HIV in PNG; an ongoing health crisis

A reflection on the political, social and economic determinants of HIV infection rates in Papua New Guinea

Over the past two decades, Papua New Guinea has been plagued by the highest incidence of HIV/AIDS in the Asia-Pacific region and there is no indication of the epidemic abating. In order to assess the prevalence of the disease in PNG it is crucial to ascertain the factors which have contributed and facilitated its spread alongside those factors which have hindered effective HIV prevention strategies. Firstly, a brief history of PNG's post-independence health system and the country's development deficiencies will provide a backdrop to a political, economic and social analysis of the conditions which have prevailed during this epidemic. To contrast this a brief discussion of the incidence of HIV/AIDS in Fiji will provide a point of comparison to the health strategies and systems in practice in PNG whilst also demonstrating a greater need for socially engaging and relevant HIV prevention strategies in both contexts. Ultimately, by discussing the political, economic and social issues which have plagued PNG during the past two decades the need for political commitment and social drive, engagement and determination for successful HIV prevention strategies will become apparent. Without effective political and social engagement the prevalence of HIV/AIDS in Papua New Guinea is expected to continue unabated and infection rates predicted to rise exponentially.

PNG, a culturally rich and diverse state, with a population of 6,732,000 (WHO 2012) is comprised of villages and towns geographically isolated from one another and is an incredibly linguistically diverse country with over 800 recognised languages spoken (Australian Geographic 2011). A traditionally religious society, PNG gained Independence in 1975 and has struggled to acquire stable government to the present day. Future population projections estimate that the population will double by 2050 in a country with one of the highest infant mortality rates in the world with an estimated 12,000 children aged under five years dying each year (DFAT 2012). Approximately 40 per cent of PNG's population live in abject poverty, on less then US$1 a day and the country has spent the last decade in a deep economic recession (World Bank 2007). It is amidst this environment that HIV/AIDS has spread prolifically throughout PNG and to further assess the incidence of the incidence of the disease in PNG it is first crucial to provide a brief overview of PNG's overall health system and health care provision.

Health outcomes have stalled in PNG since independence and have been in steep decline over the last decade (World Bank 2007). Prior to the HIV epidemic, PNG experienced high rates of infectious diseases coupled with high levels of infant and maternal mortality and its health system failed to adequately cope with the strain of these ongoing health realities (2007). Independence coincided with the introduction of a state wide government funded health system which was supplemented by the government-subsidized health services provided by Christian Missions (2007). Christian run health services represent 44 per cent of facilities in PNG and predominantly assist PNG's poorest whereas the nineteen clinical hospitals in PNG are utilised predominantly by PNG's richest citizens. (AusAid 2012) Overall, the

capacity for district and provincial governments to adequately provide health care throughout PNG continues to decrease and a crucial factor contributing to this has been "successive attempts to decentralise the provision of services" (2007:46). It is within this context that HIV/AIDS has spread throughout PNG with up to 34,000 [30,000 - 39,000] (UNAIDS 2011) currently reported cases. One third of reported cases are from rural areas with up to 18,000 [16,000 - 21,000] (UNAIDS 2012) women currently infected. Although PNG has lacked an efficient health system there are political, economic and social factors which have contributed to the rapid spread of HIV, and the failings of the health system, and it is crucial to identify these factors. By identifying the economic, political and social factors which have hindered health outcome progress in PNG the ways in which they have compounded the prevalence of HIV in PNG will become apparent.

Politically, PNG has had dysfunctional and unstable government since Independence in 1975 and to date no single party has formed government; all have been coalitions (2007). It is amidst this political inconsistency that the HIV crisis in PNG has occurred. Political instability has translated into disjointed and inconsistent policies, misallocation of resources and an overall lack of political will to effectively address HIV/AIDS. Up until 1997 there was no formal government policy for HIV/AIDS in PNG despite the first cases being reported in 1984 and although PNG receives substantial development funding, particularly for HIV/AIDS prevention strategies and predominantly from AusAid, government health spending on HIV/AIDS remains minimal with only AU $350,000 being allocated in the 2004 budget. Furthermore, successive governments have continued to decentralise the health sector despite lacking a structure to hold local and provincial health services to account or to ensure resources are optimally allocated and services, including HIV/AIDS specific services, are effectively delivered. Moreover, successive governments have lacked a cohesive message regarding HIV/AIDS and "few people in positions of power and leadership acknowledge HIV/AIDS as an issue of concern" (2007: 10). A National Aids Council was established in 1997 and a medium-term plan 1998-2002 designed and in 2002, a multi-sectoral approach, the National Strategic Plan for HIV/AIDS for 2006-2010 was implemented (2007). In the 2003 and 2004 budgets funding focused on HIV prevention programs namely condom provision whilst abstinence was socially marketed, by government, as the most effective prevention strategy for HIV/AIDS. These conflicting messages have not been culturally appropriate, have been carried out on a small scale and have not been accompanied by any discussion on sex, sexuality and sexual violence within public discourse. (2007). The National HIV/AIDS Prevention Act 2004 although marketed as a multi-sectoral plan for the management and prevention for HIV/AIDS fails to address capacity and resource constraints and has no sound financing plan. Furthermore, PNG's government health strategies have not addressed the social factors contributing to HIV, such as sexual behaviour, and all have lacked a focus on the surveillance of HIV in PNG which at present is overall unacceptably inadequate and in some areas completely absent (AusAid 2012). Although successive governments in PNG have made positive steps in identifying that HIV is an issue and that it requires a multi-sectoral approach, consistent and dedicated proactive action has been largely absent from HIV government health strategies. Moreover, a lack of a centralised government led health system creates a situation in which surveillance of HIV cases becomes unmanageable, accountability declines and resources are misallocated all of which hinders effective

health responses to the disease in PNG. All of these political factors hinder effective health strategies for HIV in PNG which contributes to the epidemic just as economic burdens in PNG have fuelled the proliferation of the disease.

PNG has grappled with a debilitating recession for the past decade with all sectors experiencing deep decline (AusAid 2012). GDP fell by 4 per cent between 1997-2002 and people living on less than US $1 a day rose from 25 to 40 per cent (2007:9). Formal employment options for men remain minimal in urban centres and formal employment for women remains incredibly low with only 5.7 per cent of women engaged in formal non-agricultural, wage earning employment (2007:10). Mining has provided employment prospects for men but such "enclave extractive developments" (2007) force men to live apart from their families and creates new transactional sex markets in mining centres throughout the country (Seckinelgin 2008). "Enclave economic developments present situations that put both men and women at significant risk of contracting HIV, as increased trade in sex in these industries for cash/gifts has been well documented" (2007:21). Furthermore, the increase in people living in poverty and the lack of employment opportunities, particularly for women, can force women to seek informal sector work such as prostitution and "there is longstanding evidence of women being attracted to logging camps, mines, fish factories and other numerous economic enclaves in rural areas, particularly on pay days, to sell sex to men" (2007:89). In the Four Corners documentary 'Sick no good' aired on 14/8/2006 (Australian Broadcasting Corporation) the development of the Highlands Highway, which spans from the coast of PNG to the highlands, is used to highlight the fact that an increase in workers, predominantly male, being transported to economic and resource centres for labour along the Highway has been quickly followed by an increase in the sex trade along this integral transport artery. Ultimately, the documentary suggests that the Highway has acted as a courier of HIV into rural villages and towns as it connects a large portion of the country and has essentially enabled HIV to reach parts of PNG typically thought immune from exposure to the disease. This example highlights the ways in which economic contexts can have profound health repercussions and how PNG's economic plight has contributed to the incidence of HIV/AIDS.

Further compounding the political and economic factors which have contributed to HIV in PNG are the social and cultural behaviours and practices particular to its people. Sexuality, sexual violence, and religion play critical roles in contributing to the HIV epidemic in PNG. In PNG sexual promiscuity in and out of marriage is widely accepted and men having sex with other men is also widely practiced within and outside of marriage (2007) with up to 71 per cent of urban and rural men having reported having had extra marital sex and with 19 per cent having had more than five extramarital partners" (2007:90). Moreover, sexual violence against women is commonplace, both in and out of marriage, and of greater concern is the commonality of 'line-up's' in which women are raped by groups of men, such (Australian Broadcasting Corporation 2006) 'line up's' often contain a homo-erotic element also. Gang sexual violence in the growing ghettos of Port Moresby continues to rise and yet sexual discussion in public discourse is somewhat taboo and this coupled with the linguistic complexity and geographic diversity of PNG, makes sending out a coherent and consistent HIV/AIDS prevention message incredibly difficult for governments,

churches, and NGOs. Christian organisations often dominate the discussion of sex in society and relay the message of abstinence as the only means for HIV prevention (Seckinelgin 2008) in spite of the high rates of sexual violence against women and the prevalence of sexual promiscuity within marriages. To further compound these concerns, transactional sex is commonplace and widely visible, particularly in urban and economic centres. These social behaviours and norms, particularly in regard to sexuality and sexual behaviours, are having a profound impact on the prevalence of HIV/AIDS in PNG. Furthermore, the lack of a public discourse to discuss issues such as sexual and domestic violence and sexual promiscuity further hinders HIV/AIDS prevention because these issues need to be publicly discussed and addressed to not only improve the lives of people in PNG but also as a way of further preventing the spread of HIV/AIDS. In order to further grasp just how the political, economic and social conditions listed previously have compounded the HIV epidemic in PNG the occurrence of HIV will be contrasted with the situation as experienced in Fiji,

Fiji has been classified as a low HIV prevalence country and this can, in part, be attributed to its proactive engagement and response to the occurrence of the disease. Fiji is a lower middle income country with a population of 837,271 and it is one of the most developed economies in the Asia-Pacific region and (UNAIDS 2011) in 2003, it had an estimated 600 cases of HIV. An estimated 34.4 per cent of the population live below the basic needs poverty line and the Ministry of Health is the primary health services provider in Fiji. As Fiji economically develops non-communicable diseases are increasingly becoming an important cause of mortality and in 2007 around 82 per cent of deaths in Fiji were due to non-communicable diseases (2011). In terms of its health system, Fiji largely struggles with staff shortages, "inadequately equipped facilities and ineffective coordination and management of programs and services" (2011). The number of people becoming infected with HIV is increasing annually despite it being categorised as having a low prevalence of HIV and the disease is disproportionately affecting young people as social and cultural constructs continue to change (2011). Up until the HIV/AIDS Decree was introduced in 2011, Fiji had no legalised framework for addressing HIV but at the same time the decree has "been acknowledged both locally and internationally as one of the most progressive HIV laws in the world" (2011) The Decree proposes ensuring the confidentiality of personal information, creating an environment conducive to encouraged access of testing and counselling services, empowering infected people to seek legal counsel should they feel their human rights have been violated and lastly the decree aims to promote personal responsibility for the health of individuals (2011). Furthermore, the national response to HIV/AIDS has focused on prevention and this is where the majority of funding is directed. UNAIDS describes Fiji's prevention approach as "Combination Prevention" as it deploys "a blend of biomedical, behavioural, and structural approaches tailored to address the particular and unique realities of those most vulnerable to HIV infection" (2011:30). Like PNG, Fiji has high incidences of domestic violence and surveillance and monitoring of HIV cases is inadequate. Conversely however, Fiji's prevention strategies have been delivered with a consistent message and have focused on confidentiality for HIV patients, increased access to testing, counselling and support services and projects targeting young people who are most at risk (2011). Major challenges for addressing HIV in Fiji have been the lack of engagement and willingness of churches and their leaders to openly discuss HIV which is viewed as a crucial step in mainstreaming the disease in public discourse.

Moreover, addressing the stigma associated with HIV needs to be prioritised by health services and by government as people are avoiding learning their HIV status due to fear of being ostracised from their community. Although Fiji has made progress in terms of developing social strategies for HIV prevention major health strategies appear to be lagging, with UNAIDS only noting an increase in testing and a decrease in the time delay between testing and results as a major improvement in HIV health services in Fiji (2011). Furthermore, more work needs to be done to reduce the stigma of HIV in Fiji society as although progress has been made HIV infection rates have been increasing and the lack of an efficient monitoring system means a distinct figure of infection rates is non-existent.

PNG's lack of political leadership and inadequately equipped decentralised health system operating within a recession has adversely contributed to an inadequate political will and response to the HIV epidemic. Furthermore, social patterns of behaviour such as the prevalence of sexual violence and sexual promiscuity operating within a public discourse which treats sex as a taboo topic has further compounded and fuelled the spread of HIV in PNG. Although health strategies, such as the National HIV/AIDS Prevention Act 2004 and National Strategic Plan for HIV/AIDS for 2006-2010, have been enacted in PNG the diversity of issues contributing to the spread of HIV needs a more direct and consistent government message. Moreover, the taboo around sex and HIV in society along with economic constraints and the levels of people living in poverty also need to be adequately addressed if there is to be any hope of suppressing HIV infection rates. Thus, cost effective high priority health outcomes and more social marketing messages and campaigns must become a PNG government priority. In contrast to PNG, Fiji has opened up discussion regarding sex and HIV in society and has prioritised and streamlined HIV prevention strategies. In Fiji, like in PNG, however more needs to be done to reduce the stigma surrounding HIV and more effective monitoring systems and greater involvement by churches and religious organisations needs to occur to reduce the spread of the disease. For PNG, greater political will, leadership and commitment to reducing the severity of the HIV epidemic is required as is addressing the core social and economic factors which contribute to increasing HIV infection rates. Without a greater political commitment and socially engaging and appropriate HIV prevention strategy the HIV/AIDS epidemic in PNG looks set to continue and what cost that will have on PNG society, only time will tell.

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