of the interviewees of the work he does provides a succinct statement of the peer counsellor role as it emerges in everyday practice in PNG:

I try to provide quiet, one-on-one sessions with reluctant clients. I use my personal story to educate men on the importance of early testing. I build rapport through consistent presence and follow-up. I encourage open discussion about adherence challenges. I help explain HIV basics in simple, non-medical language. I reassure clients they're not alone and I create safe space for clients to cry, vent, and heal. ('Pialga')

The **skills** identified by interviewees as helping them most with their work included:

- Using 'the self' as an example of someone living successfully with HIV, including working with clients to accept their status to better take charge of their lives.
- The ability to build trust and rapport with clients.
- Applying the education they have received and explaining 'HIV/AIDS' and 'living with HIV' in ways that clients can understand.
- Strong communication skills, including listening and probing skills.
- The ability to display empathy, patience and a non-judgmental approach.
- Cultivating resilience in the face of stigma and challenges, and learning how to support people in high stress situations.

Successes achieved by interviewees in the course of their work included:

- Retaining clients in care and reintegrating defaulting clients into care.
- Seeing clients transform from helplessness and disempowerment towards achieving greater levels of confidence and self-worth.
- Improvements to their own ways of working, including listening more and talking less, achieving greater clarity in their messaging to clients, and building trust with hard-to-reach populations.

- Contributing to the reduction of fear and stigma in clinical settings.
- Developing stronger community links which, amongst others, makes outreach and referrals smoother.
- Linking clients with other people with HIV, including through the running of peer education and peer support groups.

Finally, interviewees were asked about the areas of learning that they would like to pursue in order to do their work better. Their responses included:

- A much stronger focus on mental health, including undertaking mental health first aid courses and learning to better integrate their work with mental health services.
- Advanced counselling techniques e.g. trauma-informed care, crisis support, and promoting self-worth.
- Greater competence at understanding treatment plans.
- Greater competence at supporting clients to disclose to partners.
- Greater competence in developing youth-focused support groups and outreach.
- Improved public speaking and community education skills.

The interviewees were strongly in favour of ongoing structured training for peer counsellors to occur throughout PNG on a regular basis.

Where to from here?

The statistics provided on the HIV epidemic in PNG, together with the fact that it has been declared a national crisis, makes it more important than ever to ensure that institutional support and resourcing is provided to enable peer workers to become an integral part of the national response to HIV/AIDS.

Information in this report, including the accounts provided by the peer counsellors, provide evidence that, in contexts where the peer counsellors are working, tangible positive impacts can be discerned.

Where will future funding and structural supports for maintaining and upskilling of the HIV peer workforce will come from? The commitment of international donors and external philanthropic efforts have been a large part of the story of trying to manage the HIV epidemic in PNG in the past, but this is not a path of sustainability.

Ultimately, if the peer counsellor model is to be supported in-country, then a clear role and function, together with ongoing training for HIV peer counsellors in clinical settings, needs to be factored into Papua New Guinea's health planning and health care system.



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Appendix

Case studies are presented in this appendix, based on recorded interviews with a total of six peer counsellors in four clinics in PNG in 2025. To protect their privacy, the names and personal details of these peer counsellors have been changed. The clinics are located in Port Moresby, Lae, Mt Hagen and Madang. The map below shows the location of these clinics:

PAPUA NEW GUINEA MAP



Source: <https://www.freeworldmaps.net/oceania/papua-new-guinea/political-map.html>

Papua New Guinea has over 800 languages and tribal groupings, which complicates health service delivery and communication infrastructure. The map below shows the mountainous and rugged terrain of PNG, which is a confounding factor in the delivery of effective health services. The country is made up of many islands, with travel to health facilities often taking days at a time. The main island is effectively divided by a mountain range – the tallest peak is Mount Wilhelm at 4,509 metres.



Source: <https://www.freeworldmaps.net/oceania/papua-new-guinea/map.html>

PNG is affectionately known as ‘the land of a thousand stories.’

Case study: Heduru Clinic, Port Moresby

Heduru Clinic is located in the Port Moresby General Hospital, which is in the National Capital District. This clinic specialises in comprehensive HIV care: testing, treatment initiation, ART distribution, counselling, and referrals. It offers same-day initiation, psychosocial support and TB/HIV integrated care. This clinic serves both urban and rural clients from the three districts of Central province. Tau and Rhonda work at this Clinic as Expert Patient Counsellors.

Tau was a former bus driver in the Nation's Capital, in Port Moresby. In 2016, he was diagnosed with HIV after he was sick and referred from a local health centre to the general hospital. He commenced ART, his condition was stabilised, and he later trained as an Expert Patient Counsellor through Igat Hope. Over the past year, Tau has supported 675 people with HIV, including many men from surrounding urban settlements who face challenges with adherence and disclosure. His calm and respectful approach makes him a trusted figure, especially among clients hesitant to engage with formal health care services. Tau is helping to reduce stigma, improve treatment adherence, and create a welcoming and supportive environment for people with HIV.

Rhonda, who is 40 years old, is from the Gulf Province. Her parents passed away when she was 13, and she moved to Port Moresby because life had become so difficult for her. She went to live with an uncle in Port Moresby where she took on caring responsibilities for an extended family. Because she had no money of her own, Rhonda was forced to be a sex worker in Port Moresby. She was diagnosed with both HIV and TB in 2018. Rhonda was very sick at that time.

Although she had not completed formal studies, she was determined to advocate for women's health. She met people from Igat Hope and realised that there were a lot of women who had been contracting HIV through sex work and because of violent relationships with men. Rhonda was invited by an Igat Hope staff member to attend one of the peer trainings and then commenced work at Heduru just before the COVID 19 lock down. This meant that she was unable to access further trainings at that time.

In broad terms, Tau and Rhonda described their work in this way:

We work as a team, and we map out where people come from and where they live. We use the contact list from the clinic who become lost to follow up and miss appointments, sometimes we go to the settlements and in their homes to visit them and also, we bring a little bit of food that will help start the conversation.

While we are with them, we guide them on ART, explain what a viral load is, and why they must keep it low. Some want to stop taking meds once they feel better, so we tell them that medications are for life – like food. We sometimes chew betel nut and try to fit into their culture/where they are from so when we go and see them, we listen and we care for them, so that they feel like someone noticed them.

We explain in simple terms – some are illiterate so we can't rely on pamphlets it has to be word of mouth. There is no use talking at a high level to some of these people. Sometimes it is difficult because when we visit the family not everyone knows the situation. We want to find out why the person is not coming back. Sometimes they wanted to take traditional herbs, but we want them to understand both sides that ART is as important.

Rhonda and Tau were asked to discuss their work within the key peer counsellor roles:

Problem-Solving (and on what issues)

- Helping clients overcome fear of disclosing to partners.
- Managing treatment interruptions due to mobility.
- Supporting men with self-stigma.
- Resolving conflict between clients and health workers.
- Helping youth deal with self-stigma and shame.
- Supporting clients with side effects to stay on ART.
- Addressing family rejection issues.
- Navigating issues with work or school-related disclosure.

Outreach & Tracking those Lost to Follow-up

- Visits nearby settlements to follow up clients.
- Works collaboratively with partners for tracking LTFUs/miss appointments.
- Calls clients who miss appointments.
- Coordinates with other facilities when clients transfer.
- Builds relationships with families to encourage re-engagement.

Guiding Those on ART

- Reinforces the importance of taking medications even when feeling well.
- Explains how ART suppresses the virus and helps overcome fears of side effects
- Encourages setting mobile phone reminders for doses.
- Helps men understand U=U (Undetectable = Untransmittable).
- Encourages disclosure to trusted family for support.

They were then asked to discuss the skills that helped them undertake these roles:

- Empathy from lived experience.
- Strong communication skills (Tok Pisin and local dialects).
- Patience and non-judgmental approach.
- Resilience in the face of stigma and challenges.

‘What were some of your successes?’:

- Reintegrating defaulting clients into care.
- Building trust with hard-to-reach populations.
- Reducing fear and stigma in clinic settings.
- Helping clients achieve viral suppression.

‘What would you still like to learn?’:

- Advanced counselling techniques (e.g. trauma-informed care).
- Mental health first aid.
- Digital tools for tracking clients.
- Public speaking and community education.

Case Study: Idnard ART Clinic, Madang

The Idnard ART Clinic operates as a partnership between Igat Hope, Catholic Health Services and the Modilon Provincial Health Authority. It has a strong focus on providing stigma-free, community-based HIV services, and is designed to be a welcoming space for young people and people from rural areas. The Clinic serves clients from Madang town and some parts of six districts, including Bogia, Madang, Middle Ramu District, Rai Coast District, Sumkar District and Usino-Bundi District. They all provide testing, treatment, adherence counselling, and psychosocial support to people with HIV.

Pialga works at this clinic as an expert patient counsellor. He is 30 years old and originally from Madang Province. He was diagnosed with HIV at age 19, shortly after completing his Year 12 exams. Selected to study at Divine Word University, Pialga became seriously ill in his first year and was diagnosed with HIV. Though he began treatment promptly, the burden of self-stigma affected his confidence, leading him to withdraw from studies. He later worked at a local supermarket but was laid off due to ongoing health issues.

Since that time, Pialga has turned his lived experience into a strength. After receiving training through Igat Hope, he now works at Idnard ART Clinic. In the past year, Pialga has recorded 812 client interactions, including individual counselling and group education sessions. His personal journey has made him a trusted figure among young male clients, particularly those newly diagnosed or struggling with acceptance. In describing the general approach to his work, he notes:

I try to provide quiet, one-on-one sessions with reluctant clients. I use my personal story to educate men on the importance of early testing. I build rapport through consistent presence and follow-up. I encourage open discussion about adherence challenges. I help explain HIV basics in simple, non-medical language. I reassure clients they're not alone and I create safe space for clients to cry, vent, and heal.

Pialga was asked to describe what he sees as working well, as not working so well, and what he would like to see change.

What Pialga sees as working well

- Peer-led group sessions – Helps reduce isolation among young people with HIV.
- Friendly environment – Clients feel less judged in a faith-based setting.
- Strong community links – Makes outreach and referrals smoother.
- Use of local languages – Builds trust with rural clients.

What Pialga sees as not working so well

- Limited resources – Few educational materials for group sessions.
- Inconsistent drug supply – Occasional ART stock-outs affect adherence.
- Stigma in rural areas – Clients still hide their status.
- No structured referral system for mental health – Complex cases.

What Pialga would like to see change

- More youth-focused support groups and outreach.
- More information and educational materials in Tok Pisin and local languages.
- Better integration with mental health services.
- Regular capacity-building workshops for peer counsellors.

Case Study: New Town Clinic, Mt Hagen

The New Town Clinic is run by Anglicare in Mt Hagen. The clinic was opened specifically for testing, treatment and support of people with HIV in the New Town area in Mount Hagen, which is just on the edge of Mt Hagen City.

The clinic aims to support all people with HIV living in the Mt Hagen District, Mul District, Baiyer District, Tambul District and Nebilyer District. This clinic was set up in order to create an enabling environment for service provision for people from rural areas, who may not be comfortable in the general hospital but may feel more comfortable attending a clinic which is faith based. Yang and Nathaniel were placed in the clinic in 2020 working under Igat Hope in partnership with Catholic Church Health Services.

Yang is 35, she is from Mendi in the Southern Highlands province. She became pregnant and was diagnosed when she was 20. She has been living with HIV for 15 years now. She is from a village setting, she reads writes and speaks very good English, speaks Tok Pisin as well as three local languages. Yang has undergone training in the past for peer counselling. Yang recorded 1,093 client interactions in the year prior to the interview, including working with clients in group education sessions.

Nathaniel is 38, he was born in Mt Hagen. He has a wife and 4 children. Prior to the peer counselling role, he worked one of the local hotels in Mt Hagen. He was diagnosed when he came to the general hospital with TB in 2015. Nathaniel has also had some basic peer counselling from Igat Hope. Nathaniel recorded interactions with 730 clients in the past year, including those who attended group education sessions.

Yang and Nathaniel were asked to elaborate on their key peer counselling roles:

Problem- solving (and on what kind of issues)

Most of the problems that we address in the clinic are to do with forgetfulness of people taking treatments and their relationship issues. Bus fares to get the clinic are a big problem. Another is the lack of knowledge of the PLHIV such as they don't know long term effects of HIV, and they struggle to accept their status when they are tested.

Listening, being a friend, educating

We share our own experiences and try to show empathy. We share health messages with patients. When we started at the clinic the COVID epidemic had started, and this really disrupted services.

Outreach and tracking for those lost to follow-up

At the end of every month the list of loss to follow-ups is given to us. For some we take on the case together, others we do separately, and we use contact numbers or knowledge of their families and whereabouts to find them. Sharing our own personal experiences and building the network of support for people I meet at the clinic. Because we have some training, we can provide information related to suppression, adherence to treatment and maintaining good health.

They were then asked 'What were the skills that helped you to do this?':

We have good listening, let them talk, hear their side of the story including sometimes emotional problems. I like to ask them 'what can you do better' and share health messages and building trust is the most important with clients.

'What were some of your successes?':

In the past we mixed up information, now we know how to provide key messages. We know how to build up knowledge, and we know how to share information. Before we used to do all the talking, now we listen to the client/s. Visiting in the homes, reminder calls and linking the clients to support PLHIV support groups.

'What would you still like to learn in order to do this work better?':

We need to learn crisis support skills. I need support in terms of understanding mental health and self-care. These would be good trainings for me.

Case study: Anua Moriri Day Care Centre, Angau Hospital

The Anua Moriri Day Care Centre is located in the Augau Hospital in Lae, which is in Morobe Province. Augau is a large general hospital which, in addition to ART distribution, also provides Voluntary Counselling and Testing. The Anua Moriri Day Care Centre is run by the Ministry of Health and is the main distribution point for that area. The clinic is within the main hospital grounds.

Thomas is the most experienced counsellor at the Augau. He has been involved with PLHIV groups for 15 years since he was diagnosed. Thomas was educated to Year 12 level and before being diagnosed he worked for the army. He had a terrible experience when he got sick and was diagnosed, because the army kicked him out.

Thomas was asked to describe his work within the key peer counsellor roles:

Problem- solving (and on what kind of issues)

One of the big problems is stigma and maintaining confidentiality and reassuring the PLHIV and get them to have confidence and believe in themselves.

Listening, being a friend, educating

I try to encourage them and tell them they have self-worth and live well and there is nothing wrong with you and no one should put you down because of your status. Encouraging people with positivity and hope and empower to reduce internal stigma, so people feel worthy of care.

Outreach and tracking, especially for those lost to follow-up

I try to teach them to come out of self-stigma and have positivity to themselves. I sometimes go and catch the public bus and bring them back to the clinic. Bus fares are available for clinic people so we can get the bus fare from the clinic and go and help to bring the people.

Guiding those on ART

I encourage them to feel positivity and not be isolated. Mostly through sharing stories and my own and I tell them to remove this feeling of being unwanted. I used my own self as an example of someone living with HIV. I tried with whatever skills I have and mostly using my own story.

Thomas was then asked ‘What were the skills that helped you to do this?’:

Because I was in the army, I was taught to be self-confident and because I went to year 12, I can read, write and speak fluent English. I can share my experience, what I know now from the technical aspects, I break it down to simple language which they can understand. Because my background in the defence force taught me discipline, empathy and how to support people in high stress situations. I have many clients that I care for, after they have defaulted (stopped treatment) I encourage them to accept their status to take charge of their health.

‘What were some of your successes?’:

Retaining patients in care is the main measure of success. I motivate them to come back for more counselling and some of them listen to me more because I have had more experience. I have seen clients transform from helplessness to more confidence. Knowing I played a role in that journey is the most rewarding part of my work as a peer counsellor.

‘What would you still like to learn in order to do this better?’:

There is no structured training in PNG. We have had different groups and international partners, but they only do one-off training because it’s donor funded and no ongoing structured training. We invite people to come to workshops run by partners, and they come and do some learning but then the workshops and trainings don’t happen every year, it depends on the partners. Need to understand treatment plans and support clients to disclose to partners. Some do not adhere to the drugs and don’t always practice safe sex, so we need to learn more to teach the others.

Physical Tracking of Lost to follow up patients by Peer Counsellor and Educator of Igat Hope



Home visit to LTFU patient by Peer Counsellor and Educator and accompanied him back to care: Photo taken by Dickson Yano with patient consent 19/03/2020, Mt Hagen



REACHED Lost To Follow Up patient through Physical Tracking and referred him back to care: Photo taken by Dickson Yano with patients consent 10/03/2020, Mt Hagen



napwha national association of
people with HIV australia