Chapter 19

Policy Making on AIDS, to 2000

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Policy making on AIDS in Papua New Guinea has a number of features which set it apart from policy making on other subjects. Most obviously, AIDS presents a new subject for policy, unknown before the mid 1980s; the relevant inheritance from other sectors of policy is not limited to health, since AIDS affects all sectors concerned with development. Because AIDS has been a new issue, the process of its emergence on the policy agenda and the ways in which it has been defined as an issue must be examined; these are taken for granted in other sectors. Finally, because a major part of the strategy for dealing with AIDS concerns prevention through behaviour change, a range of cultural beliefs and practices concerning sensitive issues, particularly those of sexuality and gender relations, are brought to the fore in exceptional fashion; hence examining policy in isolation from practice is especially futile in relation to AIDS.[1]

Although overseas aid has played a significant role in the shaping of public policy in most sectors in Papua New Guinea, the international process of defining AIDS and of establishing a repertoire of policy responses has ensured that external precedents have been unusually forceful in shaping national AIDS policy. Thus it is impossible to discuss policy making on AIDS in Papua New Guinea without locating it within a global setting of policy making.

The international setting of AIDS policy

After the initial identification in the US of clusters of disease among immune-suppressed gay men in July 1981, other groups were found to be affected by what became known as the Acquired Immuno-Deficiency Syndrome (AIDS). In April 1984 discovery of the virus Human Immuno-Deficiency Virus (HIV) was announced and tests to identify those infected were rapidly developed. Although the World Health Organization was slow to mobilize a response to AIDS, it established in 1986 a Global Program on AIDS (GPA) which developed models, initially in Uganda, for short-term and medium-term HIV/AIDS programs for non-Western countries. GPA also convoked consultations among a growing band of AIDS specialists; these identified the principles of community-based health promotion adopted by Australia (Ballard 1998) and a few other Western countries as international best practice in the response to AIDS.

In July 1987, at the request of the Australian government, GPA turned its attention to Asia and the Pacific in a regional ministerial conference held in Sydney. GPA then organized week-long missions to most Southeast Asian and Pacific countries, including Papua New Guinea, to initiate planning for short-term programs. These followed the classical bio-medical template of responses: surveillance of sexually transmitted infection, information and education, and blood screening. From an early stage, GPA also brought together country AIDS managers for orientation and training. Up until the mid 1990s GPA provided substantial technical assistance as well as over K100,000 per year for research and projects, but little of this was actually spent.

GPA's successor UNAIDS, apart from regional conferences and training, gave low priority to the Pacific. In recent years technical assistance on AIDS has come from governments, notably Australia, while international non-government organizations, most of them faith-based, have been increasingly involved in financing, sponsoring and providing AIDS projects in Papua New Guinea, often in the context of wider health programs.

Papua New Guinea policy making on AIDS

Although no cases of HIV or AIDS had yet been identified in Papua New Guinea, in November 1986 the Department of Health established a National AIDS Surveillance Committee (NASC) to coordinate information, advise on prevention, and encourage research; later it became responsible for overseeing the activities prescribed in the Short-Term Plan for 1987–88. The first AIDS information pamphlets were prepared and distributed in a low-key exercise which sought to educate without raising fears. Letters appeared in the Papua New Guinea press, especially after the broadcast in Australia in April 1987 of the first major television campaign, *The Grim Reaper*. Much of the public discussion focused on the potential for AIDS imported by Australians, especially homosexual men, and members of the Surveillance Committee responded with factual information (Turner 1989). The death from AIDS of a PNG national in Australia was announced and a case of HIV in Papua New Guinea, that of an expatriate, was identified in June 1987, while the first clinical case of AIDS in Papua New Guinea was reported in March 1988. AIDS had made, at least in limited fashion, a public appearance.

From the start, a major issue in the Department of Health and in public discussion concerned the relative priority to be given to AIDS as against well-established health problems, notably malaria and tuberculosis. Dr Quentin Reilly, secretary for Health during the early period, was sceptical about the need for diverting resources to AIDS and he reflected the predominant view among doctors and politicians. In 1986 Clement Malau, a young doctor in the Papua New Guinea Defence Force (PNGDF), was assigned to the Department of Health as senior specialist medical officer for communicable diseases with AIDS as one

of his responsibilities, working to the assistant secretary for disease control, Dr Timothy Pyakalyia. Over the next fifteen years Malau, Pyakalyia and a venereologist, Dr Tompkins Tabua, provided continuity as central actors in AIDS policy making, though Malau was absent for extended periods for AIDS training and positions overseas. They maintained most of Papua New Guinea's contacts with international AIDS organizations, representing Papua New Guinea at global and regional meetings on AIDS.

Some of the impetus for policy development derived from ministers of Health who took an interest in AIDS. A workshop on AIDS for members of parliament was organized in April 1988, at which a former Australian minister for Health, Dr Peter Baume, was keynote speaker. Following this, Tim Ward, the Papua New Guinea minister, won adoption by the National Executive Council of a *National Policy Document on AIDS Control in Papua New Guinea* (Department of Health 1988), prepared by the NASC, which was renamed the National AIDS Committee. The *Document* laid out broad policy directions in line with GPA's guidelines for policy making, ensuring confidentiality and non-discrimination, and it addressed directly the need for the churches to collaborate with departmental messages on condoms. The National Council of Churches had begun discussing AIDS issues, as had their counterparts in Australia during 1987, and the Council was given a seat on an enlarged NASC, along with international organizations and the Department of Anthropology and Sociology at the University of Papua New Guinea. Ward was shortly thereafter replaced as minister by Robert Suckling, owner of several bars in Port Moresby, who promoted a number of initiatives on condom education through mass media. Suckling also set up an *ad hoc* parliamentary group on AIDS to provide continuing orientation for MPs, but without secretariat support, it proved short lived.

During 1989–90 a *National Medium-Term Programme for the Prevention and Control of AIDS in Papua New Guinea 1989–1995* (Department of Health 1990) was drawn up under the auspices of the Disease Control Unit of the Department of Health. The central initiatives of the program fitted with GPA's standard biomedical top-down model for medium-term programs: an epidemiological sentinel survey, expansion of education and condom promotion campaigns, upgrading of STD clinics, and expansion of training in counselling and other skills. Negotiations were undertaken with prospective international donors to fund the program's proposed budget of $US6.321 million, one third of this devoted to STD clinics. However the government was unwilling to give AIDS a high funding priority. Some components of the program were funded, notably through staffing by WHO and the EEC of specialist positions in the AIDS/STD Unit and upgrading of the Goroka STD clinic. USAID initially funded a social marketing program for condoms and several research projects through the Papua New Guinea Institute for Medical Research, but later withdrew from AIDS and other health programs in the Pacific.

In November 1990 a national workshop on AIDS in the workplace was organized to persuade government and private sector employers of the need for educating their workforce; there it was apparent that only the Ok Tedi mining project and the PNGDF had undertaken serious prevention programs. During the early 1990s the international agenda on AIDS began to absorb the lessons of African experience, as the previous decade's development was undermined by the social and economic impact of the epidemic, particularly through the loss of trained manpower and the disruption of communities. The World Bank began to focus on AIDS and the UN Development Program established an HIV and Development Program under the direction of Elizabeth Reid, who had helped shape Australia's national strategy.

The AIDS/STD Unit sought to put this new dimension of AIDS on the Papua New Guinea agenda by organizing in February 1992 its most ambitious conference, a national seminar on the social and economic impact of AIDS, strongly supported by a new minister of Health, Galeva Kwarara. Kwarara had seen an Australian documentary video, *Susie's Story*, concerning a young wife and mother dying of AIDS after infection by a drug-using partner, and he was shocked by the implications of heterosexual transmission of the virus for a country where multiple sexual partnering was increasingly commonplace. Senior ministers were persuaded to attend the conference dinner and a drama on AIDS in the village, and a number of senior officials from across government departments were introduced to the issues. The conference also launched the PNGDF's new AIDS education program, designed by the director general of PNGDF Health Services and Malau and featuring the PNGDF's own *Gumi* brand of condoms.

At this point one hundred cases of HIV infection had been identified in Papua New Guinea, the great majority of them in Port Moresby, where most testing had taken place. Initial sero-surveillance showed very low levels of prevalence among populations at risk, highest among patients at STD clinics. The National AIDS Committee estimated that there were probably between five and ten thousand cases of infection, but the prospective nature of the threat to Papua New Guinea's economy and society was still too remote to win sustained government attention and resources.

Some initiatives were taken outside government. The Seventh Day Adventist Church and the Salvation Army took AIDS seriously on an international level, and both had AIDS education and care programs within Papua New Guinea from the early 1990s. Following the first regional conference on AIDS, held in Canberra in July 1990, Australian and Papua New Guinea NGOs were in occasional contact on AIDS, but the only sustained NGO activity of any kind in Papua New Guinea at this stage was that of environmental and forest groups. However, the Papua New Guinea Institute of Medical Research, based at Goroka, began to take a role

in policy development, largely through the activities of a medical anthropologist, Dr Carol Jenkins. Jenkins organized the first major survey of sexuality in Papua New Guinea in 1991, training public servants and teachers as interviewers in their home areas during the Christmas leave period. Funded by USAID, the survey drew on 423 interviews in 40 language groups. When it was published (National Sex and Reproduction Research Team and Jenkins 1994) it was met with denial by some church groups, but it provided invaluable material for culturally sensitive education programs and served as a model for research elsewhere. With funding from a variety of sources, Jenkins also organized research interventions and peer education among provincial communicators, transport workers, sex workers, police, and security staff. She and Michael Alpers, director of the Institute of Medical Research, also organized the first explicitly AIDS-focused NGO, Action for Community Health, which, after long delays, was approved in 1996 before Jenkins left Papua New Guinea for AIDS work in Bangladesh.

Early in 1993 the Department of Health proposed that a National AIDS Council be established as a separate statutory authority with its own staff and power to coordinate a full multisectoral program. A second conference on the social and economic impact of AIDS was organized in July 1993, with a higher level of participation from senior officials, to promote the need for a council and for a national federation of non-government organizations working on AIDS. Jenkins, Malau and Barry Holloway, who directed an office of advanced planning under the Wingti government, attempted to sell the proposal for the council to government, but a cabinet committee chaired by Sir Julius Chan as deputy prime minister refused to grant space in the parliamentary agenda. When Peter Barter was named minister of Health under a new Chan government in 1994, Jenkins persuaded him to resurrect the proposal, but Chan himself rejected it, stating that AIDS needed no priority as against malaria and other diseases. However John Nilkare, as minister for Provincial Affairs, was sufficiently impressed to provide Jenkins with K100,000 for research and education programs.

Despite interest on the part of successive ministers for Health, the period from 1993 was one of reduced funding, reduced staff and no political commitment to AIDS. Jenkins described the situation as of 1995:

> [P]ositions in the STD/AIDS Unit supported by international donors were no longer filled. After mid-1994 the National AIDS Committee could no longer afford to hold its meetings, no further quarterly reports on STD and HIV/AIDS were compiled and other departments lost interest. The lack of funds has affected everything except salaries, e.g., no telephones, water, postage. Lack of funds, trained personnel, political support and leadership have had a seriously negative effect on AIDS prevention efforts (Jenkins and Passey 1998, 247).

The period also saw a sharp increase in the incidence of HIV: 351 new cases of HIV infection were reported in 1997, and 642 in 1998, despite lower levels of surveillance.

During this period of government inactivity, there were shifts in the international context of AIDS policy. The Global Program on AIDS, based in the World Health Organization, was replaced in 1996 by the Joint United Nations Program on AIDS (UNAIDS) after donor governments insisted on a unified UN focus for increasingly disparate activities. UNAIDS country program advisers were appointed to many countries and theme groups were established to coordinate all UN agencies' work on AIDS. Papua New Guinea was not provided with a country program adviser, but a theme group was formed under the leadership of the WHO representative.

The Medium-Term Plan 1998–2002 and the National AIDS Council

The arrival of a new government in 1997 produced a marked change in AIDS policy. The prime minister, Bill Skate, seeking to differentiate his policies from those of his predecessor, Julius Chan, took a direct interest in the issue, as did the secretary of Health, Dr Puka Temu, supported by his minister, Ludga Mond. Legislation to establish a National AIDS Council was fast-tracked, and the prime minister issued in August 1997 a directive calling on all departments, provincial governments, NGOs, churches, donors and the private sector to collaborate in the formulation of a national strategy on HIV/AIDS. Political support opened new possibilities for developing policy and programs.

The initial proposal for a new medium-term plan (MTP) was put forward by a team of UNAIDS/AusAID consultants. They anticipated the standard six-month arrangements for medium-term plans which had been drawn up under UNAIDS guidance in many countries. This preference was reinforced by a Papua New Guinea team that visited Uganda and returned to urge that Uganda's MTP be taken as a template for Papua New Guinea. What emerged was very different, for the process of consultation was taken seriously and led to a strategic document unusual, if not unique, in its genuinely multi-sectoral focus and its central concern with social, economic and ethical issues.

Although the Department of Health provided most resources, it agreed, in an exceptionally generous moment, that the Office of National Planning and Implementation (ONPI) should serve as lead agency. Thomas Lisenia of ONPI chaired both a multi-sectoral coordinating committee and a small secretariat, which served as interim secretariat for the National AIDS Council. A position as full-time coordinator, vital to the exercise, was funded by the UN Development Program and Katherine Lepani left the National Research Institute to take this post.

Six priority areas were defined and multi-sectoral working groups were established to focus on these:

- Education, Information and Media
- Counselling, Community Care and Support
- Legal and Ethical Issues
- Social and Economic Impact
- Monitoring, Surveillance, Evaluation and Research
- Medical and Laboratory

With over eighty people drawn from all sectors, in and out of government, the working groups met separately between September and December 1997 to produce draft strategy papers on their areas; several individual members drafted concept papers, and consultative workshops were organized. Lepani attended all meetings and pulled together the working party drafts into a draft MTP.

When the National AIDS Council legislation was passed by parliament in December 1997, Skate embraced a man living with AIDS, and a woman living with AIDS spoke movingly on national television, attempting to break the political and public silence on living with AIDS. The Council and its secretariat were in place by June 1998 when the *National HIV/AIDS Medium-Term Plan 1998–2002* (Papua New Guinea 1998) was launched. Puka Temu, then secretary for Health, argued at the launch that the process by which the plan had been developed was a suitable model not only for other policy areas in his own department, but throughout government. Acknowledgment was given in the plan to the vision and direction provided by Carol Jenkins.

As these developments materialized, AusAID, which had been slowly working its way towards support for AIDS programs in the region, announced a vast increase in AIDS funding for Papua New Guinea. When Australia had been asked for support of the first MTP, a feasibility study for a major Australian project was undertaken early in 1993 (Plummer 1993) and this was followed up the next year with another mission (Moodie *et al*. 1994). In 1996 a Sexual Health and HIV/AIDS Prevention and Care Project was established, with K3.5 million, to help the Department of Health; this was the largest AIDS project until then in Papua New Guinea. Under the direction of Dr Susan Crockett the project focused on upgrading sexual health clinics and training counsellors.

Up to this time, the Australian commitment to provide primarily budget, rather than project, aid to Papua New Guinea had meant that any major AIDS funding was dependent on Papua New Guinea government priorities. With the rise of political interest in AIDS within Papua New Guinea, the Australian government indicated that it would make available much more substantial funding, and was asked by the Papua New Guinea government to channel this through its new MTP. In March 2000 Australia announced that K100 million

was being provided for a National HIV/AIDS Support Project (2000–5), initially directed by Crockett.

On replacing Bill Skate as prime minister in 1999, Sir Mekere Morauta made clear that he supported the AIDS policies of his predecessor, and Lady Roslyn Morauta became prominent in support of AIDS NGOs. A number of local AIDS organizations had sprung up. Perhaps best known were the work of Sister Rose Bernard, who had organized care and counselling for people living with AIDS in the Western Highlands for a decade, and the Friends Foundation, established for similar purposes by Tessie Soi, a social worker at Port Moresby General Hospital. However, NGOs received little financial support and were, as in other sectors, looked upon with suspicion and scepticism by government officials.

Meanwhile, the incidence of HIV climbed inexorably. By 1999 AIDS was reported as the leading cause of death at Port Moresby General Hospital (*Papua New Guinea Post-Courier* 7 December 1999). By mid 2001, 3900 cases of HIV infection had been reported, still on the basis of limited testing, with 65 per cent from the National Capital District, where most testing was conducted. An estimated HIV incidence of 10,000–15,000 cases was accepted by the National AIDS Council on the advice of an expert epidemiology workshop.

Retrospective from 2005

The collapse of the initial response to AIDS in the mid 1990s meant that the new National AIDS Council Secretariat, (NACS) headed by Malau, and its AusAID Support Project (NHASP), had to start from scratch in 2000. Their approach, with the MTP as their charter, was to address all sectors and all provinces, without establishing priorities. Despite the substantial funding available, it was clear from reviews during 2002–4 that, although there were achievements, there were major difficulties, particularly in mobilizing provincial AIDS committees, NGOs and other sectors, including the Department of Health. A *National Strategic Plan of HIV/AIDS* (2004–8) was drawn up, again without priorities, and in December 2004 the government accepted a longstanding proposal that the National AIDS Council be transferred to the Department of the Prime Minister and Cabinet.

In December 2004 a further epidemiology workshop estimated a national prevalence rate of 1.7 per cent, the highest in the Pacific region and amongst the highest in Asia. At the same time a survey by the Australian Strategic Policy Institute, advising the Australian government, found that Papua New Guinea's deteriorating services and infrastructure, high crime rates, economic stagnation and corruption were symptoms of a systemic lack of capacity to provide effective government. It warned that 'the institutions of governance in PNG have weakened to the point that they might collapse under the effects of … a full-blown AIDS crisis [that] will now be very hard to avoid' (ASPI 2004, 9). In

July 2005 the head of UNAIDS, Dr Peter Piot, labelled Papua New Guinea as at greatest risk in Asia and the Pacific of an African-type of generalized epidemic: 'That's the one county, I would say I think is really getting out of hand'.

Anthropologists have repeatedly found that local understanding of HIV in Papua New Guinea is contingent on cultural beliefs and practices and that generalized prevention messages are reinterpreted in these terms (Lepani 2005; Wardlow 2002). Accommodating Papua New Guinea's exceptional cultural diversity within viable public policy has been a substantial hurdle in all domains since the dawn of colonial rule and perhaps reaches an apogee in the development of policy on AIDS.

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Endnotes

[1] The term AIDS is used here in relation to policy, despite the common elision of HIV/AIDS to cover HIV as virus with AIDS as a syndrome of diseases produced by deterioration of the immune system.