



HIV AUSTRALIA

**Strengthening capacity: facing up
to HIV in Papua New Guinea**

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AFAO's aims are to:

- Advocate on behalf of its members at the Federal level, thereby providing the HIV/AIDS community with a national voice;
- Stop the transmission of HIV by educating the community about HIV/AIDS, especially those whose behaviour may place them at high risk;
- Assist its members to provide material, emotional and social support to people living with HIV/AIDS;
- Develop and formulate policy on HIV/AIDS issues;
- Collect and disseminate information for its members;
- Represent its members at national and international forums; and
- Promote medical, scientific and social research into HIV/AIDS and its effects.

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AFAO is the peak non-government organisation representing Australia's community-based response to the epidemic of HIV/AIDS. AFAO's members are the state and territory AIDS councils, the National Association of People Living with HIV/AIDS, the Australian Injecting and Illicit Drug Users League, Scarlet Alliance and the Anwernekenhe National Alliance.

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This edition of *HIV Australia* focuses on responses to HIV in Papua New Guinea and Australia's involvement in these activities. For an overview of issues related to the HIV epidemic in PNG see Sally Cameron's article summarising *Turning the Tide: Report of the Commission on AIDS in the Pacific*, included in the online edition of *HIV Australia* available at www.afao.org.au

Aboriginal and Torres Strait Islander readers should be aware that this publication may contain images or names of people who have since passed away.

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Sixth National HIV Strategy released

Following unanimous endorsement by Australian federal, state and territory Health Ministers, Australia's Sixth National HIV Strategy was launched in May, together with another four new strategies that aim to reduce the transmission of blood borne viruses (BBVs) and sexually transmissible infections (STIs), and the morbidity, mortality and personal and social impacts they cause.

The endorsement of the *First Hepatitis B Strategy* represents a significant achievement. Its implementation will require new funding – for both the health sector and the community sector – but as yet no new funding has been announced.

Australian Government's health reform agenda

On 11 May 2010 the Minister for Health and Ageing, the Hon Nicola Roxon MP, released *Taking Preventative Action*¹, the Government's response to the report of the National Preventative Health Taskforce. The report presents preventative health targets to guide Australian health reform toward achieving the status of 'healthiest country' by 2020.

Two days later, on 13 May, the Government handed down the 2010/2011 Federal Budget. Notably, the Budget contained no references to the new national blood borne virus (BBV) and sexually transmitted infections (STI) national strategies, and makes no announcements relating to HIV, STI, or hepatitis prevention or services. Speaking at the Budget briefing on 13 May, Minister Roxon argued that the general absence of initiatives targeting particular health conditions (other than diabetes) was deliberate, noting that the Health Budget announcements focus on practical changes to effect reform of health and aged-care infrastructures – to address gaps resulting from fragmentation of the current system.

1 The full report is available at: <http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/taking-preventative-action>

Health issues in prisons

There are high levels of mental health problems, communicable diseases, smoking, risky alcohol consumption and illicit drug use among Australian prisoners, according to a report released by the Australian Institute of Health and Welfare. *The Health of Australia's Prisoners 2009* report is the culmination of several years' development of national indicators in relation to prisoner health in Australia. The report is the first national report of its kind in Australia.

Of significance – given the recent launch of the *National Hepatitis B Strategy* – is the finding that Indigenous prison entrants were more likely to test positive to hepatitis B compared to non-Indigenous entrants – 42% compared to 17%. The full report is available at: <http://www.aihw.gov.au/publications/phe/123/11012-c03.pdf>

HIV and migration policy review

'Australia's current health requirement for migration to this country is prejudiced against people with a disability and their families', the Chair of Parliament's Joint Standing Committee on Migration, Mr Michael Danby MP said on 21 June. Mr Danby was outlining the findings of a report by the Committee regarding the treatment of migrants with disability.

Given that HIV-positive applicants for permanent residence in Australia are generally refused permanent visas because of the assessed future cost of HAART, adoption of the Committee's recommendations would create a significantly more flexible and transparent migration program for people living with HIV and their families. Although AFAO is firm in its opposition to imposing any health test on refugees, we are pleased that the Committee has recommended

introducing access to waiver (albeit limited), for offshore refugee applicants. We are also pleased that it has recommended review of the policy precluding residence where a member of an applicant's family fails the health requirement (i.e., the 'one fails; all fail' policy, where all members of a family are refused residence if one member fails the health requirement).

HIV, criminal law and the media

A 32 year old HIV-positive man was extradited from NSW to Queensland this month, on criminal charges relating to him allegedly having had unprotected sex with at least one woman. In his piece for the *National Times* (2 June), the President of the National Association of People Living with HIV/AIDS, Robert Mitchell, outlined how reporting of such stories can promote myths and feed community fears regarding HIV: *'More than 25 years ago Australians were warned by their government about the risks of unprotected sex and the importance of using condoms: a cool-headed response in the context of much media hysteria.'*

Building on that initial approach, successive Australian governments, in partnership with clinicians and community groups, have worked to implement HIV education messages, counselling and support that have protected the vast majority of sexually active Australians from infection. As a result, Australia is recognised internationally for its public health response to HIV.'

An aspect of this public health response includes measures to monitor and manage individuals who put others at risk of infection. Options available to public health authorities are broad and range from education and counselling in the first instance to involuntary detention or psychological treatment for more serious cases. Notwithstanding the measures available, all Australians have a responsibility to minimise their risk of HIV by practising safe sex.'

Recent reporting in Australian media has shown the ignorance of many commentators of the comprehensive detail of these systems and procedures, which in the majority of cases are effective at reducing risks to the community. While tabloid media often focus on the salacious aspects of individual behaviour and

the mode of transmission, there is also a tendency to represent cases of HIV transmission as a failure of public health systems or policy.

Sydney's Daily Telegraph (May 26) reported that an "HIV-positive circus acrobat who appeared on Australia's Got Talent has triggered a national health scare after allegations he had unprotected sex with at least 11 women, including some from NSW". Beside the text on the website is a clip of the shirtless man on Australia's Got Talent under the headline "HIV carrier flirts with Dannii".

The Sunday Courier Mail in Brisbane (May 30) went to press with "What a circus: HIV acrobat ran rings around health authorities". The coverage included a suggestion that an "HIV register" be used to track people with HIV. These stories echo some of the reporting that occurred in Queensland in 1984 when four babies became infected with HIV through blood transfusions that subsequently led to the appalling scapegoating of people with HIV and gay men in particular.

The population of people with HIV in Australia is diverse and numbers about 19,000 people. It includes: men, women and children; those infected through sexual contact (both gay and heterosexual); those infected in a health care setting (as patients or workers); injecting drug users; and Australians who have acquired the virus overseas, in so-called high-prevalence countries.

All of these people caught HIV from someone else and none of them deserved it. Sometimes the complexity of our human desires leads to consequences we later regret. Sometimes, simply, accidents happen. HIV is not a morality tale; it is a blood-borne virus. It is serious but also preventable when we all take responsibility for protecting ourselves.

People living with HIV in Australia have been major architects of the programs and policies of HIV prevention and education. Public health authorities and the community are in a partnership that should be valued because of its impressive results over more than a quarter of a century, not undermined when one person's alleged aberrant behaviour becomes tabloid fodder.'

View complete article at: <http://www.nationaltimes.com.au/opinion/society-and-culture/fanning-hiv-fear-fosters-discrimination-20100602-wyu8.html>

NEWS FROM THE ASIA PACIFIC

Punitive and discriminatory laws limit access to services

Preliminary findings of a new report, *Laws affecting HIV responses among men who have sex with men and transgender persons in Asia and the Pacific: an agenda for action* reveal that more than 90% of men having sex with men in the Asia Pacific region do not have access to HIV prevention and care services. The report shows that HIV prevalence has reached alarming levels among men who have sex with men and transgender populations in many countries of Asia and the Pacific.

The report's preliminary findings were reviewed during the 'High Level Dialogue on Punitive laws, Human rights and HIV prevention among men who have sex with men in the Asia Pacific Region', convened by the United Nations Development Programme (UNDP), the Asia Pacific Coalition on Male Sexual Health (APCOM) and the Center for Comparative and Public Law (CCPL) in Hong Kong. The Panelists, including former High Court Justices, and representatives from Parliament, civil society and the UN system, reviewed how comprehensive and rights-based HIV prevention among men who have sex with men and transgender people can occur only when a conducive and enabling legal environment is created. 'Reform of laws and law enforcement practices affecting private, adult same sex activities must be seen as an imperative step in the path of reducing the isolation, stigma and vulnerability lived by communities and individuals', stated the Honourable Michael Kirby of Australia. The final report of the study's findings will be delivered at the XVIII International AIDS Conference, Vienna on 20 July.

Mobility and HIV

The impact of migration between Pacific countries and within is revealed in the report *Migration, Mobility and HIV: A Rapid Assessment*

of Risks and Vulnerabilities in the Pacific launched in Suva on 9 June. The Joint United Nations Development Programme (UNDP) and Secretariat of the Pacific Community (SPC) report was launched at the Annual meeting of National AIDS Committee (NAC)/ Capacity Development Organisation.

It is anticipated that the report will inform the development of multi-sectoral responses to address HIV in the Pacific, and prompt more targeted research on the impact of migration within and between states.

The report also highlights that a number of Pacific countries, including Australia, have restrictions on entry, stay and residence of people living with HIV. The report asserts that these restrictions have no public health justification, are discriminatory and ineffective. The report urges that these restrictions be removed as they could hinder effective HIV responses.

The report can be accessed from: http://www.undppc.org.fj/_resources/article/files/Migration,MobilityandHIV_web.pdf

China praised for lifting its ban on HIV-positive visitors

UNAIDS has applauded the decision by the Government of China to lift its national travel ban for people living with HIV. The news came ahead of the opening of Shanghai Expo 2010, which is expected to attract millions of visitors over the next six months.

'Punitive policies and practices only hamper the global AIDS response. I urge all other countries with such restrictions to remove them as a matter of priority and urgency' said United Nations Secretary-General Ban Ki-moon.

In January 2010, the USA removed its long-standing HIV-related entry, stay and residence restrictions. Several other countries, including Namibia and the Ukraine, have recently pledged to take steps to remove such restrictions.



INTERNATIONAL NEWS

Ugandan HIV/AIDS Prevention and Control Act Criticised

The *HIV/AIDS Prevention and Control Bill 2010* was introduced into the Ugandan Parliament on 19 May, following months of debate. The bill criminalises HIV transmission and requires medical personnel to disclose the HIV status of those tested. It also mandates HIV testing for pregnant women and their partners, suspected perpetrators and victims of sexual offenses, drug users and sex workers. Under a 'general penalty' clause in the bill, anyone who disobeys these provisions could be imprisoned up to 10 years.

Human Rights Watch is strident in its criticism of the bill, asserting that the bill as currently written codifies discredited approaches to the HIV epidemic and contains dangerously vague criminal provisions; the bill would criminalise HIV transmission and behavior that might result in transmission by those who know their HIV status.

The Ugandan government has recently received international criticism for a proposed 'anti-homosexuality' law, which mandated the death penalty for HIV-positive people who engage in homosexual sex, and required that individuals report suspected homosexuals to the government. 'Like the anti-homosexuality bill, the HIV/AIDS bill tramples on rights and encourages stigma and intolerance,' Joe Amon, Health and Human Rights director at Human Rights Watch said.

Human Rights Watch is among a group of organisations advocating that the bill's punitive and discriminatory provisions be removed.

The full Human Rights Watch report is available at: <http://www.hrw.org/en/news/2010/05/13/uganda-protect-don-t-punish-people-hiv>

ILO conference: unprecedented new international labour standard on HIV adopted

Governments, employers and workers meeting at the annual conference of the International Labour Organization (ILO) adopted a new international labour standard on HIV and AIDS on 17 June – the first international human rights instrument to focus specifically on HIV and work.

The standard is the first internationally sanctioned legal instrument aimed at strengthening the contribution of the world of work to universal access to HIV prevention, treatment, care and support and contains provisions on potentially life-saving prevention programmes and anti-discrimination measures at national and workplace levels. It also emphasises the importance of employment and income-generating activities for workers and people living with HIV, particularly in terms of continuing treatment.

Dr Sophia Kisting, Director of the ILO Programme on HIV and AIDS and the World of Work said that 'with this new human rights instrument we can harness the strength of the

world of work and optimise workplace interventions to significantly improve access to prevention, treatment, care and support. We cannot do it alone but this standard will, I believe, provide a major contribution to making the dream of an AIDS-free generation a reality.'

Ms Thembi Nene-Shezi (South Africa), who chaired the debates on the standard in the HIV and AIDS Committee, said 'we have an instrument that should be a source of pride for the ILO and its constituents. We have no time to waste however. We must move forward and promote the standard. The engagement of those that have given birth to it – the governments, employers and workers – will be crucial to the development of national workplace policies anchored in human rights and directed at overcoming discrimination.'

The new standard is in the form of a Recommendation, one of two types of labour standards the ILO can adopt. While distinct from a Convention in that it does not require ratification, a recommendation must still be communicated to national parliaments and discussed in terms of how it might be implemented through national policies and legislation. The Recommendation augments the existing *ILO Code of Practice on HIV/AIDS* and the world of work adopted in 2001.

'The Recommendation will not only be an important instrument to guide the work of the ILO and its constituents but will also enhance coordination in the international AIDS community. With strong provisions on prevention and social protection, the Recommendation will reinforce ILO's work in support of the UNAIDS ten priority areas,' added Dr Kisting.

The proposed standard has already drawn the support of UNAIDS and WHO during the ILC discussions.

HIV AUSTRALIA

Got something to say?

Your views are important to the success of this publication.

HIV Australia publishes letters and contributions from readers. If you want to respond to something you have read here, or have an idea for an article, please write to us at: editor@afao.org.au



Re-engaging the partnership: launch of the 6th National HIV strategy

By Professor Michael Kidd AM

On 28 May 2010, Parliamentary Secretary for Health, The Hon Mark Butler MP, launched the 6th National HIV Strategy and the 2nd National STI Strategy at AFAO's National Symposium on Prevention in Sydney. The Strategies represent major advances in national coordination and accountability, and a return to strong national leadership.

Following is the paper delivered by Professor Michael Kidd AM, Chair of the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections. Michael Kidd is also Executive Dean of the Faculty of Health Sciences at Flinders University.

It is appropriate that this launch is taking place at this national symposium on the prevention of HIV and other blood borne viruses (BBVs) and sexually transmissible infections (STIs)

because prevention has always been at the heart of Australia's effective national response to HIV and it must remain so.

In March 2009, our Health Minister, The Hon Nicola Roxon MP, established her Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections, affectionately known as MACBBVS. AFAO President, Dr Graham Brown, and NAPWA President, Robert Mitchell, are among the 18 members of MACBBVS who ensure that HIV prevention and treatment and care issues are high on our committee's agenda.

Last year, our Health Minister set her advisory committee two challenges: to lead the development of the new set of national strategies based on lessons learned about what did and did not work during the life of the last set of national strategies, and to

re-engage the partnership approach which has been fundamental to this nation's effective response to the HIV epidemic, including involving each of the jurisdictions.

We now have five new linked national strategies:

- 6th National HIV Strategy
- 2nd National STI Strategy
- 3rd National Aboriginal and Torres Strait Islander Sexually Transmissible Infections and Blood Borne Viruses Strategy
- 3rd National Hepatitis C Strategy, and
- 1st National Hepatitis B Strategy.

This set of five strategies was endorsed by all our health ministers – Federal, State and Territory – at a meeting last month. While we may not see all our governments agreeing on all aspects of

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our national health reform agenda, it is significant that every single health minister was willing to sign up to this new set of strategies and, in so doing, commit their health services to meet the targets for prevention, treatment and care set out in each strategy.

Each of the new strategies contains a set of objectives and indicators against which the Commonwealth and each State and Territory will report each year. That will allow us all to closely monitor progress in reducing rates of infection with HIV and other BBVs and STIs, while at the same time ensuring equity of access to treatment and care for all people in this nation.

The principles of our national strategies are based on applying what we know works well, to all people in this country, with a focus on:

- prevention and education of both the general population and priority populations
- ensuring community empowerment and partnership
- ensuring equity of access to treatment and care
- ensuring we do not tolerate stigma and discrimination
- building our workforce capacity and providing training and support, and
- continuing Australia's international leadership in research and surveillance.

One of the commonest questions I have been asked since being appointed Chair of MACBBVS, is whether HIV is still a problem. The answer of

course is 'yes'. Despite the success of Australia's globally recognised response, in 2008 there were more than 17,000 people living with HIV in this country. In 2008, 995 people were newly diagnosed with HIV. In 2008, 69% of new diagnoses were among men who have sex with men, and rates were rising. We are also seeing a rise in new infections among people travelling and working in high prevalence countries, among members of some culturally and linguistically diverse communities, and among injecting drug users in some Aboriginal and Torres Strait Islander communities.

The goal of the new National HIV Strategy is to reduce transmission of HIV, reduce the morbidity and mortality caused by HIV, and minimise the personal and social impact of HIV. This can be achieved by a reinvigoration of prevention efforts, strengthening of the partnership, addressing key workforce development, and renewing our focus on human-rights-based approaches.

One of the other questions I am asked, only by men and never by women, is 'What's chlamydia?'. The answer is that chlamydia is the most frequently reported notifiable infection in Australia, with 60,000 cases reported in 2008, and a doubling of the rate of reported infection from 2004 to 2008 for both women and men. The greatest number of infections is in the 20 to 29 year age group, which is a grave concern because it indicates that our messages on the prevention of STIs are failing to

reach many of the people most at risk. The new *National STI Strategy* has a strong focus on prevention, and a focus on the need to increase rates of testing and treatment.

The third and final question that I am often asked is, 'Does syphilis still exist in Australia?'. And of course the answer is 'Yes. It does'. In 2008, there were 1,300 cases diagnosed. 14% of those cases were in Aboriginal and Torres Strait Islander people, which includes cases of children being born with congenital syphilis and cases of people who had developed serious long term neurological and cardiovascular disease from undiagnosed and untreated syphilis. The new strategies aim to work towards elimination of infectious syphilis in Aboriginal and Torres Strait Islander communities.

MACBBVS worked with the Australian Government Department of Health and Ageing and each of the States and Territories and key community-based organisations, consumers, clinicians and researchers on the development of the new set of national strategies for BBVs and STIs, working with a team of talented writers led by Levinia Crooks from the Australasian Society for HIV Medicine (ASHM).

I thank everyone who has been involved in the development of the new set of strategies. Now that the strategies are in place, we all face the far more important work of implementing them and making a difference. I am looking forward to continuing to work with you all.

That will allow us all to closely monitor progress in reducing rates of infection with HIV and other BBVs and STIs, while at the same time ensuring equity of access to treatment and care for all people in this nation.

Professor Michael Kidd AM, is the Chair of the Ministerial Advisory Committee on Blood Borne Viruses and Sexually Transmissible Infections and the Executive Dean of the Faculty of Health Sciences at Flinders University.

Make ART treatment and services accessible in Papua New Guinea



National AIDS Council Secretariat

SUSTAINABILITY

Ensure immediate to long-term support by availing adequate funding, infrastructure

TREATMENT

Promote the existence and availability of ART and raise awareness on the benefits of early treatment and

LOGISTICS & SUPPLY

Ensure the logistics of ART is effectively managed and

EDUCATION

Promote early detection and treatment, and ensure service providers are adequately trained and

World AIDS Day 2009 in Papua New Guinea. Photo courtesy AusAID.

Assessing the risks: the first behavioural surveillance survey in PNG

By Dr John Millan

Papua New Guinea is experiencing a steady increase in HIV infection combined with a high prevalence of other sexually transmitted infections (STIs).

The first case of HIV was reported in PNG in 1987. By the end of December 2009, the number of reported HIV cases had risen to over 30,000.

PNG was the fourth country in the Asia-Pacific region to report a generalised HIV epidemic.¹ According to the 2004 National Consensus Workshop, the adult prevalence of HIV

was estimated at 1.7%. The workshop recommended that behavioural surveillance surveys (BSS) be developed and implemented periodically as part of the overall second generation HIV surveillance system.

The National AIDS Council Secretariat (NACS) in collaboration with the National HIV/AIDS Support Project

(NHASP) identified and prioritised certain high-risk settings (HRS) in PNG. These are settings where those groups with particularly high levels of risk behaviour and frequent negotiation of sex are based, such as the ports and markets along the major highways. Population subsets that may interact extensively with sex workers or have multiple sexual partners – such as workers in the private industries and military – were also targeted in the development of the HRS strategy, which was funded by AusAID.

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In 2006, the first BSS was conducted in high-risk settings in the National Capital District, Morobe and Western Highlands provinces.² The BSS aimed to:

- establish baseline data and a monitoring system to track trends in sexual behaviours in these high-risk settings
- provide information to guide program planning
- be used to monitor and evaluate the HRS strategy, and
- inform future behavioural surveillance.

The groups targeted in the BSS were recruited from high-risk settings using a range of sampling techniques including random sampling, respondent driven sampling, and a random walk sampling frame, with the aim of creating representative samples. The population groups and the specific sites sampled were:

- 1) adult male workers in private industries from Lae Port and Ramu Sugar, truck drivers based in Mt Hagen, and military personnel from Taurama, Murray and Igam Barracks
- 2) out of school youth from Joyce Bay and Hanuabada settlements in Port Moresby, and
- 3) women who sell sex from non-highway-based locations in Lae, Ramu and Mt Hagen or women who were highway-based in Minj Market, Umi Market, Ramu and Yang Creek Markets.

Adult male workers

Adult male workers (1,358) were interviewed from a range of industries and occupations including: 246 truck drivers, 353 Ramu Sugar workers, 421 Lae port workers and 388 military personnel. A range of sexual behaviours with high risk of HIV transmission was reported, with important differences apparent between the sampled groups. For example, the proportion of men paying women for sex in the last 12 months varied greatly between truck drivers (70%), military personnel (61%), port workers (33%) and Ramu Sugar workers (7%). While reported condom use was high during the majority of men's most recent commercial sexual transaction (62–91%); consistent condom use with sex workers during the previous 12 months was lower: varying from a low of 33% among truck drivers to 69% among Ramu Sugar workers.

Truck drivers were more likely to have non-commercial casual sex partners (71%) compared to port workers (41%), military personnel (37%) or Ramu Sugar workers (16%). Condom use was less common with casual partners than with women who sold sex. Condom use during most recent sex with regular partners was lowest by Ramu Sugar workers (10.8%), low with truck drivers (12.6%) and military officers (13.9%), but slightly higher with Lae Port Workers (24.9%). Consistent condom use was recorded at 5.6% (military officers), 6.5% (truck drivers), 7.7% (Ramu sugar workers), and 9.3% (Lae Port Workers).

A range of sexual practices was reported between men, and between men and women. Oral sex was more common than anal sex (with a man or a woman) for all interviewed except for 59% of truck drivers who reported anal sex with women. There was variation in men reporting anal sex with other men. Truck drivers and Ramu Sugar workers reported no male to male sex (0%), a very small proportion of military personnel (1%) reported male to male sex, but 13% of port workers reported male to male sex. Men and women were both at risk of HIV transmission given the higher transmission risk associated with receptive anal intercourse.

Men working in private industries were also asked if they had ever had sexual intercourse (vaginal, anal, or oral) with a woman when she was unwilling. Almost half of the military personnel and close to 40% of truck drivers said that they had forced a woman to have sex without consent. A large proportion of Ramu Sugar workers (18.4%) and Lae Port workers (27.3%) also reported sex with a woman without her consent. Both men and women are at risk of HIV infection from non-consensual sex with women.

Out of school youth

A total of 1,701 out of school youth, aged 15–24 years (913 female and 788 male) were sampled from the communities of Joyce Bay and Hanuabada. Most young people interviewed were sexually active with over two-thirds of unmarried male (72.3%) and female (67.6%) youth reporting that they had had sex. The median age of first sexual experience was 16 years for both female and male youth. Anal sex between married and unmarried female and male youth was very common, with almost 50% of male youth and 20% of female youth reporting that they had ever had anal sex. Just over 12% of young men reported having had sex with another man.

Almost 50% of married female youth and two-thirds of unmarried female

Men working in private industries were also asked if they had ever had sexual intercourse (vaginal, anal, or oral) with a woman when she was unwilling. Almost half of the military personnel and close to 40% of truck drivers said that they had forced a woman to have sex without consent.

youth reported having exchanged sex for money or favours during the previous 12 months, and 28% of unmarried female youth had engaged in transactional sex three or more times during the previous year. A large proportion of married (46%) and unmarried men (42%) had also engaged in transactional sex during the previous year.³ Married male youth were almost three times more likely than unmarried male youth to have bought sex three or more times in the past year. Reported condom use during transactional sex was significantly higher among unmarried male youth (70% reported condom usage during the last instance of commercial sex) than unmarried female youth (29%). Condom use for married female and male youth during transactional sex was 40% and 49% respectively. While exchange of sex was high for both married and unmarried female youth; condom use was lowest for unmarried female youth, who also reported more transactional sex and with more partners.

Among unmarried sexually active youth, 20% of female youth and 37% of male youth had more than one non-commercial sexual partner during the previous 12 months. Among married youth, 9% of female youth and 39% of male youth had more than one regular and non-regular sexual partner over the past 12 months.

Over 40% of both married and unmarried female and male youth reported they had been forced to have sex without their consent. Also, 61.4% of married male youth and 49.3% of unmarried male youth had forced partners to have sex with them. Alcohol was linked to forced sex by married male youth. Female youth were not asked if they had coerced or exerted force with male youth to have sex with them.

Women who sell sex

634 women who sold sex were surveyed; 415 from two non-highway-based sites (Lae and Mt Hagen) and 219 from four highway-based sites

(Umi Market, Yang Creek Market, Ramu Market and Minj Markets). Just under half (40%) were 25 years old or younger in both samples. Sex workers reported having started to sell sex at a young age (median age 16 for highway-based and 17 for non-highway-based). They also reported marrying at a young age (17 years for both samples) and many got divorced not long after marriage.

Non-highway-based female sex workers reported higher numbers of paying sexual partners in the previous week (median of 4) compared to highway-based women (median of 2). Approximately 76% of non-highway-based and 66% of highway-based women used a condom with their last client; while 43% of highway and 24% of non-highway-based women who exchanged sex said that they used a condom with their last paying client. Condom use was significantly lower between sex workers and their non-paying sex partners with 56% of non-highway-based sex workers and 50% of highway-based sex workers using condoms during their last sex with a non-paying client. Consistent condom use was much lower (18% non-highway; 21% highway-based).

Approximately 75% of women selling sex said they knew consistent condom use was an effective HIV prevention method, however, this knowledge did not translate into consistent practice. The most common reasons for not using condoms among non-highway-based women with their commercial and non-paying partners were:

- their partner objected (39%)
- they lacked access to condoms (31%)
- they trusted their partner (21%)
- they thought using condoms was not necessary (15%), and
- they were not comfortable about initiating condom use (14%).

The most common reasons for highway based women who exchanged sex for not using condoms with their clients or other non-paying partners were:

- their partner objected (61%)
- they trusted their partner (51%)
- they were not confident about initiating condom use (44%)
- they thought using condoms was not necessary (31%), and
- they were not available (30%).

Other reasons given with a lower frequency (<10%) included: dislike of condoms, or that they didn't trust them, or were too stoned or drunk to remember to use them.

The women interviewed reported they had had a sexually transmitted infection in the past 12 months (32% of non-highway-based and 42% of highway-based women) and the majority sought treatment at a hospital or clinic (81% and 88% respectively). Close to 50% of non-highway-based and 42% of highway-based women had been tested for HIV. Approximately 80% of those women said their test had been positive. Misconceptions about HIV transmission were common.

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Approximately 75% of women selling sex said they knew consistent condom use was an effective HIV prevention method, however, this knowledge did not translate into consistent practice.



Experiencing PNG's HIV epidemic: a far north Queensland perspective

By Dr Darren Russell and Carla Gorton

Many people in the south of Australia (wryly denoted by north Queenslanders as that area of the continent south of Mackay) would not be aware of Far North Queensland's (FNQ) proximity to Papua New Guinea (PNG). The closest capital city to Cairns is in fact Port Moresby, which lies 827km to our north. Brisbane, on the other hand, lies 1,400km to the south. Business, tourism, education, shopping, and kinship trigger a constant flow of people to and from PNG, with the majority travelling via Cairns.

Cairns has the largest PNG expatriate population in Australia, estimated at more than 3,000 residents. Hundreds more PNG nationals commute to PNG job sites on a regular basis. Many Australian expatriates who live and work in PNG frequently travel to and from Cairns. This two-way travel is expected to increase significantly in the coming

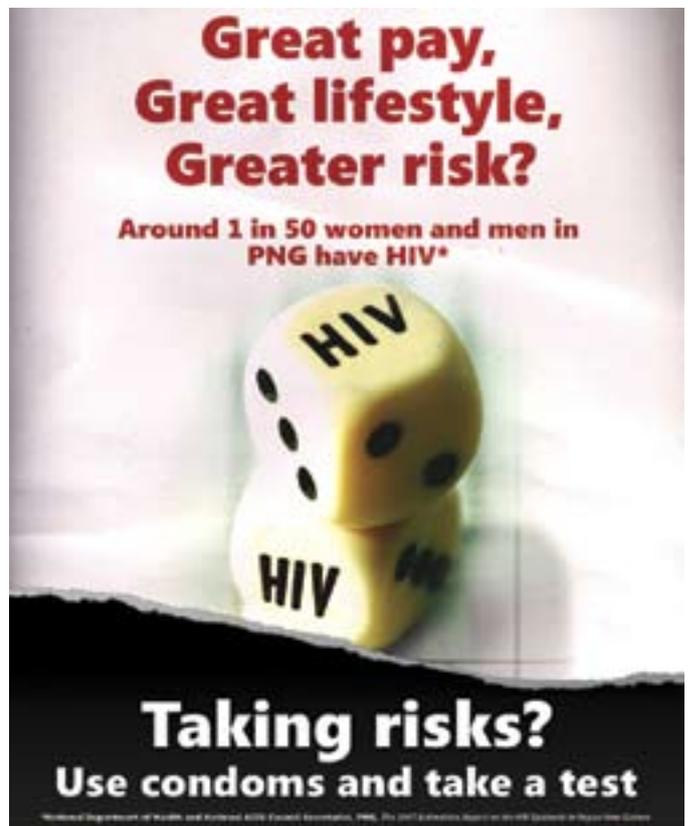
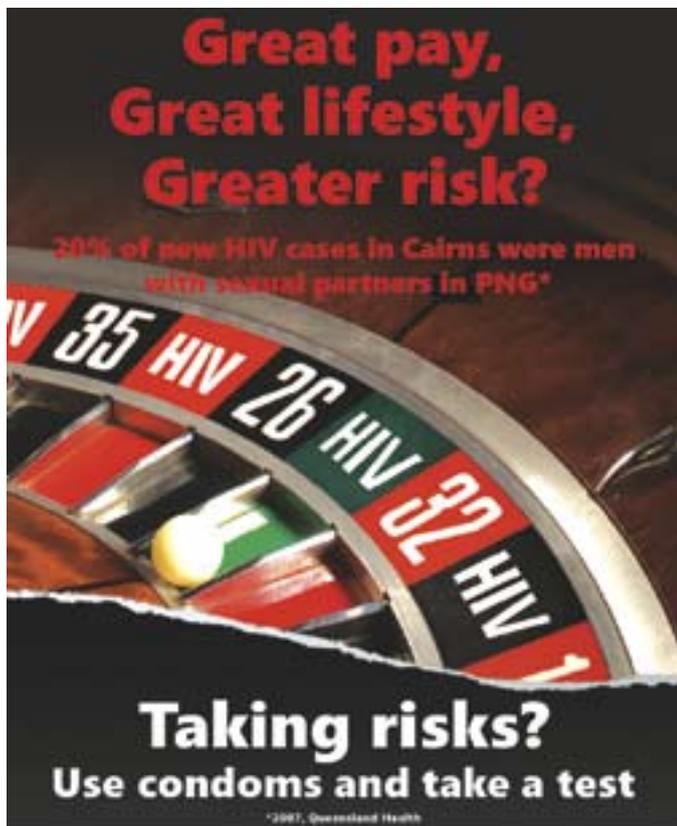
years, with a \$US12 billion, 30-year Liquefied Natural Gas (LNG) project led by Exxon Mobil currently under development. This huge project will have a construction phase over the next four years, and 12,000 to 15,000 people will be employed; 1,250 of whom will be required as a permanent workforce. The Queensland Treasurer's trade mission to PNG from 15 to 17 March was the largest trade mission ever undertaken by Trade Queensland, and is testament to the increasing importance of the PNG economy and resources to northern Australia.¹

PNG's HIV epidemic impacting Cairns

Cairns Sexual Health Service is a multidisciplinary service comprising doctors, nurses, Indigenous health workers, administration officers, project officers and psychologists. The

service provides programs on HIV, viral hepatitis and sexual health. The Cairns and Hinterland Health Service District includes the major rural centres of Atherton, Mareeba and Innisfail, covering an area of approximately 142,900 kilometres. The Cairns Sexual Health service also provides specialist services to the FNQ cluster which includes Cape York and the Torres Strait Islands. Our service has a current caseload of around 300 HIV-positive clients: the highest prevalence of any region in Queensland, and one of the highest in Australia.

In 2007, 21% of all new HIV diagnoses in Cairns were acquired by heterosexual males reporting sexual contact in PNG: a marked and significant increase from 6% in 2006. This increase caught our service somewhat by surprise, with resulting concern that it may herald the start of a major rise in the number




Contact:
 Cairns Sexual Health Service (07) 4050 6200
 Family Planning Queensland (07) 4051 3700
 Queensland Association for Healthy Communities (07) 4043 9455
 or your GP


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Pictured above Family Planning Queensland's HIV and sexually transmitted infection (STI) awareness raising materials targeting heterosexual men aged over 35 who travel through Cairns for work or holiday purposes. The project was funded by Queensland Health.

of new HIV diagnoses attributable to PNG. As a result of this rapid rise, Queensland Health funded Family Planning Queensland to develop HIV and sexually transmitted infection (STI) awareness raising materials targeting heterosexual men aged over 35 who travel through Cairns for work or holiday purposes. The project focused on media commonly accessed by men travelling to PNG. It included advertising in the *Cairns Post* over three months, and half page advertisements in each issue of *Paradise* (Air Niugini's in-flight magazine) and *Our Way* (Airlines PNG's in-flight magazine) for the six month campaign period. Posters and flyers were distributed to travel health clinics, medical centres, and Cairns-based mining companies with contracts in PNG. The PNG Business Coalition Against HIV/AIDS (BAHA) promoted the campaign through their online newsletter, which is widely circulated to PNG workplaces.

The campaign was evaluated by local market research company Compass Research. Surveys targeting males returning from PNG were conducted at Cairns International Airport to assess recall/recognition and effectiveness of the campaign materials. 89% of respondents said they had seen advertising or media related to HIV, either in Cairns, in-flight, or in PNG. The majority said they had seen it in PNG. 35% recalled seeing it in Cairns and/or in-flight: that figure increasing to 55% when respondents were prompted with the names of the in-flight magazines. 64% of the men rated the campaign as effective or very effective.

The HIV-related clinical workload remains very high, much of it associated with PNG: Australian expats, PNG expats, international workers based in PNG visiting Cairns for their HIV management and antiretroviral

medication, or people from PNG who happen to be visiting Cairns for one reason or another. New diagnoses of HIV in Cairns continue to be influenced by people who have contracted HIV in PNG, but the proportion of cases in 2008 and 2009 has been less than in 2007.

PNG's relationship with the Torres Strait

The Torres Strait marks the border between Australia and PNG. The area is home to Torres Strait Islanders, who became citizens of Queensland in 1967. The population of the Torres Strait is a little under 10,000, of whom the vast majority are either of Torres Strait and/or Aboriginal origin.

The Torres Strait's proximity to PNG became an issue in the 1970s when PNG was moving towards

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independence from Australia.² Torres Strait Islanders insisted they were Australian, but the PNG Government objected to complete Australian control over the waters of the strait. Eventually an agreement was struck whereby the islands and their inhabitants remain Australian, but the maritime frontier between Australia and PNG runs through the centre of the strait. In practice, the two countries cooperate closely in the management of the strait's resources.

Free movement (without passports or visas) is available to all people living within the Torres Strait 'Protected Zone', including those on most of the Torres Strait Islands³ and in 13 prescribed coastal villages in the Western Province (WP) of PNG. Saibai Island (part of Australia) is only some 5km from the low-lying coast of PNG. PNG is readily visible from Saibai and only a short 'tinny' ride away.

Traditional activities and visits are carried out across the border, with 59,000 people movements recorded in the 2008/2009 financial year.⁴ Traditional activities under the Treaty include activities on land (such as gardening, food collection and hunting), activities on water (such as fishing for food), ceremonies or social gatherings (such as marriages), and traditional trade. Such numerous visits across the 'border' combined with knowledge of PNG's escalating HIV transmission rates have triggered some concern about possible increases in transmission of HIV.

Lack of data and services

Given the poor state of WP's health facilities and the lack of surveillance data, it is difficult to get a clear picture of the scale of the HIV epidemic in WP. Health workers on both sides of the border are aware of HIV diagnoses. Diagnoses of people from PNG occur sporadically in the health services of the Torres Strait, as well as in the hospital in Daru, the capital of WP. There is

an urgent need for more data, both to inform our response to the problem in the region and for the sake of those living in WP.

Some (limited) access to antiretroviral treatments is available in Daru, but accurate information about the scope and coverage of treatment is unavailable. It is believed that there is no HIV testing or treatment available to those living in Protected Zone villages. In order to access treatments, villagers must journey by boat to Daru (on Daru Island), or alternatively, visit one of the health facilities in the Torres Strait: most commonly either Saibai or Boigu Islands. Health centres exist on both islands, with villagers from Protected Zone villages travelling to these centres to obtain medical treatment, usually in the event of emergencies. People are treated locally on humanitarian grounds, and may then be transported to Thursday Island Hospital, or occasionally further afield if necessary.

Until now, very few people with serious HIV-related illnesses have travelled across the border, although the diagnosis and treatment of tuberculosis, for example, is commonplace in those from the Protected Zone. Possible causes for the low number of HIV-positive PNG villagers attending Torres Strait health centres include:

- very little HIV infection in Protected Zone villages
- an early HIV epidemic, with very few people currently at an advanced state of immunosuppression
- a feeling by villagers that treatment would be futile and/or too costly, and
- inability to access the transport and fuel necessary to make the journey across the border.

The degree to which these possibilities are currently playing out is unknown.

FNQ remains uniquely susceptible to a widespread, heterosexually-driven HIV epidemic that could

affect Indigenous Australians in high numbers. The increasing movement of people between PNG and Cairns has resulted in a rise in HIV notifications in Cairns, and to an increase in the workload of the local sexual health clinic and hospital. Responses will need to be complex, particularly given that the players include the Australian and PNG Governments, the State of Queensland, the Province of Western Province, and local governments and administrations.

There is an urgent need for more information about what is taking place with regards to the HIV epidemic in WP, and for more information regarding people movements and sexual networks in the Torres Strait and Cairns. Support is needed for those already diagnosed with HIV, and for those who will be diagnosed in the coming years. Services will also require additional support in dealing with the rising workload attributable to the unique geopolitical situation that links PNG and FNQ.

References

- 1 Fraser, A. (2010). *Queensland Government Trade Mission Report – Papua New Guinea*, <http://www.parliament.qld.gov.au/view/legislativeAssembly/tableOffice/documents/TabledPapers/2010/5310T1953.pdf> (accessed 7 June, 2010).
- 2 Independence was achieved in 1975.
- 3 A notable exception being the islands of the Thursday Island group.
- 4 McKenna, M. (2009). PNG 'illegals' flooding Torres Strait, *The Australian*, 9 November, 2009. Available at <http://www.theaustralian.com.au/news/nation/png-illegals-flooding-torres-strait/story-e6frg6nf-1225795569991> (accessed 7 June, 2010).

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The rise of positive champions in Papua New Guinea¹

By Robert Baldwin

We take people off the streets ... encourage them to be tested. Some are HIV-positive. What then?²

The Poro Sapot Project (PSP) is an HIV/AIDS behaviour change intervention project based on peer outreach, primarily targeting female sex workers and men who have sex with men, including transgender people.³ Importantly, it uses a peer outreach model to reduce the negative impact of HIV. Poro Sapot basically means 'friends supporting friends'.

Implemented by Save the Children PNG in Port Moresby, Lae, Goroka and Kainantu, PSP addresses the needs of target populations who engage in high risk behaviours, and who are not easily reached by traditional activities promoting HIV/STI prevention and care. One indication of the success of PSP's peer approach is the number of current PSP staff who first came into contact with the service as clients, and who then became volunteers and employees. They know what it means to be sex workers and men who have sex with men in PNG: an understanding crucial to PSP's work.

The July 2008 review of PSP found that: *... due to the good work of the project in reaching female sex workers and men who have sex with men, and promoting voluntary counselling and HIV testing, many more HIV-positive*

*female sex workers and men who have sex with men are becoming involved in the project.*⁴

The review recommended that PSP, in collaboration with partners, develop innovative programs to 'support holistic health and well-being needs of HIV-positive female sex workers and men who have sex with men'. On the basis of those findings, PSP initiated a GIPA (Greater Involvement of people living with HIV [PLHIV]) Audit.

Undertaking a GIPA Audit

The PSP GIPA Audit was conducted in April 2009 by a team of four people living with HIV: two current PSP staff members (Nick and Dorothy), the GIPA Advocacy Officer from *Sanap Wantaim* (Maura, PNG AusAID agency) and an international consultant (Robert). Nick, Dorothy and Maura are all past Board Members of Igat Hope, the PNG PLHIV network. Between them, the four members of the team had nearly fifty years of combined experience of living with HIV.

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Pictured top left Poro Sapot (PSP) Banner, Port Moresby, PNG. Photo courtesy PSP; **and right** PSP GIPA Audit Team: Maura, Nick and Dorothy in the PSP Port Moresby Memorial Garden, April 2010. Photo courtesy Robert Baldwin.

The GIPA Audit aimed to:

- assess how PSP has worked with people living with HIV, including the strengths and weaknesses of that work
- deepen PSP's understanding of the concepts of GIPA and 'positive prevention'
- recommend ways to incorporate these concepts into ongoing work
- share experiences
- develop local skills required to perform such an audit, and
- pilot this method for use by other civil society organisations within PNG.

The audit process involved consultations at all four project sites with staff, female sex workers and men who have sex with men outreach volunteers, local PLHIV leaders and project partners.

Findings of the GIPA Audit

The GIPA Audit Team found:

- several activities by and for HIV-positive people had already been successfully conducted at PSP
- a wide variety of ongoing care activities for HIV-positive female sex workers and men who have sex with men had been willingly conducted by staff and volunteers, usually beyond their job descriptions and often utilising their own resources
- most positive staff and volunteers within PSP seemed to be hidden behind a veil of secrecy around being HIV-positive, and
- since the PSP Review in mid-2008 there had been four deaths of HIV-positive volunteers and clients.

Sadly, since the 2009 Audit there have been a number of other deaths at PSP from HIV-related illness, including a much-loved member of the PSP senior staff, Jason.

The GIPA Audit Team also found that while overall there was a low level of theoretical knowledge about GIPA and 'positive prevention'⁵, there was general agreement by PSP staff, volunteers and

partners on the need to meaningfully involve people living with HIV as equal partners in the project and to work collaboratively to empower positive people to improve their health and well-being. The Audit Team was particularly impressed that despite the project being formally defined as HIV prevention focused, there was clear willingness of PSP staff and volunteers to incorporate care and support activities for positive female sex workers and men who have sex with men within their project: 'This was outstanding to me. Something great is coming up and I'm very proud'.⁶

Progressing inclusivity

To progress the PSP's goals of inclusivity, the GIPA Audit Team made a number of relatively simple recommendations, although these will require significant effort to effectively implement.

The Audit Team recommended the development of a PSP *Code of Conduct* that specifically addresses issues relating to working with people living with HIV, including confidentiality and non-discrimination. The Audit Team also recommended development of a workplace policy on chronic illnesses, including HIV, to cover both staff and volunteers.

The continuing veil of secrecy around being HIV-positive in PNG is a real challenge to everyone's health and well-being. The Audit Team supported recognition of 'GIPA Champions' within PSP: those HIV-positive staff and volunteers who are able and willing to be open about their HIV status to some degree and who take on an active role in promoting GIPA and provide peer support to other positive staff, volunteers and clients.

PNG's *National HIV Prevention Strategy* has recognised the limits of medicalised approaches to HIV support:

Programs must move from a narrow medical approach to a life cycle approach to positive living, involving a series of strategies to increase the confidence,

*motivation, and ability of people living with HIV to manage and protect their own health, sexual life, and relationships.*⁷

The PSP Audit Team recommended that:

- the holistic health and well-being needs of positive female sex workers and men who have sex with men be confirmed, promoted and funded in the PSP Workplan
- existing welfare/charity funds be formalised at all project sites, and
- simple positive prevention activities be commenced such as healthy cooking and exercise classes.

It was recommended that PSP work with partners to increase efforts to promote GIPA Principles, join in partnership with local PLHIV networks, and promote the fair treatment of positive female sex workers and men who have sex with men by HIV health services.

The Audit recommendations also include the setting of long term goals:

- working with *Sanap Wantaim* to encourage uptake of the *Code of Good Practice for NGOs Responding to HIV/AIDS* by all NGOs working on HIV issues in PNG
- creating PSP Positive Peer Support Worker positions to provide support to HIV-positive female sex workers and men who have sex with men, and
- working towards an environment within PSP that encourages all staff and volunteers to regularly monitor their HIV status.

PSP recognises its obligation to develop a formalised program providing access to holistic care and support to female sex workers and men who have sex with men who are living with HIV. The GIPA Audit clearly demonstrated that many PSP staff and volunteers were already providing care and support to positive female sex workers and men who have sex with men. PSP aims to build on this good work.

Moving forward

The GIPA Audit Team believes that if the Audit recommendations are implemented in a timely manner, there will be increasing leadership by positive people and access to good quality care both within PSP, and hopefully to some degree, within all NGOs working on HIV issues in PNG.

At a recent follow-up GIPA consultation meeting with PSP staff in Port Moresby (13 April, 2010), Nick and Dorothy outlined some of the excellent progress that has been made to date. Their successes have included progress on developing the PSP *Code of Conduct*, the establishment of small but vibrant peer support groups of positive women and men in Lae and Port Moresby; an increase in collaborations between PSP and local PLHIV groups; and the building of a memorial garden at PSP in Port Moresby to remember their many lost friends. Since the GIPA Audit, several more PSP staff and volunteers are now more open in their workplaces about being positive and are keenly working together to provide support to other positive staff, volunteers and clients.

AFAO is delivering a men who have sex with men Community Leadership Pilot Project in partnership with the PSP and the PNG-Australia HIV and AIDS Program (*Sanap Wantaim*). The Poro Sapot Project (PSP) is also currently undertaking ground-breaking community mobilisation work, advocacy, and capacity building with police. Further information is included in the online version of this article, available at www.afao.org.au

References

- 1 Enquiries welcome to Robert Baldwin tuntablecreek@bigpond.com
- 2 Comment from a PSP staff member during the GIPA Audit.
- 3 Many men who have sex with men we spoke to preferred to use words such as 'sistagirls' or 'palopas' to describe their sexual identity, many viewed terms such as 'gay' as an insulting term when used by society in general, and some men who have sex with men said they had no term

Positive PSP staff perspective: feedback from Nick and Dorothy

We were both very pleased to be part of the GIPA Audit Team, a process which gave us the opportunity to discuss current and possible future PSP work with our PSP staff and volunteer colleagues. We also got to meet with several fellow HIV-positive staff and volunteers to talk about their needs and ideas. Those conversations mostly occurred in private: one-on-one meetings outside the work environment. . Most positive people within PSP are still very secret about being HIV positive. We intend to continue to keep close contact with our new friends.

We learnt much from being part of the GIPA Audit Team, including how to plan and conduct a review process. It was also a first to work in an all HIV-positive team. We increased our skills and confidence, and Nick learnt much about logistics by being the key person responsible for organising Team travel and meetings. It was great to hear the thoughts and opinions of many people, including our PSP partners, and we now have many new ideas about how to work with positive people in the future.

Dorothy's story: the experience of being HIV-positive

In November 2003, I decided to go for an HIV test at Anglicare StopAIDS because I was feeling really sick with chest infections, and was losing a lot of weight. I had also lost a lot of hair.

After counselling and having a blood test, I was asked to come back to collect my results in two weeks. When I did return for my results, the male counsellor that I went to see, referred me to a female counsellor. She was very nice in the way she approached me and greeted me. She brought me into one of the rooms for counselling and then asked me if I was ready for my results. I said I was ready. She told me that I was HIV-positive.

I did not know what to do and started crying. While crying I thought to myself that it was the end of my life and the world. When I stopped crying, the female counsellor comforted me and said she was also living with HIV. That was a shock to me because I was thinking that I was the only person who had HIV. The counsellor asked me if I wanted to meet with other HIV-positive people. I said I really wanted to meet them so the counsellor showed me the Drop-in Centre and introduced me to the positive people there. They all shared their experiences with me which really gave me hope and strength to live on.

to describe their sexual identity. The term 'straight' was often used by the men who have sex with men we met to describe men who 'would have sex with us'. Generally the men who have sex with men we met said they were not publicly open about their sexual practices or identities. Sexual activity between men in PNG remains illegal.

- 4 Shaw, L. and Baldwin, R. (2008). *Review of Poro Sapot Project*.
- 5 It is acknowledged that there is a continuing discussion at the global level, lead by GNP+ (Global Network of PLHIV), about 'positive prevention': both the terminology and the components. There is still much contention about the use of the term 'positive prevention', mainly because it implies a strong focus on 'controlling' PLHIV to not transmit the virus, rather

than supporting PLHIV to prevent them becoming unwell and to encourage them to maintain safe behaviours and healthy living. More recently the term 'Positive Health, Dignity and Prevention' has been coined, though at APN+ (Asia Pacific Network of PLHIV) we prefer to use the term 'positive health'.

- 6 From GIPA Audit Report
- 7 National AIDS Council of Papua New Guinea. (2009). *Papua New Guinea National Prevention Strategy 2008–2013: Expanding and Scaling up the Response*, p10, Draft: 09/02/2009.

Robert Baldwin is a volunteer advisor for Asia Pacific Network of PLHIV (APN+).



Hope through positive governance

By Annie McPherson and John Rule

Pictured clockwise from left: Staff members of AusAID PNG and Igat Hope in feedback sessions at the treatments advocacy workshop; Clinicians, health care workers and members of Igat Hope working together to prepare the *Waigani Statement*; and NAPWA staff and Igat Hope members talking about treatments advocacy models.

Five years ago, the National Association of People Living with HIV/AIDS (NAPWA) embarked on a partnership project to provide mentoring and support to an emerging network for people living with HIV (PLHIV) in Papua New Guinea (PNG): *Igat Hope* (meaning ‘there is hope’). At that time, those involved in the NAPWA/Igat Hope partnership may have queried the chances of Igat Hope engaging in a national leadership role. Igat Hope had aspirations but no office, no staff, no

direct funding, and no documentation. It lacked relationships with emergent PLHIV groups in the provinces, and members were unsure how to proceed in setting the organisation’s directions. Importantly, Igat Hope was without access points in national discussions in relation to the epidemic and national power structures, and its potential as a national representative organisation remained unrecognised.

Now, Igat Hope has a well established office in Port Moresby. There are seven staff members¹, with various levels of external technical support provided by partner organisations. Direct core funding is received through AusAID, and project funding through PNG’s National HIV/AIDS program. Additional funding has recently been secured from the Asian Development Bank and other development partners. Governance practices are strong,

with Igat Hope providing audited accounts and successfully acquitting and renegotiating future contracts in-country during the last two years. *The Waigani Statement on HIV Treatments Action* (see page 19) demonstrates that Igat Hope is now well-positioned to engage in national advocacy work for all people living with HIV in PNG.

Positive governance PNG style

The development of Igat Hope would not have been possible without the determination of the many people living with HIV who have been part of the establishment and running of the organisation over the last seven years. PNG does not have a long history of community-based organisation governance. Igat Hope was in fact charting new territory², as positive people from many different backgrounds got together to form the

organisation, apply for money to run projects, and manage projects and staff. There were many different expectations and enormous need to be met.

During the last five years, NAPWA has provided significant support for governance development within Igat Hope through AusAID funding under the AHAPI project (2005–2008) and the *Sanap Wantaim* project (2009–2010).

NAPWA has provided technical support prior to and at every Igat Hope Annual General Meeting. NAPWA staff, consultants and volunteers have shared their experiences of positive governance. Governance training has been conducted for each newly elected Board, and at the Board's request, NAPWA consultants and HIV-positive mentors have also attended and supported significant organisational and Board planning meetings. Last year, the Melanesian NGO Centre for Leadership (MNCL) was brought on board, delivering a successful workshop on Board roles and responsibilities, and how to define organisational aims. It is hoped MNCL will be able to provide ongoing, local support for governance-related learning. Igat Hope is now well placed to continue the tradition of a national PLHIV organisation managed and governed by positive people.

Inaugural PNG National People Living with HIV Conference

The first national conference for people living with HIV (PLHIV), held November 2008, represented a significant milestone in the development of the PNG PLHIV organisational response. The conference attracted participants and representatives from every province in PNG; all of the PLHIV groups outside Port Moresby were represented.

The conference program was developed through Igat Hope's consultation with affiliated PLHIV groups, and conference recommendations were genuinely representative of national interests of PLHIV. Themes and

recommendations related to:

- HIV training, and the need for PLHIV to be more integrally involved in the design and implementation of training programs
- Using research to develop understandings of positive peoples' treatment experiences
- Better use of the *HIV/AIDS Management and Prevention Act* (HAMP)
- Better access to HIV care and support, free from stigma and discrimination for men who have sex with men (MSM)
- HIV treatments, care and support, and greater consultation between Igat Hope and those partners providing care and support programs for PLHIV, and
- Media, and the need for a public campaign that advocates for treatment, care and support for PLHIV.

The conference debated a national representative structure for Igat Hope which would include regional and provincial PLHIV groups, and it was agreed that inclusion of regional representatives on the Igat Hope Board would strengthen the national network. NAPWA was asked to work with Igat Hope to identify and develop the necessary constitutional changes. The Igat Hope membership will vote on those proposed changes at the next AGM.

Treatments literacy in PNG

NAPWA's Treataware Project has supported treatment related workshops for Igat Hope over the course of the partnership. Workshops, combining input from experienced NAPWA trainers and respected care practitioners based in PNG, provided treatments literacy information and an opportunity to discuss peer and nutrition support.³ The workshops have been evaluated, with support for continuation of this model of knowledge transfer and exchange.⁴

Expanding people living with HIV's role in clinical/community care teams^{5,6}

The Collaboration for Health in PNG⁷ has provided an opportunity to support people living with HIV (PLHIV) organisational development through a partnership approach. The initial focus was on increasing understanding of the benefits of day care centres and similar 'positive spaces' outside Port Moresby.

In 2008/09, Igat Hope endorsed NAPWA undertaking a snapshot assessment of the different models⁸ of positive spaces and PLHIV group development outside Port Moresby. It represented a first step in considering the role such spaces could play in developing sustainable health partnerships. Not aiming for universal coverage, the project identified sites most relevant to Igat Hope. Interviews with key stakeholders and meetings with PLHIV representatives were conducted, and a narrative report was circulated to all Collaboration Partners.

A major recommendation from that assessment is the piloting of a PNG-specific model of engaging PLHIV health service delivery. A project seeking a clearer and expanded active role for positive people in clinical and community care teams in PNG has been proposed to the Collaboration (running July 2010 to end 2011). The project aims to address four areas, including:

- Planning and advocacy in relation to treatments roll-out
- Better use of trained people living with in HIV in the HIV response
- Creating a legitimate role for PLHIV in clinical/community care teams, and
- Operational research to assess progress.

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The Waigani Statement

Another milestone in the development of the PNG people living with HIV (PLHIV) response occurred in March 2010, when Igat Hope hosted a week-long treatment advocacy workshop. The workshop produced *The Waigani Statement*:

The participants of the Igat Hope National HIV Treatments Workshop, held in March 2010, declare that they will work together to bring about urgent changes in the way that HIV treatments are provided and how people living with HIV on ART are monitored and supported in PNG. The workshop participants included HIV-positive people, community workers, policy makers, development partners, doctors, nurses and other health care providers. It was supported by a team of people from the National Association of People Living with HIV/AIDS (NAPWA), Australia.

The Waigani Statement provides a set of detailed recommendations in relation to:

- support for people receiving antiretroviral therapy (ART)
- prescribing and monitoring of ART
- supply and distribution of medicines, test kits, reagents and equipment, and
- HIV Treatments Advocacy, which includes the development and implementation of a treatments campaign, strengthening personal advocacy for people living with HIV, and seeking formal partnerships to enable positive people's participation in response to HIV in PNG.

The Waigani Statement was presented to the Director of the National AIDS Council, and also sent to senior representatives within the Department of Health, who have since agreed the statement is significant and timely. They have indicated they will incorporate the recommendations into various workplans.

The Waigani Statement represents the beginnings of a plan for Igat Hope's ongoing activities in relation to treatment advocacy. The organisation will continue to work using a Treatments Alliance model with in-country partners and ongoing external support from partners such as NAPWA.

The future

Igat Hope, as the name implies, is looking forward. This year will see a new constitution genuinely supporting a national structure by including regional representation, further developments within the Secretariat structure, an active treatments advocacy agenda, research into HIV related stigma and discrimination and a second national conference. All this stands as testimony to the work of Igat Hope members and their partner organisations, as they continue to push for the meaningful involvement of people living with HIV and an improved response to the HIV epidemic in PNG.

References

- 1 See *UNGASS 2008 PNG Country Report*, PNG National AIDS Council Secretariat which notes at page 35 "A full time coordinator was employed by July 2006. 2007 kicked off on a positive note with the employment of two new staff; the program office and the finance and admin officer which make up the secretariat of Igat Hope Inc. Securing an office space was another major step forward for the group."
- 2 See introduction to *Making Sense of AIDS, Culture, Sexuality, and Power in Melanesia*, Butt, L. and Eves, R. (eds.). (2008). For a good discussion of the ways in which local culture and power relationships complicate governance patterns and the way in which historical diversity provides an enormous challenge to planning and organisation.
- 3 See *UNGASS 2008 PNG Country Report*, PNG National AIDS Council Secretariat which notes at page 37 'Treatment is one area where Igat Hope members are not consulted or involved much in terms of their thoughts and inputs as people living with HIV or in setting up treatment guidelines and treatments rollout'. All training programs involving Igat Hope and

NAPWA have been modelled on a co-facilitation basis, with Igat Hope members engaged as workshop facilitators and providing expert local knowledge.

- 4 Ibid page 37 'Not much and adequate training is provided on treatments literacy and treatment advocacy to positive people which makes it even harder for them to talk about treatments to their peers and also to advocate on issues of treatments which they are often faced with.'
- 5 Reports provided by the Australasian Society of HIV Medicine to the Collaboration for Health in PNG, *Clinical and Laboratory Mentoring, 2008-2010* have noted that there are: overloaded referral pathways; HIV is presenting in more complex ways; treatment toxicities and side effects are now being seen in clinics; new models of service delivery are required; assistance is needed with compliance and patient support; there is a lack of trained persons; and succession planning in many sites. PLHIV community development has the potential to assist in response to these problems.
- 6 An independent review of HIV Training Programs in PNG conducted in March 2009 and reported to AusAID notes the importance of 'incorporating PLHIV as an integral part of clinical teams, to support self-care and for PLHIV to act as a liaison between the clinic and the community'.
- 7 For further information on the activities of the Collaboration see www.chpng.com.au
- 8 The report provides a snapshot of the stages of development of PLHIV groups in Alotau, Goroka, Hagen, Mendi, Vanimo, Buka, Madang and Rabaul. It also identified that there is a wide range of large and small groups across the country providing support. Many are involved in voluntary counselling and testing, and at Mt Hagen, three to six people were being diagnosed HIV-positive per day. Some of the PLHIV group links to clinics were formal while others were less so.

Annie McPherson is Coordinator of Igat Hope and John Rule is the former Deputy Director of NAPWA.



World AIDS Day 2009 in Port Moresby, PNG. Photo courtesy David Traynor.

Moving towards sexual citizenship in the response to HIV

By Katherine Lepani

HIV has become a permanent, defining feature of the development landscape in Papua New Guinea (PNG), directly linked to the processes of social change and modernity. Over the last several years, the presence of the epidemic has firmly settled into the national consciousness. Peter Piot, the former executive director of UNAIDS, talks about the ‘familiarisation of the epidemic’¹, a notion that reflects the continuing transformation of our understanding of HIV and how the virus moves and mutates within different populations. Whether isolated, concentrated, clustered, generalised or feminised, perhaps the best way to acknowledge HIV in our midst is to say the epidemic in PNG has become familiarised.

National policies and programs of response have been in place for over 15 years, utilising broadly consultative

and participatory processes to activate awareness, engage multisectoral commitment, and engender local ownership. Recent years have seen a groundswell of popular and political interest as more resources are committed and mobilised. Large injections of donor funding and technical support have produced a virtual industry of stakeholders and interventions, as different international agencies and local groups claim areas of special interest and expertise and attempt to collaborate and coordinate efforts in areas of common concern.

Yet the destructive effects of fear, stigma, and blame continue to plague these efforts, as made disturbingly apparent in a recent commentary in one of the daily newspapers that recklessly speaks of ‘harsh truths’ and disparages the national response as ‘too fair, too lenient and too sympathetic’². Such

views are harsh, but they are far from the truth. Rather, they perpetuate harmful myths that spread more rapidly than HIV, while locking the collective understanding of HIV in a moralistic frame. They also indicate that for some people, fear has been replaced by fatigue and disengagement, along with charges of wasteful and misdirected funding. Unfortunately, like fear, fatigue also reinforces stigma and discrimination, allowing blame to continue to thwart communication about sexuality, sexual practice, and the structural factors that contribute to social risk and vulnerability. The persistent anti-condom rhetoric, and resistance to condom supply and distribution, reinforces negative associations between condoms and

continued overleaf

sexual practice, deeming protected sex to be morally bad while unprotected sex is held to be morally good and assumed to occur within marriage and other intimate relationships³.

Well-intentioned programmatic efforts also lend themselves to negative perceptions and harmful rhetoric. Biased assumptions about risk groups and the so-called drivers of HIV continue to inform surveillance and program interventions, reinforcing moralistic viewpoints so that it becomes hard to see beyond boxed categories.^{4,5} Standardised categories of risk link HIV transmission to promiscuity more readily than whether or not sexually active people have access to condoms and health facilities that provide non-judgemental and confidential services. Details of social structure and cultural context remain hidden while the statistical analysis of individual practice dominates the push for an evidence-based response, belying the fact that epidemics are, above all, 'collective events'⁶. Very little is said about sexual desire.

Largely missing from our understanding of HIV transmission dynamics in PNG is an appreciation for how sexual networks operate within the larger social networks of reciprocal exchange which underpin the subsistence and informal economies. Sexuality as a resource of value activates the circulation and redistribution of exchange items, underscoring how intimate transactions are embedded in larger fields of exchange.⁷ In other words, PNG social systems create spaces of desire wherein the exchange of resources and the exchange of sex are 'mutually reinforcing'⁸. That sex might be valued and practised as a form of exchange disturbs the moral underpinnings of HIV prevention discourse.⁹ Also missing is a deeper understanding of the structured practices of abstinence and infidelity that create HIV risk and vulnerability within intimate relationships and marriage.¹⁰ The moralisms that continue

to frame interventions undermine the ability to question preconceived notions of what constitutes 'proper' sexual behaviour and to recognise risk in the familiar.

HIV exceptionalism

Early in the global pandemic, the public health response to HIV took a different approach from standard strategies for infectious disease control, intent on ensuring clinical confidentiality and anonymous surveillance systems because of the unique pathology of HIV and the implications for stigma and discrimination. This approach created what is known as HIV exceptionalism.¹¹ Responding to HIV also involved a major shift in focus away from the health sector and towards multisectoral and mainstreaming strategies that approach HIV as a development issue and not simply a public health concern.

HIV has lived up to its exceptional tag, bringing to the forefront of the policy arena the need: to address structural causes of poverty and gender inequalities; to understand how gender violence and the fear of violence create risk and vulnerability, particularly for women; and to position HIV within a human rights framework that recognises the fluid diversity of sexual identities and desires. On many counts, PNG has responded to this challenge in an equally exceptional way. For example, it is one of only a few countries that has passed legislation to uphold the rights of people living with HIV (*HIV and AIDS Management and Prevention Act 2003*) and that has developed a *National Gender Policy and Plan for HIV and AIDS*¹².

With the advent of diagnostic testing and drug therapy, there is a trend towards normalising HIV, or treating HIV like other infectious diseases where early diagnosis contributes to effective preventive measures and therapeutic management. Ironically, perhaps, this has meant situating HIV within a biomedical response once again. This shift of focus presents significant challenges for countries like PNG where basic health infrastructure

and services are poorly resourced, with limited capacity to provide effective diagnostic and treatment services. Yet exceptionalism prevails: the significant potential for HIV treatment and care services to transform health delivery systems, to reinforce primary health care, and to enhance the relationship between communities and health providers. The provision of treatment and care for people with HIV and AIDS-related illnesses encourages greater awareness of human rights and increased demands for accountability and improvement in the quality and range of health resources and services.

There is no argument that medical treatment for HIV should not become normalised through available, accessible, and effective service provision.

However, the complex interaction of social, cultural, and economic factors that influence HIV epidemiology, and upon which HIV has considerable impact, continues to mean that HIV requires an exceptional response. There is shared recognition that the most effective approaches to reducing HIV transmission focus on the deep-rooted structural and social inequities of resource distribution, wealth creation and power, and gender relations.¹³ With the advent of the Liquefied Natural Gas (LNG) project in PNG, it is imperative to contextualise HIV in relation to economic development and the livelihood opportunities that the project generates in both the formal and informal economies. At this 'nation-changing, life-transforming' moment¹⁴, now more than ever PNG must not lose sight of the epidemic and let fatigue set in, but rather must reinvigorate multisectoral and mainstreaming strategies for HIV prevention, treatment and care.

Sexual citizenship

Positioning the response within a human rights framework has been essential for addressing discriminatory and harmful attitudes towards people living with HIV and people whose social and economic circumstances make them more vulnerable to HIV, and for ensuring legal protection. Now is the time to work more critically to

elaborate human rights in relation to sexual citizenship; that is, upholding the rights and responsibilities of all people to have control over their sexual and reproductive health and to express sexual identity, desire, and pleasure in healthy and safe ways, free of fear, harm, and force, as an expected part of membership in a shared community¹⁵, recognising that good sexual health is good public health.

How might the language of human rights articulate rights and responsibilities in relation to sexuality and what exactly do we mean by sexual rights and responsibilities? This leads us again into the importance of cultural and social context and how gender and sexuality are conceptualised and given meaning and value differently in different places, not only here in PNG but throughout the world.¹⁶ It also highlights the importance of understanding power and control within intimate relationships, and how relations of coercion or mutual consent either constrain or support people's ability to protect themselves and their sexual partners from HIV. 'Practise safe sex' has long been the mainstay message of HIV awareness and prevention programs in PNG and elsewhere. This assumes that people have access to the information, resources, and services that enable them to make informed decisions about their sexual practice. But experience and evidence tells us time and again that the message has betrayed most people, particularly girls and women in unequal gender relations, whose sexual experience does not involve mutual consent or the ability to negotiate condom use.

Sexual citizenship also challenges us to think how sexual rights and responsibilities operate not only at the individual level but the collective level. In PNG, sexuality and sexual citizenship necessarily involves the importance of kinship systems and social relations based on networks of exchange. The notion of citizenship raises the challenging issues of transcending cultural relativity to reach consensus on the common good and to uphold diversity through collective

understandings. It also resonates with the attention being given now to good governance and leadership issues, and the law and justice sector, and how HIV is being addressed within these important arenas of response.

I am not proposing that the national response to HIV get weighed down by conceptual debates when the major challenge is to ensure that quality services are available and accessible and delivered in a sensitive, ethical way. Nonetheless, the interface between theory and practice offers a productive site for clarification and consensus. Critically important for the national response are opportunities for continual reflection and dialogue to better articulate the ideas that inform how programs and projects are designed and implemented. It is timely to call to mind the late Carol Jenkins's farsighted warning during the initial years of PNG's experience with the impending epidemic: 'In the rush to develop programs to diminish the spread of HIV, we must be aware that we could do lasting damage to the image of sexuality we create for ourselves'¹⁷.

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Children at school in Papua New Guinea. Image © bigstockphoto.com

Developing good HIV practices in PNG: the Serendipity Educational Endowment Fund (SEFF)

By Elizabeth Reid

Too often the stories from the HIV epidemic in PNG are stories of humiliation, of violence, of indifference and of despair. Yet there are stories of goodness, of good practice. Let us look at some of them.

The first is of a young woman whose husband and baby died of HIV. She has her two remaining children and her mother to support. She used to live with her father but now he has taken a second wife who does not want the daughter and her children in the house. She is determined to find work and become independent. She asked around and has now enrolled in a technical course to gain a certificate. She is living with HIV.

The second is of a young man who, as a school boy, used to take, even carry, his mother to the clinic every time she became sick. He would encourage her to eat and to take care of herself. His father had taken a second wife and his mother had thrown her husband out. There were only the two of them. Eventually his mother was diagnosed with HIV. They were stripped of their house, land and coffee trees in the village. They shifted from place to place. He worked whenever he could to earn the money to finish his schooling and to take care of his mother. He is now studying to be a school teacher so that he can provide shelter and care to his mother. His mother prayed for courage

and went to visit her husband and his second wife. She told them that she had been diagnosed with HIV. She told them how well she was now that she was on ART. She urged them to go and get tested. Eventually they did. He is infected but so far she is not. Both the young man and his mother are now trained in community conversations and work hard to prevent others from getting infected in their area.

There is a story of a man who has two wives and, he thinks, about ten children. After his brother and his wife died of HIV, he took in their five children. He was struggling to take care of all of them and determined to treat them all the same. But he and his first

wife are also living with HIV, so it was difficult. Now that the burden of school fees has been lifted and his children have support to go to school, he is a changed man. He has come alive. He has built two study huts for the children to do their homework. They are simple huts, with mud floors, no desks or bookshelves, but with lamps by which they can read. He has put nails along the wall so that each of the children can hang up their school bags when they get home from school each day. He has also built some fish ponds so that he can contribute towards the cost of their schooling as well as feed the family. One of his daughters had been scattered, sent to relatives in a far village. She was unhappy and not treated well. She was not in school. She missed her family. She heard that things had changed at home and made a decision. She told no-one in the village but left, walked back to her father's house and asked if she could come home and go to school. He welcomed her back.

One boy's mother died some years ago. He is now about nine years old. Both he and his father are living with HIV. Both are on ART. His father is unemployed and they only survive through the kindness of others. The young nine year old takes his ART faithfully and is overjoyed to be in school. One young student was raped by her teacher. She is infected with HIV. She was taken unwillingly out of school. But she is now continuing with her education.

What do Ave Maria, Tina Arena and these stories have in common?

The answer is Craig McMahon and Andrea Bocelli. In 2008, as a young Australian entrepreneur, Craig signed up singer Andrea Bocelli for his third tour to Australia. Not only was it negotiated that Tina Arena join Bocelli on stage for part of the concert, it was also negotiated that a percentage of

each ticket sold would be donated to the Asia Pacific Business Coalition on AIDS (APBCA).

The concerts were a spectacular success and K250,000 was set aside to help address HIV issues in PNG. But what issues? And how?

APBCA immediately consulted with its national affiliate, the PNG Business Coalition Against HIV and AIDS (BAHA) and together they consulted others. With all the confusion, fear, sadness, indifference and suffering surrounding the HIV epidemic in PNG, there was much that needed to be done. How could a relatively small amount of corporate money be effectively used? And could it be used to leverage more funding from within the corporate sector?

One possibility was to support children of parents living with HIV so that they may be able to continue in school. In PNG most people living with HIV are between 20 and 35 years. They are mostly married and most of them have children. They are as likely to live in rural areas, even isolated rural areas, as in urban areas.

There has been little focus on the children of the epidemic. There is little understanding of their situation. Few

people are working with them. Some of these children are infected, all are affected. They face many problems. One overwhelming problem is the likely loss of an education, which has serious ramifications for their futures.

Children whose parents are infected are often lost to school long before their parents die: tension in the family, unaffordable school fees, family break down, a parent leaves or dies, they are stripped of their inheritance, of land or home, and more. Supporting HIV-affected children through education was an area of unmet need where the gift of K250,000 could be effectively used.

Once this decision was taken, there were more questions. So, more thought. More consultation.

A scholarship scheme was a possibility but in situations of need, school fees alone may not ensure that children can remain in school. There are all the other costs associated with schooling: transport, school books and supplies, uniforms or clothing, meals, maybe boarding, and more.

An approach needed to be designed that took such issues into account and

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He is now about nine years old. Both he and his father are living with HIV. Both are on ART.

His father is unemployed and they only survive through the kindness of others. The young nine year old takes his ART faithfully and is overjoyed to be in school.



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also addressed issues of wise selection, transparency and accountability, monitoring of progress, retention, etc. The Serendipity Educational Endowment Fund was born.

The Serendipity Educational Endowment Fund (SEEF)

Four Trustees were appointed, with at least one being required to be an APBCA board member and another, a BAHA board member. One was to be knowledgeable about the children of PNG's HIV epidemic.

The first principle applied was the principle of subsidiarity: that decisions should be taken as close as possible to the situation. It was clear that a board of Trustees would not be in a position to handle the day to day issues that would inevitably arise, so it was decided the Fund would work with partner organisations: organisations already working with people living with HIV, which had gained their trust and respect.

Two sets of guiding principles were developed. The first related to the selection of children:

- The parents, guardians, foster parents or carers of the children will be known to the Fund partner or its partners.
- The parents, guardians, foster parents or carers of the children will contribute towards the children's education, in cash, kind or labour. The Fund will top up this contribution.
- The parents, guardians, foster parents or carers of the children will be asked to commit themselves to encourage the children to do their homework, school projects and other tasks assigned by the school, and to provide care for children in school holidays.
- The parents, guardians, foster parents or carers of the children will be asked to provide or authorise the school to provide

copies of the child's report cards to the Fund partners. Trustees and Fund partners will place priority on consistent school attendance by the beneficiaries and will monitor educational progress.

- The parents of the children, where one or both are alive, will be asked to demonstrate their will and determination to stay alive and well to care for their children, for example, by accessing and adhering to HIV prophylaxis and treatment.
- The Fund and Fund partners need to ensure that the principles of social justice are honoured in the selection of the children, in particular, those of gender equity and need.

The second set of principles related to the Fund's operation:

- Funds will be provided only to approved Fund partners. No support or funding will be provided directly to parents or guardians of the children or to other organisations or institutions.
- The Fund will commit itself to provide support to the education of children in the scheme throughout their schooling, subject to the advice of the Fund partners and in accordance with the operating procedures of the Fund.
- Where relevant and appropriate, the Fund will support families of children as well as individual children.
- Where the guardians, foster parents or carers of the children are themselves in need, consideration

will be given to supporting the education of all the children in the household.

- The Fund and Fund partners need to strive to ensure that the rights of the children are honoured and protected, in particular the rights to be free from abuse and exploitation.
- The Fund and Fund partners need to ensure that the provisions of the *HIV and AIDS Management and Prevention (HAMP) Act* are followed.

The Trustees have now developed Operating Guidelines for SEEF, have finalised the choice of partners, and decided on the initial allocation of funds for each partner. 2010 is the first year of the Fund's operation. SEEF is working with five local partners in five provinces, and together they support over forty families touched by the HIV epidemic, and more than one hundred children have been enabled to continue their education.

The stories are pouring out, rendering the invisible visible, documenting the realities of the epidemic across the country, bringing to light vast acts of kindness and care. They are stories of empowerment, of agency, of regained dignity, of fulfilment, within the ongoing tapestry of pain and discrimination that marks the HIV epidemic in PNG.

Elizabeth Reid is a development practitioner, feminist and academic with a distinguished career in public service. She is a SEEF trustee.

The stories are pouring out, rendering the invisible visible, documenting the realities of the epidemic across the country, bringing to light vast acts of kindness and care.



World AIDS Day 2009 in Papua New Guinea.
Photo courtesy AusAID.

Making a difference: Australia's support to the Papua New Guinea HIV response

By Donna-Jean Nicholson

Australia has supported Papua New Guinea's (PNG's) response to HIV since the mid-1990s. Efforts were significantly expanded in 2003 following declaration of a generalised epidemic, marked by prevalence estimates of more than one percent of the general population likely to be HIV infected.

The challenge

Evidence shows that HIV transmission in PNG is driven by unsafe sexual practices, sexual violence and the practice of having multiple concurrent sexual partners.

The profile of PNG's epidemic is closely aligned with the nation's major economic corridors, specifically impacting communities along the Highlands Highway and in the National Capital District. The potential social and economic impact of the impending Liquefied Natural Gas (LNG) project may trigger a new dimension in PNG's HIV epidemic. The project will operate in the Southern Highlands, Gulf and Central Provinces (including Port Moresby) but will impact nationwide.

Despite the potential economic benefits for PNG, the LNG project brings together critical risk factors for

HIV transmission likely to exacerbate current high HIV prevalence throughout the highlands region. These factors include a mobile and extensive internal and international workforce, the dislocation of communities from their land, and sudden wealth within communities benefiting from the project. These changes will likely trigger increased alcohol and drug use, and an increase in transactional sex which, combined with high rates of sexually transmissible infections, will be likely to impact PNG's epidemic.

The HIV epidemic and other human development indicators highlight the challenges PNG faces attempting to meet the Millennium Development Goals. The seriousness of PNG's HIV epidemic has recently been reaffirmed by the report of the Commission on AIDS in the Pacific (2009), and by Australia's international development assistance strategy for HIV, *Intensifying the response: Halting the spread of HIV* (2009), which prioritises support to the HIV response in PNG.

Australia's role

The PNG National AIDS Council and its Secretariat are mandated to manage and coordinate the national response to HIV. Australia supports PNG's

HIV response through the Council and its Secretariat, guided by the PNG Government's policy framework and priority setting processes. Australia also provides ongoing technical assistance to strengthen the framework.

In accordance with the Paris *Declaration on Aid Effectiveness* (2005) and *Accra Agenda for Action* (2008), Australia is committed to ensuring that international development assistance contributes to tangible outcomes in partner countries. PNG's HIV response is supported by an international independent technical review group, which provides guidance to continuously improve the relevance, effectiveness and efficiency of the response. Australia relies on this annual assessment to respond to new knowledge about the unfolding HIV epidemic.

The PNG Australia HIV and AIDS Program, mobilised in 2007 and managed by AusAID, is the primary mechanism for Australian Government support to PNG's HIV response. The initiative has been designed to be broad and flexible to respond to the dynamic context of PNG's HIV epidemic.

To complement the lead taken by the PNG Government, Australia has supported efforts to enhance the

capacity of numerous organisations to increase delivery of evidence-informed services that address PNG's HIV response goals and objectives. That work has resulted in rapid scale-up of prevention and treatment services since 2007, and increased engagement by the private sector, community and faith-based groups.

Today, HIV-related services are available nationally in urban, peri urban, rural and a range of high risk settings, although population-wide coverage remains inadequate. PNG nevertheless leads the Pacific region in HIV treatment access, with over 70% of those eligible for treatment receiving antiretroviral (ARV) therapies. This achievement can be attributed to the combination of support from the Global Fund and Australia's financial and technical support to more than 20 partners throughout the country.

Taking forward the response

Challenges lie ahead. Despite the enactment of the *PNG HIV and AIDS Management and Prevention Act* (2003), people and communities living with HIV and AIDS, sex workers and men who have sex with men continue to face severe stigma and discrimination. There is limited access to legal protection, and many people live in fear, reluctant to access available prevention and treatment services. Advocates and partners in the legal and social sectors are chipping away at this systemic constraint which threatens to undermine the long-term effectiveness of the HIV response.

The National AIDS Council has recently initiated a strategic shift by devolving coordination and management of the HIV response to sub-national structures. This measure aims to ensure increased access by PNG's rural majority population to HIV-related services. Provincial Administrations have been encouraged to step up their leadership role, to better steer unique provincial responses, and particularly to strengthen coherence between public and private sector efforts.

In response to LNG Project risks, Australia has begun working more

Key achievements

Scaling up of:

- **HIV voluntary counselling and testing:** 123,661 tests reported by 250 facilities in 2009, compared to 120,607 tests by 201 sites in 2008, and 32,645 tests in 2006.
- **Advocacy and support:** an estimated 1,500 people living with HIV are now registered as members of advocacy and support networks.
- **HIV education:** 184,000 people, including school children, have received formal HIV training and benefited from awareness programs delivered by non-government organisations.

Making a difference: Australia's partners in the PNG HIV response

- Susu Mamas, a PNG non-profit organisation, is dedicated to reducing PNG's high infant and maternal mortality rate, and providing care to HIV-positive mothers and babies. The free service helps up to 10,000 clients per month in provinces where there is high HIV prevalence.
- The Clinton Foundation supports the Well Baby Clinics in Port Moresby with a specialist service to care for mothers and babies living with HIV. An outreach service to villages is also provided to counsel couples and their extended families where a mother and baby are HIV-positive, providing information on how HIV is transmitted, options for care and future prevention.
- Catholic AIDS Office has established 84 sites nationally. During 2009, 35,091 people (12,324 males and 22,767 females) were tested. Ante natal testing was accessed by 4,959 women at 14 sites, and 10 centres delivered ARV treatment.
- Anglicare STOPAIDS operates in three provinces. In 2009, Anglicare provided information on HIV to 102,460 males and 97,172 females, and distributed 2,765,464 male and 85,423 female condoms nationally.
- National HIV and AIDS Training Unit (which is outsourced) in 2009 provided 300 courses to 4,900 males and 4,256 females. Eight hundred health workers were trained in voluntary counselling and testing, and HIV testing management. Peer education training was delivered to 200 teachers, and in-service training to 204 trainers.
- Family Health International (FHI) supported 115 Tingim Laip ('Community prevention' site committee members (44 women and 71 men) from 23 sites in 11 provinces to become behaviour change communication implementers. FHI also delivered home based care train-the-trainer training to 20 participants. Ninety three trained community home based care team members provided services to 20 sites.
- Tingim Laip provided prevention and treatment services in high risk settings at 39 sites in 11 provinces in 2009. The network distributed 1,425,988 male and 136,007 female condoms.

closely with the National AIDS Council Secretariat, the Southern Highlands Provincial Administration, and civil society partners to scale up prevention efforts near project sites. Australia is also looking at ways to work more closely with the companies working in the area (particularly Oil Search) to address the social impact of the extractive industry on the HIV epidemic.

Australia will continue to work with local and international partners to

ensure support is effectively targeted at addressing the drivers of the HIV epidemic and to meet the challenges facing PNG's most at-risk populations.

Donna-Jean Nicholson is Deputy Program Director for AusAID's HIV/AIDS Program in PNG.



Collaboration for Health in Papua New Guinea (CHPNG): ASHM's Clinical Mentoring Program in PNG

By Jacinta Ankus

Pictured from left to right: Brother Chris (Nursing student), Sr Gaudentia and Felix Wakoi (Community Health Worker, Williame Aid Post, Southern Highlands); A bridge on the way to Puren; and Sr Gaudentia and Dr Arun Menon, Southern Highlands

The Collaboration for Health in PNG (CHPNG) is a consortium of several Australian based pharmaceutical companies focused on addressing HIV/AIDS in PNG through a philanthropic initiative developed in 2003.¹ The Australasian Society for HIV Medicine (ASHM) began working with CHPNG to provide training to PNG-based health care workers soon after the Collaboration's establishment. In 2007, at the ASHM Conference in Melbourne, a meeting of clinical advisers, ASHM and Catholic AIDS Office staff triggered a programmatic shift and the development of a clinical mentoring program. Working with the National Catholic AIDS Office of PNG, the CHPNG mentoring

program aims to improve clinical care of people living with HIV (PLHIV) through the provision of clinical training and mentoring to health care workers in the Highlands, East New Britain and Port Moresby.

The program recruits Australian based specialists in HIV, infectious diseases and sexual health to conduct short but regular mentoring visits to selected sites. The program also includes an annual workshop in Mingendi and the opportunity for PNG health care workers to attend the annual ASHM International Short Course in HIV Medicine and Related Issues, and the Australasian HIV/AIDS Conference.

Sister Tarcisia Hunhoff, Director of PNG National Catholic AIDS Office, oversees more than 80 stand-alone and integrated voluntary counselling and testing sites and 10 treatment centres across PNG. Sister Tarcisia, CHPNG and ASHM work closely to ensure the mentoring program meets the needs of health care workers and of each site

in dealing with increasing numbers of HIV-positive patients. Sister Tarcisia is enthusiastic about the positive impact the mentoring program is having on health care workers:

The medical doctors who come to visit regularly have shown a great deal of expertise, but also seem to understand the cultural aspects, stigma and discrimination and the difficulties people face. Through [the program's] support, our organisation has grown and has become a leading partner with the PNG Department of Health to combat the pandemic in this country.

Mentors often face challenging situations such as five to six hour drives on rough roads, the absence of some basic medical equipment, little or no electricity, and a reliance on satellite phones for telecommunications. They work with dedicated and hard working locally based staff, some of whom have previously had little experience in HIV care but now face high case loads, with ever increasing numbers of patients.

Dr Arun Menon (ASHM Clinical Advisor) participated in the program's development, and has been conducting mentoring and training visits to the Highlands since 2006. Dr Menon has witnessed the increasing demand for HIV treatment and care services, and the professional development of dedicated and skilled staff through the ongoing support of the clinical mentoring program.

When I first started going in 2006, we were struggling to put four people on treatment and some difficult clinical decisions had to be made, but now we have hundreds of people on treatment and several hundred others on co-trimoxazole prophylaxis. Most people are doing well.
(See Table 1.)

Sister Gaudentia is the HIV Coordinator at the Epeanda clinic in Mendi in the Southern Highlands Province. Sister Gaudentia also provides outreach to voluntary counselling and testing, care and treatment sites in Det, Kagua, Hiwanda, Lake Kopiago, Pangia, Puren, Tari and Williame:

As soon as we hear the date is confirmed when Dr Arun comes, we are happy to get word to all our patients, especially those we are concerned about, to come and see the specialist who helps us to give the best treatment the patients need. The patients are proud when they see Dr Arun, as they know they get the best treatment.

There are numerous challenges to be overcome in effectively supporting the Catholic Health Service's work providing testing, treatment, care and support to people living with HIV, their families and friends. These include maintaining consistent access to anti-retroviral therapy, increasing demands on laboratory services, and the retention of trained health care workers. Security and safety of mentors travelling to often remote sites is also an important factor in program planning.

A recent evaluation of the first phase of the project (2008–2009) found that health care workers and clients appreciated the regular visits by clinical mentors. Those mentors provide health care workers with the opportunity to learn and to build confidence in



CHPNG ASHM Clinical Mentoring Program Sites in PNG 2008–2009

Table 1

Timeframe	EPEANDA CLINIC IN MENDI	
	Patients on ART	Patients on Co-trimoxazole Prophylaxis
June 2008	72	170
December 2008	126	130
June 2009	210	140
December 2009	270	150
April 2010	320	150

the work they are doing. Patients appreciated mentors' efforts assisting their medical treatment and ensuring quality of services.

All key informants agree that beneficiaries of the program are more technically skilled and confident, which results in appropriate and prompt treatment rather than patients' treatment being delayed until an 'expert' arrives, triggering treatment delays, inconveniencing patients and their carers, and further jeopardising patients' health.²

Overall the CHPNG-ASHM Clinical Mentoring Program is successfully supporting capacity development within the National Catholic AIDS Office clinical sites throughout PNG. Over the next two years, ASHM aims

to increase the number of visits and sites participating in the program, and has recently recruited a number of new clinical mentors to that end.

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- 2 Worth, H. (2009). *Review of the ASHM Clinical and Laboratory Mentoring Program: 2008–2010, Clinical Mentoring Component*. Sydney: International HIV Research Group, SPHCM, University of New South Wales.

Jacinta Ankus is the Senior Project Officer (International) at the Australasian Society for HIV Medicine and has been co-ordinator of the Collaboration for Health in PNG ASHM Clinical Mentoring Program since 2007.

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On shifting sand? Building capacity in remote PNG

By Aly Murray and Ruth Bearpark

Clockwise from top left Aly Murray and a canoe festival dancer at the Canoe Festival; The Igat Hope office (From left: Ipunesa, Sipi, Loraine, Moses and Mega); and health promotion at the Canoe Festival. The T-shirts were designed through a collaboration of various stakeholders with the message “love life protection”.

Arriving in Milne Bay

Arriving at Alotau’s tiny, shiny airport in a bumbling Dash-8, I was welcomed by a beaming Siemu Bate, the HIV Response Coordinator for Milne Bay’s Provincial AIDS Committee (PAC). As the new Capacity Building Coordinator I was to team up with him for two years, ‘to provide interactive and direct mentoring services towards the establishment of a well-functioning and networked organisation’.¹

Mr Bate threw my heavy bags into the rusting office ute, with its grilled windows and idiosyncratic mechanics, and we navigated the jarring road to town through lush oil palm plantations.

The next day a cyclone whipped up fierce winds and rain as I walked to the PAC office: a fibro extension under a giant rain tree. Four staff and dozens of volunteers shared the space with piles of semi-broken equipment and a temperamental phone/fax. Power was unreliable and the only running water was coming through the roof, here at the hub of the province’s response to escalating HIV rates. I was met with blank looks as Mr Bate was off work with a bad back, and I silently blamed my suitcase. There was no space for me to work, sit, or stand: did I want to take some dusty reports to read at home? I did, unsure of my role or my welcome.

Eventually Mr Bate sat down with me to describe my role in the vacant position of Behaviour Change Coordinator with at-risk groups – totally at odds with the job description I’d been given! That first conversation indicated how little consultation there’d been before ‘capacity building’ was imposed, and prompted this discussion

of its effectiveness in the HIV response in remote provinces like Milne Bay.

The need for capacity building in remote PNG

PNG is still 85% rural, with HIV affecting every province, but the provincial response has lagged behind the attention on Port Moresby. HIV policy is dominated by AusAID, but implementation is necessarily governed by national politics. Funds for the National AIDS Council Secretariat (NACS) mostly pay salaries and administration, with little ‘decentralisation’. NACS is supposed to support PACs with advice and finance, but the Moresby focus and corruption mean that PACs are generally ignored.² Only the dedication of staff and volunteers kept Milne Bay PAC running with funds always arriving late; condoms ran out for six months when boxes were notoriously left rotting past their use-by-date in Port Moresby.

Operating in isolation meant some PACs were dysfunctional, and many

just served their office's vicinity, not their rugged, sprawling hinterlands.³ Recognising all this, the Capacity Building Coordinator project would bring in ex-pat volunteers to, theoretically, work in collaboration with their HIV Response Coordinator. In practice the project's administration became hopelessly muddled between Australian, Canadian and British volunteer agencies. Volunteer Service Overseas (VSO), the British agency who finally took over, conducted no field evaluation at all for several of the assignments, showing a lack of interest in real outcomes and social capital as opposed to funding deliverables.

So what is capacity building?

'Capacity building' has become ubiquitous in aid-speak as a new model for knowledge-transfer-as-development^{4,5,6}, where advisors aim to make themselves redundant by enabling and mobilising selected people to understand and implement project objectives, activities, timelines and accountability structures. The recruitment of ex-pats for this project acknowledged that in remote resource-poor settings jobs are scarce and coveted; those employed are more likely to entrench their positions than to accede to transferring the skills and knowledge that maintain those jobs.⁷

It also acknowledges that the enabling taking place is meant to establish Western ideals of efficiency, efficacy, and liberal democratic notions of empowerment. It is an equal partnership on Western terms. To engage with this system, and the funding that goes with it, local community workers need to be trained in its mindset and vocabulary^{8,9}. Policy is typically written without grassroots input, in current international jargon that is parroted without comprehension when documents arrive in the provinces. Such documents then usually languish on the shelf.

For instance, the HIV Gender Policy¹⁰ is a well considered response to the gender privilege driving the HIV epidemic through overarching heterosexual male power, with very high levels of male violence and gang rape^{11,12,13,14,15}. Without having been

involved in the process though, Mr Bate did not see the relevance of going to the policy's roll-out, and PAC staff struggled with its underlying message, for instance taking 'gender balance' to mean equal numbers of men and women in workshops – *not* on decision making committees like the PAC executive.

Contesting the project

Incomprehension due to lack of consultation makes it hard to foster 'ownership', after the fact, both with the National AIDS Strategy as a whole, and with the capacity building project. Where people are disenfranchised from decision making and uninformed about issues and their likely consequences, more time gets spent on mediation and conflict resolution than on making progress.¹⁶

This was obvious at Milne Bay PAC. Several PACs actively contested the project, while its attempt to circumvent a National AIDS Council that was identified as part of the problem meant that, unsurprisingly, NACS was also resistant. The volunteer coordinators had to attend repeated workshops trying to redesign the project, taking up more time and funds than were actually being used to further its goals.

Capacity building is a professional form of community development, so principles of social justice must apply, involving human rights, empowerment, and especially *participation*. Yet we have to ask whether precisely the *lack* of participation that capacity building aims to counter, has actually been replicated in its imposition.

Back in Milne Bay

Against this backdrop, the two year placement did produce some good outcomes while illustrating the project's limitations. Functionality improved within weeks when we all moved into a new office purpose-built by AusAID and the provincial government.

Milne Bay's established PAC workers were understandably unsure about 'upskilling' from someone female, younger and unfamiliar with complex local cultures. However Mr Bate

overcame these doubts to pursue a productive collaboration, in contrast to other provincial placements where sustained efforts never resulted in effective communication.

Applying national strategic plan priorities to the specifics of Milne Bay was difficult when power and gender hierarchies all centre on Alotau rather than the province's plethora of cultures and remote maritime communities. The Trobriands, for example, have a famously distinctive sex-positive culture, the antithesis of HIV prevention messages framed in conservative Christian morality. The province's highest rates of STIs and teenage pregnancies are in the Trobriands, but they receive only sporadic service provision from Alotau. Ironically, the only reliable, and confidential, care and support services have been offered by a group of tireless Catholic nuns.

Meanwhile a successful conference, 'Spotlight on Alotau', was held in July 2008 and the Governor-General officially opened the new PAC office on World AIDS Day that year. The annual Canoe Festivals and World AIDS Day were both saturated with health promotion campaigns and volunteers, and AusAID was impressed enough to feature (unacknowledged) Alotau's 2008 World AIDS Day poster at the 9th International Congress on AIDS in Asia and the Pacific (ICAAP 2009). The PAC also supported the formation of a sex worker group, Buyeta, overcoming stigma and a lack of interest from the Moresby-based, Australian-funded national sex worker network. A fundraiser enabled them to open an account at the local microfinance corporation.

We still have to question sustainability. Deference to ex-pats is so ingrained that activities were often shelved when the Capacity Building Coordinator was away, and sometimes to keep things running she took responsibility for events and cash at personal risk. Since effective and sustainable community development is reflective in practice¹⁷,

continued overleaf

it follows that we should adapt to the provincial response and local conditions, rather than having the PAC fit into the work-plans of foreign donor agencies.

Conclusions

Elizabeth Pisani has stated that ‘honest analysis that would lead to program improvement is a great way to be hated by just about everybody’. Pisani also asks, ‘what the hell difference are we making, anyway?’¹⁸

The idea of capacity building is not new, and is something we’ve argued for elsewhere^{19,20}. Problems begin with the failure to involve communities in decision making and to understand their needs. Improved technology is a valid goal only if appropriate content is adapted to PNG’s great variations of culture, and above all our contributions should be sustainable. Otherwise it feels like we are constantly building on shifting sand: edifices that will disappear as soon as the project finishes.

Ultimately, getting things working in remote PACs depends on the skills of a few individuals, where human nature’s quirks override Western strategies and templates. That means there is an important role for a qualified individual to bridge the gap for a limited time (in other words a Capacity Building Coordinator), *but* the role will only achieve sustainable results with genuine, not tokenistic, participation.

It follows from all this that capacity building initiatives should use locally designed and targeted training and content, intended to make a real difference in local contexts, rather than a macro-level template applied across all PACs. Expecting macro ‘best practice’ to be implemented at the grassroots, without involving the community and local understandings of issues like male dominance, is ineffective. The project should:

- cultivate a sense of ownership by PAC staff and communities from the start, and involve them in the recruitment process for a Capacity Building Coordinator

- work with the NAC to provide adequate and timely support for remote provinces, instead of treating PACs as inconsequential, and
- give genuine support, supervision, feedback and back-up resources for the Capacity Building Coordinator, isolated from her own culture and living standards.

These measures would reduce some of the frustrations involved in implementing HIV prevention, care and support in remote provinces. This paper has suggested the reasons why well-meant assistance in the form of capacity building may be contested at the local level, and why the top-down approach leaves the HIV Response Coordinator and Capacity Building Coordinator counterparts in an untenable position. A more participatory approach to community engagement and skills development would ensure the significance and sustainability of capacity building in PNG’s HIV response.

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In good company: the PNG Business Coalition Against HIV and AIDS

By Rod Mitchell

The PNG Business Coalition against HIV and AIDS (BAHA) represents the formal private sector response to HIV. Unlike many other jurisdictions, in PNG the business sector has led aspects of the HIV response.

Pictured clockwise from top left The PNG National Parliament on World AIDS Day 2009; Post PNG and BAHA's commemorative postage stamps; Deloitte Tower was the first major building to wear red; and 7 Mile Tower, World AIDS Day 2009.

BAHA is a not for profit NGO, directed by a board of private sector interest groups and major sponsors. It works in line with the National AIDS Council's National Strategic Plan. Since its inception in January 2007, BAHA has been funded primarily by the PNG private sector with some support from AusAID via the National AIDS Council Secretariat grants program. BAHA's funding model consists of four platinum sponsors (K200,000 per annum for three years) and ten gold sponsors (K50,000 per annum for three years). BAHA also receives in kind support from other private sector companies, such as office accommodation, annual audit services, support for primary school educational programs, and toll-free HIV information mobile phone lines services by two mobile phone companies.

BAHA's priority in managing the impact of HIV is the development and implementation of HIV workplace policies and programs, although BAHA has also demonstrated considerable success in other areas.

Workplace policy guidelines

BAHA has developed an HIV policy template to inform workplace policies and programs based on internationally recognised best practice principles. Key areas to be addressed in each workplace policy include:

- working within the law of PNG
- recognising issues around women and violence
- workplace education and training for a wide range of HIV and AIDS issues
- key prevention and management services:
 - the distribution of condoms in the workplace
 - promotion of and referral to voluntary confidential counselling and testing, including support and care services in PNG
 - post-exposure prophylaxis management at the workplace
 - greater involvement of people living with HIV

continued overleaf

- promotion of, and referral to, services related to significant other infections in PNG, including:
 - tuberculosis (TB)
 - sexually transmitted infections (STIs), and
 - all other opportunistic infections.

Policy development and implementation

In the process of working with a company to develop an effective HIV policy, BAHA invites the company to send at least two employees to BAHA's workplace training program. This course introduces participants to basic biomedical concepts related to HIV, the key principals required in a policy, and importantly, how a policy may be practically implemented in a worksite. In the case of large multi-subsidary organisations (such as Steamships Trading Company or Rimbunan Hijau Group PNG), BAHA invites top management from major subsidiary, agency sites or divisions. The targeting of senior management aims to ensure policies do not sit on a shelf at headquarters, but remain active. (See Table 1.)

Policy development activities include fifteen Government Statutory Agencies and government departments. Policy review meetings continue to be held once a month and include review of existing policies. Workplace audits of HIV programs are conducted in the provinces on a regular basis.

BAHA website

BAHA hosts a comprehensive website at www.baha.com.pg The website includes:

- all resources required to enable a business to develop its own HIV workplace policy
- BAHA approved workplace policies
- HIV resources such as a list of PNG testing sites, TB services, information about issues affecting women, and information for people living with HIV
- a database of contacts for STI, antiretroviral therapy (ART), TB, voluntary counselling and testing (VCT) and the National AIDS Council, and
- Department of Health treatment guidelines and other health professional resources.

Member companies receive a CD of the BAHA website for use on office intranet systems.

BAHA newsletter

BAHA distributes a monthly electronic newsletter disseminated to over 20,000 recipients. In May 2008, the BAHA newsletter was awarded the United Nations Educational, Scientific and Cultural Organization Award for Communications and Development. Themes for the newsletters have included VCT, issues impacting men and women, condoms, positive living, general health and nutrition, policy development, and other BAHA activities including preparation for each World AIDS Day.

BAHA HIV Smart Workplace Toolkit

BAHA has developed a toolkit to assist the private sector to design, implement and monitor their respective HIV Workplace Policies. The toolkit was recently adapted by the Asia Pacific Business Coalition to be distributed throughout its regional network.

HIV tollfree information line services

As a community service, BAHA operates two tollfree HIV information lines sponsored by the two PNG mobile networks: Digicel and Be Mobile. Receiving 3,000 calls a month from all over PNG, callers ask about

Table 1 HIV workplace policy development and implementation¹

Activity	2007	2008	2009 ²	Total	Comment
Workplace policies developed	40	100	95	235	Does not include subsidiary/agency numbers
Workplace training conducted	2	14	16	32	In 16 of 20 PNG provinces
Employees trained	53	292	295	640	3.5 days training
Employees certified	0	30	100	130	Provided with fully outfitted training kit
No. of implementing companies	0	30	100	130	Including subsidiaries and agencies
Specific industry projects					
– Hotel and Tourism	0	100	102	202	Includes a condom program
– Security Industry			20	20	Including Industry Office

Table 2 HIV tollfree information line caller data (callers include adult and children)

Activity	2008	2009	Comment
Actual calls received and serviced	17,304	37,178	Male and female callers
Male callers	14,153	31,212	Cross country
Female callers	3,151	5,966	Cross country
Urban Callers	9,129	22,327	Male and female
Rural Callers	7,703	14,393	Male and female
Unknown locations	472	458	Gender not determined

HIV transmission, HIV testing, distribution and use of condoms, antiretroviral therapies, sex, HIV/STI prevention, the World Health Organization's (WHO's) TB Directly Observed Treatment Short-course (DOTS) program, care and support for people living with HIV, and other related issues. By the end of 2009, over 30,000 calls had been received from most regions of the country with mobile phone coverage. (See Table 2.)

Most frequently asked questions relate to:

- What are HIV and AIDS?
- How is HIV transmitted?
- What is anal sex?
- Will I get infected if I have sex with an HIV-positive person?
- Can HIV-positive persons have sex with each other?
- Can I get infected from unprotected oral sex?
- Can I get infected from unprotected group sex?
- What is oral sex?
- Can I get infected doing oral sex?
- What are the consequences of doubling condoms during sex?
- What will happen if I use expired condoms?
- Will using alternative plastics other than condoms cause infection?
- What are the signs and symptoms of sexually transmissible infections?
- Voluntary confidential counselling and testing procedures
- Voluntary confidential counselling and testing sites in each province
- Antiretroviral Therapy (ART)
- Antiretroviral drugs (ARG)
- HIV care support and counselling services
- Nutrition for HIV-positive people
- Sharing things with HIV-positive people
- Parent-to-child transmission
- Can people on antiretroviral therapy have sex with non-positive people?
- Finger sex and HIV
- Kissing and HIV
- Condom demonstration for male and female condoms
- Circumcision: is it a safe alternative to other HIV prevention methods?
- Can I get infected from contact with another person's blood?

Annual World AIDS Day Program

During the past three years, World AIDS Day 'Wear Red' campaigns have become an effective tool for BAHA to reinforce the message of HIV prevention, treatment and support. Although it was primarily targeted at the private sector, there has been a gradual build-up of community interest. In 2009, there was great support by both the private and public sector as over 300 companies and organisations and 100,000 employees registered to be part of the BAHA program. An intensive media campaign via television, radio, print and electronic media is conducted each year to build interest and participation by all communities to ensure accurate information about prevention and available services is accessible via BAHA and other service providers.

Education Awards, Postage Stamp Commemoration and Annual Calendar

Working with the ANZ Bank of PNG, BAHA has annually conducted an education competition targeting primary and high school teachers who are making a real effort to roll out their respective curricula on HIV. Although impact is difficult to measure, there are reports of decreasing cases of high school and primary school pregnancies and increasing interest by students around the promotion and use of condoms.

In 2008, POST PNG and BAHA ran an HIV art competition for established and developing local artists. The competition promoted the theme of 'Positive Living': aiming to communicate warm, positive and strong messages about dealing with HIV within a community. Winning entries were selected by POST PNG, and postage stamps were created. The stamps continue to be used in PNG today.

With support from WESTPAC Bank, BAHA produces an annual calendar that provides helpful information on HIV prevention, treatment, care, and support as well as basic health care. The calendar is popular on workplace noticeboards and in school classrooms around the country.

Strategy for 2010–2015

For 2010–2015, BAHA has prioritised:

- leadership and partnership initiatives within the private sector
- workplace policy development services, with an emphasis on workplace vulnerability issues that contribute to the spread of HIV
- policy development, implementation and support activities targeting new and large mining/gas, etc., projects
- monitoring, supporting and evaluating existing workplace activities
- training, monitoring and certifying HIV policy and program implementation for private sector staff
- generating information, education, and communication materials (including electronic newsletters and website information updates)
- delivering BAHA promotions such as World AIDS week and the Wear/Hang RED campaign
- enabling workplace access to post-exposure prophylaxis, condom distribution and education
- expanding reach to people in the rural and public sector via toll free info lines and radio talkback, and
- building a more effective and innovative reach to more people and business.

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- 1 Includes Lae office operations catering for the business sector in the second largest city in PNG (Lae in Morobe Province).
- 2 To November 2009.

Rod Mitchell is CEO of the PNG Business Coalition against HIV and AIDS (BAHA).



Uptake of mobile/outreach HIV counselling and testing in Morobe province: successes and challenges

By Dr Elsie Ryan

Morobe Province is a province in Papua New Guinea (PNG) with medium HIV and AIDS prevalence. The Province consists of nine districts and 33 Local Level Government areas, with an estimated population of 700,000. The Province has 49 functioning Health Centres and 300 Aidposts (only 50% of which are currently functioning). The Province is linked to the highlands region through the Highlands Highway, and to the northern coastal province of Madang through the Lae-Madang Highway. HIV prevalence in Morobe Province has been increasing over the last five years.¹

The first diagnosis of HIV recorded in the Morobe Province was at the Angau Memorial Hospital in Lae (the provincial capital) in 1989. There have now been 2,228 diagnoses: 917 male and 1,064 female.² Overall, Morobe Province accounts for 7.87% of the total number of HIV infections diagnosed in PNG since 1987.³

There were no HIV testing sites in Morobe Province until 2006, when a single site was introduced. In that year it conducted 138 tests. In 2007, four sites conducted a total of 1,863 tests. In 2008, Morobe Province conducted 11,460 HIV tests, representing 9% of

the total number of HIV tests in PNG that year. Those tests identified 325 new cases of HIV infection: 99 male and 226 female.

Morobe Province now has integrated provincial HIV and sexually transmissible infection (STI) testing facilities, and antiretroviral treatment is available. The 2007 establishment of the MOMASE regional support unit at the Anua Moriri Day Care Centre (AMDCC) in Angau Memorial Hospital, and the resulting recruitment of key staff, has greatly increased capacity for coordination of regional STI and HIV/AIDS programs in

Morobe Province, and three other provinces in the region (Madang, East Sepik and West Sepik).

Unfortunately, despite the impressive scale up and best efforts to deliver HIV and STI prevention, care, treatment and support programs across the entire Morobe province, most services continue to be provided within urban and peri-urban centres.

Regional initiatives

The challenges of delivering STI and HIV/AIDS services in the Province are manifold, and complex including: lack of skilled human resources, poor resourcing of services, poor logistical arrangements and distribution of consumables, deteriorating infrastructure, poor quality service delivery on the part of ancillary services, and lack of effective monitoring and evaluation of programs.

AMDCC has been working in collaboration with some private companies in Morobe Province to conduct mobile/outreach HIV counselling and testing services in five communities in the Province. Given that Morobe Province is PNG's industrial centre, involvement of the private sector had been seen as a big step in scaling up HIV counselling and testing services.

Since January 2008, four staff from AMDCC have engaged with Nestlé medical delegates in Lae to conduct monthly mobile/outreach HIV counselling and testing sessions in five rural communities based along the Highlands Highway. This initiative evolved as a result of 2007 discussions between the Nestlé medical team and Day Care Centre staff which identified that whenever Nestlé travelled to conduct HIV education, many people requested HIV testing and/or counselling. The mobile/outreach HIV counselling and testing service was born.

Community education conducted by the service generally involves one full day of HIV awareness-raising through the medium of drama, with performances by Nestlé medical delegates. Staff from the AMDCC

clinic then provide HIV testing and counselling for those who volunteer for testing.

The Papua New Guinea National Department of Health's HIV counselling and testing unit is currently finalising guidelines for mobile HIV outreach services but in the meantime, the team abides by existing national policies and guidelines. Counselling and testing services are always provided using an existing health facility within the community to ensure privacy, and confidentiality is maintained at all times.

Successes

Successes include:

- Provision of HIV counselling and testing services in five communities of between 1,000 and 3,000 people (Wampar, Wampit and Gabensis villages in Huon district, and Tararang and Zifasing villages in Markham district)
- Visits to each community approximately four times each year (with the number of visits determined by demand for services), and provision of counselling and testing services to more than 45% of the population within each community
- Good penetration of the 15 to 45 year age group. Most people tested to date have been aged between 15 and 45 years of age, with more females than males tested (60% to 40%), all of whom were from subsistence farming communities with low level of literacy, and
- Growing understanding that the target group has some knowledge about HIV/AIDS, with communities prioritising greater availability of HIV testing. Turnout was excellent each time outreach services were provided.

Ongoing limitations

Issues continuing to limit the program's potential include:

- Lack of adequate human resources and gender specific services: there are only four female staff at AMDCC (one Medical Officer, two Nursing Officers and one Community Health Worker). In

addition to conducting the mobile/outreach HIV counselling and testing services, these same four staff continue to provide clinical care and services to people living with HIV who access Anua Moriri Day Care Centre

- Lack of logistical support: the service lacks transportation, so is dependent on Nestlé Medical delegates for transportation
- Lack of financial support from the National Department of Health
- Poor infrastructure: some health facilities within communities are in dire need of repair and are not conducive to HIV/AIDS counselling and testing services, and
- Lack of HIV/AIDS trained Health Care Workers in the community: none of the health care workers based in the communities visited have been trained as HIV Counsellors, and none are able to pick up the work provided by the outreach workers.

Pressing need for support

The mobile/outreach HIV counselling and testing service has enhanced the public-private partnership between AMDCC (government run) and Nestlé medical delegates (private company) to facilitate the uptake of HIV counselling and testing in Morobe Province communities. There is good support from the private sector in Morobe Province, however, the sustainability of the service depends on support from the National Department of Health.

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The Tale of an Activist

By **Christine Stewart**

Coding the moving, painful, secret stories of gay, positive people in PNG, I come to the letter 'V'. What should it be: 'Vincent'? 'Vernon'? 'Vaughan'? No ... he is frightened, lonely, and now far from home. But he is willing to risk telling his story, wanting to tell it 'to help all those gays in PNG'. So it has to be 'Victor': my prayer and hope for him.

Victor began life in a village far from Port Moresby. As a little child, he preferred playing with girls, and despite his parents' scolding and even beatings, he persisted. He was fascinated with girls' clothing and when alone in the house, he would sneak into his mother's room and try on her dresses.

Victor hated going to school because he felt so lonely and so different from the other students. He was tormented by the boys for his effeminate looks and behaviour. Sports lessons were

the worst: the girls played netball or volleyball, which fascinated him, and the boys played rugby or soccer, which he hated. On sports days, he would pretend to be sick or simply skip school.

When Victor was only ten, a man lured him into the bushes with bribes of lollies, fondled him and forced him to perform oral sex. That was his first 'sexual experience'. Throughout his teenage years, Victor had a number of sexual encounters with various boys. Some were consensual, but others were

forced on him, usually by threatening to reveal his sexual activities to his parents: a possibility which terrified him. He knew that disclosure of his sexual orientation would bring shame on him and his family, and lead to a beating from family elders. Given the enormous stigma surrounding homosexuality in rural areas, Victor learned to be very circumspect about his sexual encounters.

Victor left home to pursue tertiary education, and then got a good job in Port Moresby. His work gave him opportunities to travel overseas to countries where gay sex was not illegal or culturally denied. There, for the first time, he experienced the pleasure of meeting, talking and socialising with other gay men in an atmosphere of freedom and trust.

While in Port Moresby, Victor gained a reputation for working with gay men, particularly men recently arrived from other parts of the country. He was involved in awareness and intervention programs relating to drugs and alcohol, gender, human rights, child abuse,

and HIV. In fact, gay groups in the urban centres of PNG used this work as a cover for discussion and action on gay issues, but the cover was not absolute. Sometimes, when featuring stories about these programs, the media publicised details about the activists involved, including Victor. He and his friends knew the greatest chance of a gay man achieving social acceptance was by earning respect for 'giving back' to the community. So, to reinforce his social status and that of his family, Victor went along with the publicity.

But there was a price. Victor encountered abuse from strangers on the street and nuisance phone calls to his workplace: sneers of 'being smart', and epithets like 'poofta' and 'homosexual bastard'. It was impossible to retaliate. Victor simply bore it, and carried on with his work. Then one night, returning home late after a publicity event, his lift dropped him off at the track leading up the steep hill to his home. Halfway up, a gang of young men ambushed him at gunpoint, dragged him into the bushes and took turns raping him. Shaking, he begged his assailants at least to use condoms, but this only aggravated them and they became increasingly violent, beating and raping him until he lost consciousness.

When he was able, Victor staggered home, took a shower and then sat thinking through the night. Should he report the incident to the police? But how could he feel safe? How could he explain that a group of men had 'raped' him? How could he trust the police officers on night shift? Police rape was not unknown. He worried that his fear would make his voice high-pitched and he would sound effeminate. The police would insist he had brought it on himself simply by being gay. They would not respect his confidentiality. And should they actually investigate and make any arrests, Victor would be in great danger from the friends and relatives of his rapists. The PNG 'payback' system would ensure Victor

would be harmed in retaliation for the arrests. He did not report the rape.

Victor had never had an HIV test. Should he get one now? In PNG, a positive result would not be treated confidentially by hospital or clinic staff, and Victor was well-aware of the problems gay men experienced locating user-friendly and genuinely confidential health services. So, Victor packed his bags and fled the country, without even saying goodbye to his relatives or his circle of friends. Once outside PNG, he had an HIV test. It was positive.

Victor believes he can never return to PNG. He knows that given his reputation as an activist, news of his HIV status and sexuality would quickly become public knowledge, and this would mean discrimination and shaming, which would reflect badly on his family and community. They would reject him or worse. Victor knew of instances of people being killed or buried alive by a community fearful, ashamed and angered by the person's HIV status and sexuality.

Victor also faces the prospect of revenge. He knows that because HIV infection is attributed to sex workers and gay men, the young men who raped him would blame him for infecting them, not the other way around. They

would hunt him down, and his life would be in danger from the threat of a 'payback' killing. The police would be of no help. He was all too aware of incidents involving police brutality against gay and transgendered people.

Victor the activist, who had been determined to help 'all those powerless and vulnerable gays back in PNG', is exiled.



A gay friend once told me that because of the stigma and other dangers faced by gay men in PNG, no gay man would dare stand up as an advocate for gay rights, decriminalisation, or a better deal. But I can. So I thank Victor for allowing me to hear his story, and for giving me permission to publish it. Like Victor, I hope to be a social agent for change, and I hope that his story will enable him to continue his advocacy to improve the lives of gay men and positive people living in PNG.

Christine Stewart is a PhD candidate at the Australian National University (ANU), writing a thesis on the effects of criminalisation of sex work and sodomy in PNG. Christine was formerly a member of the early National AIDS Committee and legal adviser to the AusAID National HIV/AIDS Support Project.

Halfway up, a gang of young men ambushed him at gunpoint, dragged him into the bushes and took turns raping him. Shaking, he begged his assailants at least to use condoms, but this only aggravated them and they became increasingly violent, beating and raping him until he lost consciousness.

I wrote *Sin, Sex and Stigma: a Pacific response to HIV and AIDS* because I'm angry. I'm angry about the above. I'm angry because qualitative findings about the social structuring of transmission risks have not been allowed systematically to inform PNG's national response to HIV and AIDS. Policy-makers tend to blame this on the language of or the speed with which ethnography is conducted, but anthropological knowledge about the social structuring of risk implicates the sacred cows of religious faith, marriage, and (heterosexual) male privilege, and poor-quality data collected speedily help no-one. I'm angry at how commonly STI reinfection occurs. I'm especially angry about facile understandings of gender relations, for example, the mindless repetition of claims about female vulnerability on biological grounds that let people off the hook of thinking harder about the real context of transmissible vulnerability. Females are said to be 'up to four times as likely to contract HIV from a single act of unprotected vaginal intercourse'.³ This is a specious statistic on the face of it: 'up to' in terms of what? Study design? Age of girl? Seroprevalence in a population? More importantly, however, it profoundly misses the social context of PNG's HIV and AIDS epidemics. There's nothing inherently vulnerable about 'the female body'. Transmissible vulnerability doesn't lie in possession of tender tissues and fragile cervixes *per se*, but rather, in the fact of frequently being poked and prodded, molested and violated at young ages. Females are forced into unhappy, non-consensual unions, whether marital or not, against their will and often with much older men, including businessmen, landowners, and politicians, and who often have a multitude of STIs and other sexual partners. A leading religious official has claimed that '100% of those following abstinence before marriage will never get infected'⁴, but many virgins at marriage nevertheless become infected with STIs and even HIV. I'm angry that national and expatriate officials keep labeling people regarding

identities and activities they don't understand very well. As Stephen Vete wrote long ago, 'labeling people has also been used to perpetuate prejudices, promote intolerance and discredit people for no legitimate reasons'.⁵ Label Bottles, he says, Not People.

Sin, Sex and Stigma ... has just been published by Sean Kingston Publishing in a series called Anthropology Matters. The series brings out works that open up 'new themes' that deal with 'specific development or policy related issues', and that intervene in 'current affairs and decision-making'.⁶ My goals in writing the book were to provide ethnographic and social historical data to challenge the tendency in the national response to externalise transmission risks and to ignore marriage as a setting of high-risk sex. I show that condom use has been pitched awkwardly and that quite un-Papua New Guinean terminology and concepts have been imposed on the tasks of monitoring and evaluating HIV and AIDS. It's easier, of course, to M(onitor) & E(valuate) the number of condoms available in a warehouse than the number of times husbands force wives into sex, or the frequency that mutually pleasurable but non-penetrative sex occurs, or the extent to which policemen sexually violate females. I'm angry because terms and acronyms from Western practices

of public health and epidemiology clank so hard against the realities of life in PNG. 'Rural-urban divide', 'surveillance', 'high-risk settings', 'MSM', and 'general population' don't square with the high levels of mobility seen between town and countryside, the decentralisation of health services delivery, the imported nature of sexual identities, and the multiple and contingent social identities that all people, not just Papua New Guineans, construct and perform. 'ABC', the main ideological plank in the national response's platform, which stands for Abstain, Be Faithful, and if those don't work, use Condoms, is flatly contradicted by the ubiquity of transactional sex, the taken-for-granted nature of male sexual prerogative, and the political-economy of sexual networking.

I'm angry that the untoward Christian *and* secular tenets and policies about condoms that have resulted in such extraordinary myth-making about them have been accommodated more than challenged; the 'C' in 'ABC' for example, has come also to mean 'Commitment', 'Christian values', and several other things other than 'Condom'. It makes me angry that so much lip service is paid to qualitative

continued overleaf

I'm angry that the untoward Christian *and* secular tenets and policies about condoms that have resulted in such extraordinary myth-making about them have been accommodated more than challenged; the 'C' in 'ABC' for example, has come also to mean 'Commitment', 'Christian values', and several other things other than 'Condom'.

findings but that those findings are then ignored – go read 50 Desk Reviews, Workshop Reports, national plans and newspaper editorials if you don't believe me. I can't help but read the national response also as an exercise in impression management. As did Elizabeth Pisani reveal in *The Wisdom of Whores*, there has occurred egregious massaging and 'beating up' of dubious, sometimes counter-factual quantitative data by and between epidemiologists, consultants, their bosses, and the media.⁷

I told [the expatriate consultant in charge of the High-Risk Settings Strategy] we could take him to where the married women are having the sex without the condoms, and lots of drinking, at the officers' quarters and the hotel, but he said to take him to the border and to Karanas Pit Place because of all the condoms there. He likes those 'hot-spots'.⁸

This quote from a Papua New Guinean counterpart to the controversial donor country-sponsored HRSS program made me happy. 'Whew! It's not just me!' Along with many other Papua New Guineans who had been labeled to be living in 'high risk settings', she was mad about the fixation of donor country representatives on prostitution, not marriage, and about their seeming inability to accept the existence of transmission risk in companionate relationships. I'm mad that little 'surveillance' has been conducted in the original meaning of the term; the repeated and systematic guarding or watching

over of persons and peoples; and that there has not emerged progressively more nuanced understandings of the social contexts of HIV transmission. What does 'antenatal mother' mean, to epidemiologists? The Burnet Institute referred to people at such settings as 'low hanging fruit', which is to say, easy to pick, not necessarily representative of how ripe, nutritious, or evenly dispersed the rest of the fruit on the tree is.

Aid workers concerned about consultancies and promotions are anxious not to rock the boat, challenge the status quo or admit to mistakes made by their predecessors. Holly Aruwafu-Buchanan (correctly) notes that, '[t]he degree of HIV infection among pregnant women is often used as an indicator of how HIV has spread throughout the general population, as a proxy for the general population'⁹: that is, good 'low risk' people like you and me. Unfortunately, high rates of STIs are routinely found in antenatal clinics (ANC) throughout the Pacific, and not seemingly for reasons of female promiscuity. For example, even though only 2.8% of Fijian women in the 2004–2005 behavioral surveys reported multiple or concurrent sexual partners in the previous 12 months, 29% were infected with chlamydia¹⁰. In 2007, the National AIDS Council Secretariat in PNG reported that HIV antibody seroprevalence among ANC attendees had actually become *higher* (1.6%) than the country-wide figure of 1.28% among 'the general population' accepted to that point.¹¹ I'm angry that pregnant females thus careened in a single stroke from 'low risk' to 'high

risk' without any critical commentary whatsoever upon the presumption of their low transmission risk to begin with or what 'the general population' means to public health officials and epidemiologists. Really, who came up with 'general population'? I'll bet they were heterosexual and not very vulnerable.

To take another example, the 'High-Risk Settings Strategy' was dropped in 2006 after three years, but again, without any reflexive, critical accounting of its origins and extraordinary resistance to criticism. Consultants are answerable to donors; neither are answerable to the peoples whom they are supposed to be serving, and both hide behind 'culture' and 'tradition' in preserving *per diems*, travel and other perks. Graham Fordham¹² is mad, too; the 'normative AIDS paradigm' in Thailand, he says, has refused to focus where the great bulk of STI and HIV infections lie: between girlfriends and boyfriends, husbands and wives, in the intimate settings of or on the way to marriage. Culture has been reified and qualitative data, ignored.

I'm angry about the ways in which HIV seroprevalence data have been bandied about and at the ways in which 'risk,' 'risk groups' and 'epidemic' have been conceptualised. In the Preface to the *2007 Estimation Report*, the then Minister for Health, Sir Peter Barter, wrote:

The trend of the epidemic is showing a high increase, especially in rural areas where 85% of the PNG population lives. It is projected that starting in 2007 the prevalence among the rural population will become higher than in urban areas. The new 2006 prevalence estimate, when compared to previous estimates, show that while the prevalence is lower than what has been previously estimated; the trends in the epidemic are increasing more sharply than what has been previously documented.¹³

The PNG media reported further misunderstanding almost immediately, reporting statistical artefacts as evidence of efficacy and implying that

I'm angry about the ways in which HIV seroprevalence data have been bandied about and at the ways in which 'risk,' 'risk groups' and 'epidemic' have been conceptualised.

HIV testing is prevention:

Sir Peter said while there was a 'levelling-off' in the urban areas due to establishments of Volunteer Counselling and Testing (VCT) sites or projections from the estimation report showed the epidemic was increasing in the rural areas where the majority of the people live. 'The HIV prevalence of 1.28 percent which was less than previously documented does not mean that the HIV epidemic was decreasing. Rather all projected HIV indicators show an increase,' he said ... 'Papua New Guineans should continue prevention methods like abstaining from sex, being faithful or using a condom every time to prevent infection, and also go for testing to know their HIV status,' Sir Peter said.¹⁴

In a 'Pacific Beat' interview with an Australian journalist, a health official was then allowed many times to conflate HIV and AIDS and commit statistical errors on the order of magnitude:

I'm talking about 2% to 3.5%. When you're talking about, say, for ten people, we're talking about two people infected with HIV, out of every ten [thus moving from 2% to 20%]. So it could be between two to four people [thus sliding from 2% to 40% in a single paragraph!].¹⁵

Elizabeth Reid interrogates the same figures and misunderstandings thereof in a sterling Discussion Paper, but I think she was being too polite in declining to challenge their accuracy, wishing instead only to register that 'the social and personal consequences [of bogus seroprevalence findings] can be quite serious'¹⁶.

In the fine Introduction they wrote to the even finer 2008 collection they co-edited, *Making Sense of AIDS: culture, power, and sexuality in Melanesia*, my anthropologist colleagues Richard Eves and Leslie Butt wrote that 'No ethnography of AIDS in any part of the Pacific exists ... Neither are there any volumes detailing the failures and inadequacies of prevention campaigns'.¹⁷ This is no longer the case. My contribution thereto, and those of Holly Wardlow

and Naomi McPherson, too, provided much-needed sociology-of-knowledge perspectives about the national response in PNG to HIV and AIDS. In 2007, Katherine Lepani completed a first-rate PhD dissertation for the Australian National University, *In the Process of Knowing: making sense of HIV and AIDS in the Trobriand Islands of Papua New Guinea*, that highlighted the good health-inducing effects of mutuality and pleasure in sex and sexual networking. Alison Dundon and Charles Wilde guest-edited and contributed to a special issue in 2007 of *Oceania* that was devoted to the problems posed by HIV and AIDS in rural PNG.¹⁸ The special issue of the *Papua New Guinea Medical Journal* that I guest-edited in 2004 also contained ethnographic pieces.¹⁹

The bibliographies to these works and to my book are stuffed with references to an impressive corpus of qualitative research conducted in resource extraction enclaves and towns, villages and settlements throughout PNG in the wake of HIV and AIDS. It makes me mad that so little of it has been used to guide the national response. It's not just that anthropologists need to explain themselves better, but rather, that preachers, public health officials and policy-makers need to begin to read qualitative research findings, starting with those that are 20 or even 30 years old. They have already captured the voices and lives and problems of the peoples they are supposed to be understanding and serving.²⁰

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- 20 Many thanks to Stephen Vete, Crystal Bryson and Elise Thomasson for their helpful comments on this essay.

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A review of *Sin, Sex and Stigma: a pacific response to HIV* appears on page 50.



Staff from the Salvation Army Goroka Church, one of the seven churches involved in the Church Partnership Programme, Goroka, PNG. Photo courtesy of Salvation Army.

Changing attitudes: the church-led response to HIV in PNG

By Frieda Kana

Papua New Guinea's rugged high mountains, fast flowing rivers and thick rain forests constitute the formidable terrain of the main island. Many of the scattered islands in the coastal provinces are reachable only by small banana motor boats. That challenging geography contributes much to the lack of essential communication and development interventions. Even as mining generates profits for some, poverty keeps rising and the disparity between rich and poor widens. Although schools are established all over the country, the literacy rate remains at approximately 66%. Few are educated enough to have a decent paid

job, run a successful business or read health education literature.

Papua New Guineans are very spiritual. There are tribal beliefs of spirits in everything good and bad, however, Christianity is now the main religion. Among the population there are: Roman Catholic 22%, Lutheran 16%, Presbyterian/Methodist/London Missionary Society 8%, Anglican 5%, Evangelical Alliance 4%, Seventh-day Adventist 1%, other Protestant 10%, Indigenous beliefs 34%.

Given the above, church leaders have a critical role in turning the tide of this epidemic, which has engulfed the

unsuspecting population so suddenly in the last 10 to 15 years. Church attitudes are changing. While HIV was initially understood as a health problem originating from sexually transmitted diseases, the HIV epidemic is now being recognised as a deadly epidemic attributable in part to poor social and economical development.

The PNG Church Partnership Programme aims to equip and educate church leaders and influential members of the Christian Community to understand the HIV epidemic, and to take the required drastic measures to minimise and slow down HIV transmission in PNG. It is a collaboration between the seven largest and most established Christian Churches: Catholic Church, Anglican Church, United Church, Baptist Union, Seventh Day Adventist, the Salvation Army and the Evangelical Lutheran Church.

Although schools are established all over the country, the literacy rate remains at approximately 66%.

The Church Partnership Programme has been funded through AusAID's Democratic Governance Program and the PNG Sanap Wantaim Program to enable churches to fund programmes on HIV and AIDS. Much of that effort has gone into building Voluntary Counselling and Testing (VCT) Centres, purchasing drugs for treatment of opportunistic diseases, organising antiretroviral treatment, conducting HIV awareness, providing home based care training, creating innovative micro-economic schemes, as well as many other original initiatives. Education initiatives have included a focus on influencing church clergy to be less judgemental so that they may extend care of those affected by HIV.

Following are some of the achievements of four of the Church Partnership Programme partners:

- **The Baptist Union of PNG**, based in Mt Hagen, created an avenue for women living with HIV to come together for moral and spiritual support. That initiative has developed into a micro enterprise program, so that women can better financially support themselves. The group, registered as 'Tru Prens', is engaged in making billums (wool /string bags) to sell in bulk to customers overseas. To address difficulties finding overseas markets, the Baptist Church has established links with Australian Business Volunteers and the Volunteer Service Overseas personnel in Madang, PNG. That relationship aims to provide direct export opportunities to secure markets in Australia and Europe. The Baptist Union has also established 'Tru Warriors' and the Mt Hagen Handicraft group, which combines commercial skills training with ongoing group support and encouragement.
- **The Catholic Church** has undertaken 110,000 instances of HIV testing at VCT Centres around the country in the last four years, with 45,000 tested in 2009 alone. There are 84 VCT Centres,

with some 500 to 700 people on ART. According to the HIV and AIDS Program Manager, the 84 VCT Centres are not enough, so more are to be established.

- **The Anglican Church of PNG** has established HIV and AIDS development coordinators for four dioceses; Popondetta, Dogura, AIPO-Rongo and New Guinea Islands. In December 2009, AusAID and the Department of National Planning and Monitoring representatives were invited to the opening of the first VCT Centre at Lower Jimi, a very remote area of Western Highlands Province. The VCT Centre, which took almost five years to complete, will be the only facility available to a population of 28,000 or more in the area.
- **The United Church of PNG** HIV Coordinator manages: four HIV Desk Coordinators, one recognised VCT Centre in Mendi with three others proposed to be established in other United Church Regions of Hela SHP, Tonu in the Autonomous Region of Bougainville, and Salamo in Milne Bay. There are plans for an 'Introduction to HIV and AIDS' course for nurses in the four regions impacted by the liquified natural gas industry.

With funding from the PNG Sustainable Development Program, the United Church has erected their first Drop-in Centre under

their church in Mendi. The church hopes to have 11 HIV and AIDS Coordinators around the country by the year 2011. With additional funding from the National AIDS Council Secretariat, the church will recruit an HIV and AIDS PICT (Provide Initiated Counseling Testing) Coordinator to enhance church efforts.

Other churches

Mainline churches had begun to address the epidemic before Churches Partnership funding came into play, however, other smaller churches were without facilities, resources and a work force to manage social programs. Some were slow in developing a positive and supportive response to people living with HIV. That has now changed. In recent months, many smaller churches have come together under the umbrella of faith-based organisations and, in collaboration with the Provincial AIDS Council Secretariats, have been educating church clergy on the gravity of the HIV-related issues. Clergy of those smaller churches are challenging the Government to be more proactive and put more emphasis on prevention rather than cure. The churches believe that observing strong moral and Christian beliefs will save future generations.

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Photo courtesy AusAID.

Regional Snapshot: West Papua

By Abigail Groves

The western half of the island of New Guinea, which is part of Indonesia, is popularly and internationally known as West Papua. Historically, the region has had a number of different names. In colonial times it was known as Dutch New Guinea, and during the Suharto years it was called Irian Jaya. Its official name in Indonesia is 'Papua'.

The division of New Guinea into two halves is a colonial invention dating from the nineteenth century. Geographically, West Papua is similar to Papua New Guinea (PNG), with coastal areas of mangroves and rainforests, and inland areas dominated by mountains. As in PNG, much of the highlands of West Papua remain remote and inaccessible.

Historically, the demography of the two halves of New Guinea was also

similar. While the eastern half of the island (now PNG) had a larger population, both halves were populated by numerous Melanesian tribes. The incorporation of West Papua into Indonesia in 1963 changed that. In a program known as *transmigrasi* ('transmigration' in Bahasa), the Indonesian government has encouraged Indonesians to move to the sparsely-populated province. Thousands have done so, mostly in search of jobs: particularly as the mining industry in West Papua has grown.

This migration has transformed West Papua. In 1963, some 98% of the population was ethnic Papuan. By 2005, ethnic Indonesians comprised as much as 40% of a total population that had increased to 2.5 million. The radical shift in the population's ethnic composition combined with the impact

of Indonesian rule has created a society that is ostensibly divided into two groups: 'Indonesians' and 'Papuan'. Ethnic Indonesians dominate the government, the military and the economy, while poverty is concentrated among Papuans. Notably, West Papua is the poorest province in Indonesia. Indonesian rule was never supported by the local population, and while current public attitudes are difficult to measure, the 'Free West Papua' movement (or OPM) is still active, both in West Papua and internationally.

The HIV epidemic in West Papua more closely resembles the epidemic in PNG than it does the HIV epidemic in the rest of Indonesia. With HIV prevalence estimated at 0.2%, Indonesia is categorised as a low prevalence country, although this still equates to over 300,000 people living with HIV by the end of 2009.¹ The epidemic in Indonesia is concentrated in urban areas, among injecting drug users, sex workers and more recently, men who have sex with men. Among *waria* (men who assume a female identity – many of whom work as sex workers), HIV prevalence is particularly high: as high as 34% in Jakarta.

In West Papua, HIV prevalence is estimated at 2.4%, more than ten times

The West Papuan epidemic is also more generalised, meaning it is not confined to 'high-risk' groups. The main mode of transmission is sex, rather than injecting drug use.

the prevalence in the rest of Indonesia. The West Papuan epidemic is also more generalised, meaning it is not confined to 'high-risk' groups. The main mode of transmission is sex, rather than injecting drug use.

In 2006, AusAID commissioned some research to project likely trends in the HIV epidemic in Indonesia, PNG and East Timor. That research factored in key variables such as current prevalence, transmission risk, levels of condom use and access to antiretrovirals. It made some alarming projections, including that under current conditions, HIV prevalence would rise to 10% of the population in PNG by 2025, and 7% in neighbouring West Papua. That means 84,000 deaths, and over 100,000 orphans.²

The aim of such research is to persuade governments to allocate resources to HIV prevention and treatment, and to assist planning for an effective HIV response. The Indonesian Government has made significant attempts to scale up its response to HIV in recent years, including the establishment of the National AIDS Commission in 2006. President Susilo Bambang Yudhoyono's opening address to the Asia-Pacific AIDS conference in Bali in 2009 listed Indonesia's recent achievements: increasing the budget for HIV programs, increasing access to voluntary counselling and treatment, trebling access to antiretrovirals, and the introduction of harm reduction programs. He acknowledged, however, 'fighting AIDS in Indonesia is still very much an uphill battle ... The biggest battle must be in West Papua where the AIDS problem is acute due to social behaviour'³.

But what is 'social behaviour'? Isn't the virus transmitted in the same ways in West Papua as it is anywhere else? What makes 'social behaviour' in West Papua different from the rest of Indonesia? In fact, the research points to a number of economic and political factors intersecting with social and cultural factors to drive the West Papuan epidemic. The growth of mining and timber industries in West Papua, as in neighbouring PNG, has brought an influx of new migrants.

West Papua also has a significant military presence. Those developments have brought economic and social change, as people leave their homes to seek jobs in the cash economy rather than traditional village economies.⁴

Growth in income and mobility has impacted the sex industry. HIV prevalence among sex workers in West Papua is very high. According to one recent study, HIV prevalence is 15.9% among direct sex workers, with STI prevalence (which can facilitate HIV transmission) even higher.⁵ The same study found that 72% of female sex workers reported using condoms during the last week, though the figure was lower among indirect sex workers, such as bar girls and hostesses.

Leslie Butt, one of the few western academics to have written extensively about West Papua, has noted that the sex industry in West Papua is highly stratified according to ethnicity. Many brothels in West Papua are semi-official and operate with the approval of the government. Sex work related HIV prevention programs are generally concentrated in those venues, which predominantly employ Indonesian women.

Many Papuan sex workers, however, operate outside those venues: often working part-time to support their families, or exchanging sex for food or other goods. These sex workers are harder to reach. They are working outside the 'formal' sex industry, often in rural areas, and they are often less educated. Awareness of HIV in West Papua is low. One study in 2006 found that 48% of people had never heard of HIV or AIDS. With poverty and illiteracy concentrated among ethnic Papuans, it is hardly surprising that HIV prevalence among ethnic

Papuans is twice as high as it is among ethnic Indonesians.

Butt and others suggest that cultural differences also affect responses to HIV. Myths and misconceptions about HIV and AIDS are common among Papuans. One of the more obviously politicised beliefs is the apparently widespread opinion that HIV was introduced by Indonesians to destroy the local population. Such beliefs, are hardly likely to encourage Papuans to engage with the health system or with HIV prevention programs that are usually run by Indonesians. Conversely, Butt reports that racist attitudes towards Papuans are common among Indonesians, depicting Papuan women as promiscuous and Papuan men as sexually voracious.⁶

West Papua represents a challenging environment in which to run HIV prevention programs. Nonetheless, the provincial AIDS Commission is very active and reportedly does some excellent work, with the Indonesian Government reporting increases in the number of Papuans accessing voluntary testing and counselling. Agencies such as UNAIDS and AusAID also run programs in West Papua though the Catholic Church, which has been active in the response to HIV in PNG, although with a lesser presence in West Papua.

Development of an international response is stymied by lack of access to West Papua. Much less is written about West Papua than about PNG, partly because travel in West Papua is restricted: the Indonesian Government requiring special passes to enter the province. Reporting from West Papua

continued on page 52

Development of an international response is stymied by lack of access to West Papua. Much less is written about West Papua than about PNG, partly because travel in West Papua is restricted ...

BOOK REVIEW

Sin, Sex and Stigma: A Pacific Response to HIV and AIDS by Lawrence James Hammar

Reviewed by Abigail Groves

Any book called *Sin, Sex and Stigma* is bound to be a good read, if not an easy read. Lawrence Hammar's new book on HIV and AIDS in the Pacific is certainly not an easy read, for a number of reasons. At over 400 pages, this is not an airport-lounge book. It's dense and packed with ideas, arguments and references to the history of anthropological discourses about Pacific cultures.

Sin Sex and Stigma: A Pacific response to HIV and AIDS is a relentlessly depressing survey of the response to HIV in the Pacific – mostly in relation to Papua New Guinea (PNG). An effective response to HIV in PNG faces enormous barriers: the diversity of languages and cultures, poverty, uneven development, corruption, the weakness of the health system and of research, the widespread denigration of women – and this is hardly a complete list.

The state of the national response to HIV in PNG and the ineffectiveness of some of the prevention programs there would make any reader with the slightest background in HIV issues grind their teeth in frustration. Hammar saves his most withering criticism for the Christian churches in PNG which, while leading the provision of health and care services for people with HIV, have for the most part promoted the notorious 'ABC' – Abstinence, Be

faithful, use Condoms approach to HIV prevention. Even worse is the promotion of anti-condom messages by religious leaders such as the Catholic Bishop Bonivento, who believes that condoms are ineffective in preventing HIV transmission and cause promiscuity (p 224).

Hammar argues that there is a dialectical relationship between marriage and sex work, meaning that the two feed into each other. To anyone with a background in feminism, this is hardly a new insight. However, it takes on a different meaning in the context of PNG, where historically many groups practised polygamy and various forms of wife-swapping – both practices that colonial authorities sought to eliminate. The result, Hammar argues, is that women were forced into western, cash-based forms of sex work.

With the development of resource-extraction industries, many husbands now leave their villages to look for work and women trade sex for food, transport, or even medicines. Marriage is often promoted – especially in Christian-based messages – as the institution that will protect them from HIV, but this assumption, as married women who acquired HIV from their husbands have found out, is faulty and even dangerous. Hammar's

chapter on the dynamics of 'tu kina bus' – sex work – and its relationship to traditional cultural forms of sexual network, is fascinating.

It's little wonder that Hammar's writing burns with the 'hot glow of anger', as he calls it (p 37). In his conclusion he says that, 'I consider the contents of this book to represent my special responsibilities in the world ... I have tried my best to speak Truth as clearly as I can to Power' (p 387). Hammar feels the tragedy of the situation in PNG keenly, and feels for its most vulnerable residents.

That said, *Sin, Sex and Stigma* ... has some problems in its construction, despite the power of its arguments. The book is made up of several chapters which, while fascinating in themselves, lack a level of continuity. Likewise, the inclusion of three lengthy interviews, with anthropologist Sarah Hewat on West Papua, with academic and sex work activist Alison Murray on sex work, and with doctor Mark Boyd on treatments – are each fascinating – and would have benefited from further development into complete chapters. Perhaps Hammar didn't have time for this. The HIV epidemic in Papua New Guinea is just too urgent.

Abi Groves is a former policy analyst at AFAO and a freelance writer.

The logo for HIV Australia, featuring the word 'HIV' in large, bold, yellow capital letters above the word 'AUSTRALIA' in smaller, bold, yellow capital letters. The text is set against a white background with a subtle shadow effect.

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WEB WATCH

Evidence to Action: HIV and AIDS Data Hub for Asia-Pacific website

www.aidsdatahub.org

The HIV and AIDS Data Hub for Asia-Pacific website provides access to a comprehensive range of data and other resources about the HIV epidemic in the Asia-Pacific region. The premise behind the site is summed up by its tagline 'Evidence to Action': in order to achieve change, advocates must have access to current, good quality data about the HIV epidemic in specific locations, as opposed to generalised global summaries, which are often more readily available.

The Data Hub is one component of a larger project, 'Evidence-based Advocacy for Action', funded by the Swedish International Development Cooperation Agency (Sida) through the Asian Development Bank (ADB). The site itself is a collaborative partnership between UNICEF, UNAIDS, and ADB. Its operations are overseen by a Science and Technical Advisory Group made up of expert health practitioners from across the Asia-Pacific.

The website is impressive in its scope, providing a detailed profile of HIV in 27 distinct locations. What is immediately obvious is the great care with which it has been put together. It is regularly updated, visually appealing and easy to use. It has recently been given a complete overhaul in appearance and its search functions have been improved.

There are five key areas where users can access data related to their country of inquiry: Country Profiles, Regional Profiles, Tools, Reference Materials and Videos.

The 'Country Profiles' menu allows users to select a country, which takes them to a landing page providing a range of related information and resources. All data and resources can



be viewed online and can also be downloaded for later reference.

Datasets for each country are broken down into five broad areas: HIV prevalence and epidemiological status; vulnerability and HIV knowledge; risk behaviours; socio-economic impact of the epidemic in the region (the 'economics of AIDS'); national response; and key issues. Users can download an Excel report on each or all of these topic areas.

HIV prevalence data are split into subcategories, including most-at-risk populations, prevalence in major urban areas and non-urban areas, and prevalence among subpopulation groups such as MSM, transgender, women and children.

In addition to the Excel formatted reports, datasets can be downloaded as PowerPoint presentations. This is a great tool and an important feature of the site, because it brings the data to life using coloured graphs, maps and diagrams ready for use in a presentation setting.

A briefing about the epidemiology and trajectory of the epidemic within each country is available under the 'Country Profiles' heading. These reports provide a succinct overview of the HIV epidemic by country, including the date of the first officially recorded case, percentages relating to HIV prevalence for population sub-groups (including groups most at risk), details about national and government responses, and

analysis of other specific factors relevant to the epidemic in each location.

The site also provides access to some 2000 resource documents, including national strategic plans, surveillance reports, population-based surveys, targeted studies and epidemiological fact sheets. These can be accessed from the 'Reference Materials' or individual Country Profiles. Featured resources are also highlighted on the site's homepage.

The 'Regional Profile' section of the site provides data that compares specific aspects of the epidemic between different countries, providing a comparative overview of data across the region. It focuses on areas including migration, law and policy, and women and children.

Under 'Guidelines' in the Tools section (a newer area of the site), there is a range of documents well worth downloading. Resources include *The People Living with HIV Stigma Index* and *Sexwork, violence and HIV – a guide for programmes with sex workers*. The 'Tools' section also contains National AIDS Spending Assessment (NASA) reports, as well as a training manual section.

In summary, the AIDS Datahub website provides access to a rich array of resources for anyone wanting current information about HIV in the Asia Pacific. All resources can be reproduced free of charge, providing www.aidsdatahub.org is acknowledged, making this site an essential tool for advocacy.

The women interviewed reported both physical abuse and sexual violence, with three out of four women having experienced sexual coercion and/or having been forced to have sex when they were not willing (74% highway-based and 73% non-highway-based). A third (33%) from both samples reported they had been raped. Close to half the women in both samples had experienced physical abuse and had been assaulted by a man (47% highway and 53% non-highway-based).

Recommendations

The recommendations resulting from the study findings include the need to:

- strengthen and expand programs that address violence against women
- strengthen and expand programs that address alcohol and drug abuse
- conduct additional qualitative research to improve understanding of high-risk behaviour
- evaluate the effectiveness of behaviour change communication interventions being supported by Tingim Laip and other community-based programs
- expand the coverage of youth-focused HIV prevention programs, including provision of information on sexuality risks of certain sexual behaviours, access to male and female condoms
- scale up and strengthen coverage of intervention programs targeting port workers and long distance truck drivers by involving private industry
- scale up and improve coverage of intervention programs focusing on women who sell sex, both in towns and along the highways
- reinforce and extend prevention programs to include both formal and informal settings where transactional sex is negotiated
- improve condom availability and condom access by expanding the number of retail outlets, dispensers, and community centres
- increase awareness of the availability of voluntary counselling and testing services among all population groups in settings where high-risk behaviour is likely to occur and encourage participation in testing
- address common incorrect beliefs about HIV transmission through a range of appropriate behavioural change communication (BCC) interventions, and
- improve attitudes towards people living with HIV.

Finally, the behavioural surveillance survey needs to be repeated at two-yearly intervals to monitor the effectiveness of behaviour change interventions.

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Dr John Millan is President of the Sexual Health Society of Papua New Guinea.

is also restricted. The ABC's current affairs program *Foreign Correspondent* apparently engaged in months of negotiation with the Indonesian Government to gain permission to research and air a program on HIV in West Papua in 2008.⁷ Partnerships and research are also hampered by language barriers, as West Papua does not have a culture of people speaking English or even pidgin as they do in PNG. Most Papuans speak their local languages and, if they are educated, also speak Bahasa.

The Indonesian Government has acknowledged the need for more research into the views, culture and behaviour of Papuans, as well as the need to increase: awareness of HIV; the availability of condoms (which can be hard to get in rural areas); and the

availability of treatment services. In fact, the list of needs is long.⁸ Butt, however, believes that the priority in West Papua is involving Papuans in HIV prevention: developing West Papuan programs designed by and for Papuans.⁹

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Abigail Groves is a former Policy Analyst at AFAO and a freelance writer.

TREATMENT BRIEFS

Pre-exposure prophylaxis (PrEP) could reduce condom use by some gay men

A substantial proportion of gay men say they would reduce their condom use if pre-exposure prophylaxis (PrEP) proves to be effective, US investigators report in the online edition of the *Journal of Acquired Immune Deficiency Syndromes*.

The investigators found that the availability of 80% effective PrEP could reduce inhibitions about unprotected sex. Their results also showed that it could lead men to view unprotected sex as having an acceptable level of risk.

'A better understanding of the emergent issues inherent in the provision of PrEP will allow for the development of both individual-level interventions supporting

PrEP users and community-level interventions designed to increase awareness and acceptability of PrEP', comment the investigators.

PrEP involves the treatment of HIV-negative individuals with antiretroviral drugs to prevent infection with HIV. Laboratory and animal tests have had promising results. A number of clinical trials using PrEP are currently underway and some results are expected shortly.

There is considerable optimism about the impact PrEP could have on the transmission of HIV. However, some have cautioned that the availability of a biomedical method of prevention could lead some individuals to become less reliant on condom use and reduction in number of partners to avoid HIV. It has been suggested that an increase in risky sexual behaviour could undermine the potential benefits of PrEP.

Two psychological mechanisms could lead to PrEP increasing sexual risk taking. The first is "behavioural disinhibition". This means that individuals who desire unprotected sex

would view PrEP as a substitute for behavioural control, or condom use.

It is also possible that PrEP could lead to 'risk compensation'. Some individuals may consider that PrEP reduces the risk of HIV transmission to such an extent that they are willing to have unprotected sex when taking PrEP.

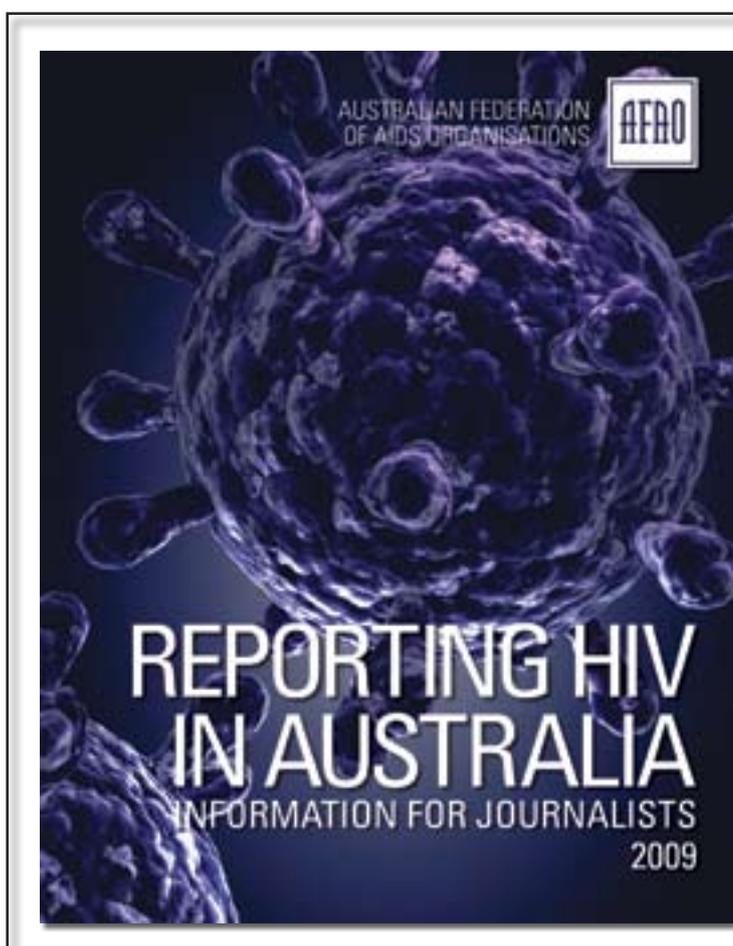
Little research has been undertaken into the potential impact of PrEP on sexual behaviour. Therefore investigators in New York designed a study involving 180 substance-using HIV-negative gay men who had had at least one recent episode of unprotected anal sex.

Reference

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— Michael Carter, *Aidsmap*

continued overleaf



RESPONSIBLE REPORTING ABOUT HIV.

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www.afao.org.au

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www.afao.org.au/ReportingHIVinAustralia

Six existing drug classes now being tested as microbicides

A number of presentations at the 2010 International Microbicides Conference in Pittsburgh concerned microbicide research using established classes of HIV drugs that have not been used as microbicides before.

Trial of microbicides and pre-exposure prophylaxis (PrEP) in humans have so far only involved two classes of drugs: the nucleoside reverse transcriptase inhibitors (NRTIs) tenofovir and FTC in large randomised controlled trials, and the non-nucleoside reverse transcriptase inhibitors (NNRTIs) dapivirine and UC781 in phase 1 safety trials.

If people taking PrEP are nonetheless infected with HIV, or are doing so with an undiagnosed infection, there is a significant possibility of the development of HIV drug resistance, and there is a theoretical risk of resistance in microbicides too. There is therefore an urgent need to research other drugs as microbicides and PrEP agents, both to minimise the risk of prevention and to provide 'second-line prevention' should HIV drug resistance become prevalent.

There are many experimental classes of drug being tested for use as microbicides, but using ones with a history as HIV treatments removes some of the need to demonstrate safety and shortens the preclinical and phase 1 phases of development:

leading researcher Robin Shattock told the conference that the failure of microbicide-specific classes to show efficacy has injected new urgency into the need to demonstrate proof of concept.

Two new classes of drug – an integrase inhibitor and the CCR5 inhibitor, maraviroc (*Celsentri*) – are amongst drugs that have now been used to prevent HIV infection in monkeys, and await funding to go into human trials.

L-870812 is an integrase inhibitor, and one of the compounds that was investigated as a candidate HIV treatment drug during the development of the first one eventually licensed, raltegravir (*Isentress*).

Fuller data was also presented on a study of the CCR5 inhibitor maraviroc, initially presented at the Conference on Retroviruses and Opportunistic Infections in February 2010. Maraviroc also underwent further investigation as a possible rectal microbicide and for use in combination. This CCR5 inhibitor drug was licensed by Pfizer to the International Partnership for Microbicides (IPM) in 2008.

Maraviroc had previously shown only modest anti-HIV activity as a microbicide. The current studies confirmed that its potency in preventing infection of cervical and penile tissue was relatively modest, unless the cells are already in an inflammatory state. The fact that, despite this, it protected monkeys from vaginal viral challenge suggests it might be a very potent rectal microbicide.

This is partly because, since rectal cells are more easily infected by HIV, a microbicide can make the most obvious difference to their vulnerability; it offers the most protection to the most easily-infected tissue cells, but makes less difference to less easily-infected tissue.

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— Gus Cairns, *Aidsmap*



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17

MSM Pre-conference (prior to International AIDS Conference)

Vienna, Austria

<http://www.msmsgf.org/ViennaEN/>

17

AIDS 2010 Pre-Conference: International Indigenous Working Group on HIV/AIDS (IIWGHA)

Vienna, Austria

<http://www.caan.ca>

18–23

AIDS 2010: XVIII International AIDS Conference

Vienna, Austria

www.aids2010.org

22

Doing Time: BBV health research, practice and possibilities for people in the prison population in NSW

Sydney, Australia

http://nchsr.arts.unsw.edu.au/media/File/1_NCHSR_Consortium_workshop_1_invitation.pdf

August

11

Emerging Health Policy Research Conference

University of Sydney, Australia

http://www.menzieshealthpolicy.edu.au/events_upcoming.php#ehpr2010

September

6–8

The 7th Australasian Viral Hepatitis Conference

Melbourne, Australia

<http://hepatitis.org.au>

27–29

Public Health Association of Australia – 40th Annual Conference

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[40thPHAAAnnualConference.php](http://www.phaa.net.au/40thPHAAAnnualConference.php)

October

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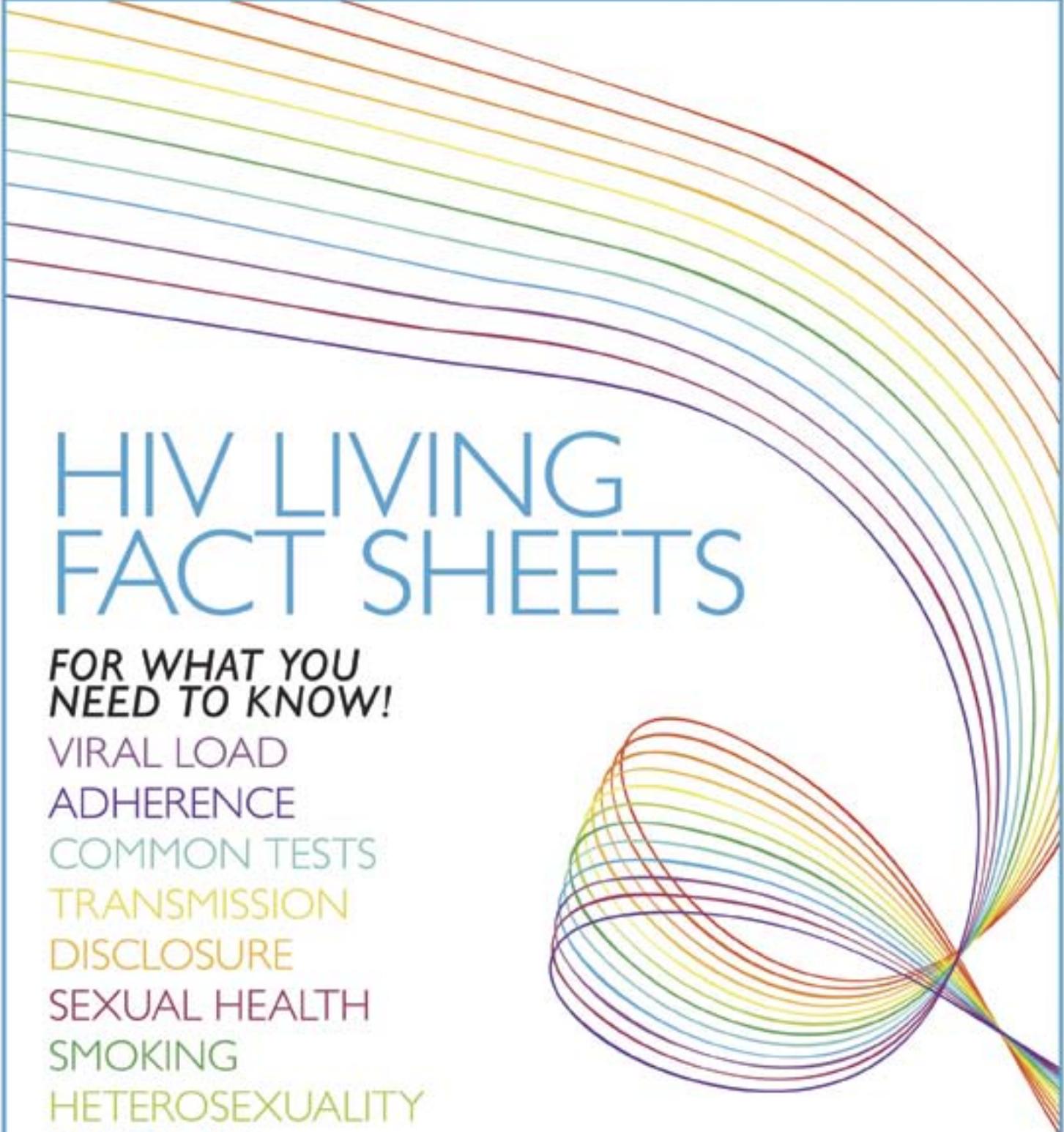
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Diary



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