

Report of the Commission on AIDS in the Pacific



TURNING THE TIDE:

An OPEN Strategy for a response to AIDS in the Pacific

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to AIDS in the Pacific**

**Report of the Commission on
AIDS in the Pacific**

Presented to
**Mr Ban Ki-moon,
UN Secretary General,
on 2 December 2009
in New York**



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Preface

The Pacific region covers an immense geographical area and for the most part comprises countries with very small, dispersed and highly mobile populations. Within the Pacific region are some of the world's smallest, most isolated and least developed countries. Development progress over the past 30 years, particularly in economic growth and poverty reduction, has been uneven across the region; it would be fair to say that it has been slow and even negative in some countries.

The reasons for this are many and complex. Geographical isolation, wide dispersal, poor internal transport infrastructure and small populations preclude many Pacific island countries from benefiting from economies of scale in commerce and in the provision of public services. The narrow economic bases of most of the countries limit their means to create employment and improve living standards. This has resulted in escalating urbanization and poverty, extremely limited job opportunities particularly for youth, and erosion of human capital.

The Pacific island region has also experienced pockets of instability. Social and political unrest, civil conflicts and natural disasters have all contributed to the development burden. The region's vulnerability is compounded by the impact of climate change and globalization. In the context of these and other challenges, the HIV epidemic, which has had enormous health, social and economic consequences throughout the world, is posing an additional threat. Failure to slow the epidemic in the Pacific would have direct and significant impacts, nationally and regionally, on social, health and economic development gains.

A number of factors have hindered the region's response to the epidemic: limited awareness and understanding of the potential long-term impact of the epidemic, unsupportive policy and legislative environments, weak health care delivery systems and low levels of community engagement and capacity to respond spring immediately to mind. As in other parts of the world, the low levels of support and commitment among communities and policy makers can possibly be attributed to a preoccupation with the many and competing health and development issues facing the region.

This is the context in which the former Executive Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS) Dr Peter Piot proposed an objective and independent analysis of the status and impacts of the epidemics in the region, in order to assess and provide policy options to countries and territories and their development partners. This work, has received the full support of Michel Sidibe, the current Executive Director of UNAIDS.

This task was entrusted to an Independent Commission on AIDS in the Pacific, established in October 2007 with a mandate to study and consider the real and potential impacts of HIV on the Pacific region, and to recommend strategies for accelerated and strengthened responses to HIV.

Given the short time frame, the Commission agreed to make use of already available data and information and to commission operational research around identified critical gaps in the region's knowledge base.

The commitment and zeal with which Commission members have taken on this task reflects their passion for the importance of this work and its significance in achieving an inclusive and caring society that is a living expression of the cherished values of the Pacific way of life.

With great sorrow, members of the Commission learnt that in the course of his tenure, the Chairperson, Dr Langi Kavaliku of Tonga, a highly respected and experienced Pacific leader, had passed away. The Commission members, the UNAIDS Secretariat and its country offices in Papua New Guinea and Fiji offer their respect and condolences to Dr Kavaliku's family and the people of the Kingdom of Tonga, and dedicate this report to his memory.

The Commission members use this opportunity to thank UNAIDS for the initiative and interest in this work and for the financial and technical support provided to the Commission.

The Commission members also thank the governments, civil society organizations and people of the Pacific who contributed to its work.

The findings and recommendations contained in the report are intended for policy-makers, programme implementers, development partners, communities, people living with HIV and all those concerned about the impact of and responses to HIV and AIDS in the Pacific.

In Dr Kavaliku's memory, we, the members of the Commission on AIDS in the Pacific, present this report to all thinking and concerned people of the Pacific region.

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Country Partners

The Commission thanks all of the people and Organizations who gave their time to meet with us during our visits to Fiji, Papua New Guinea, Solomon Islands, Samoa and New Caledonia. We regret that time constraints prevented us from visiting all Pacific countries.

Abbreviations

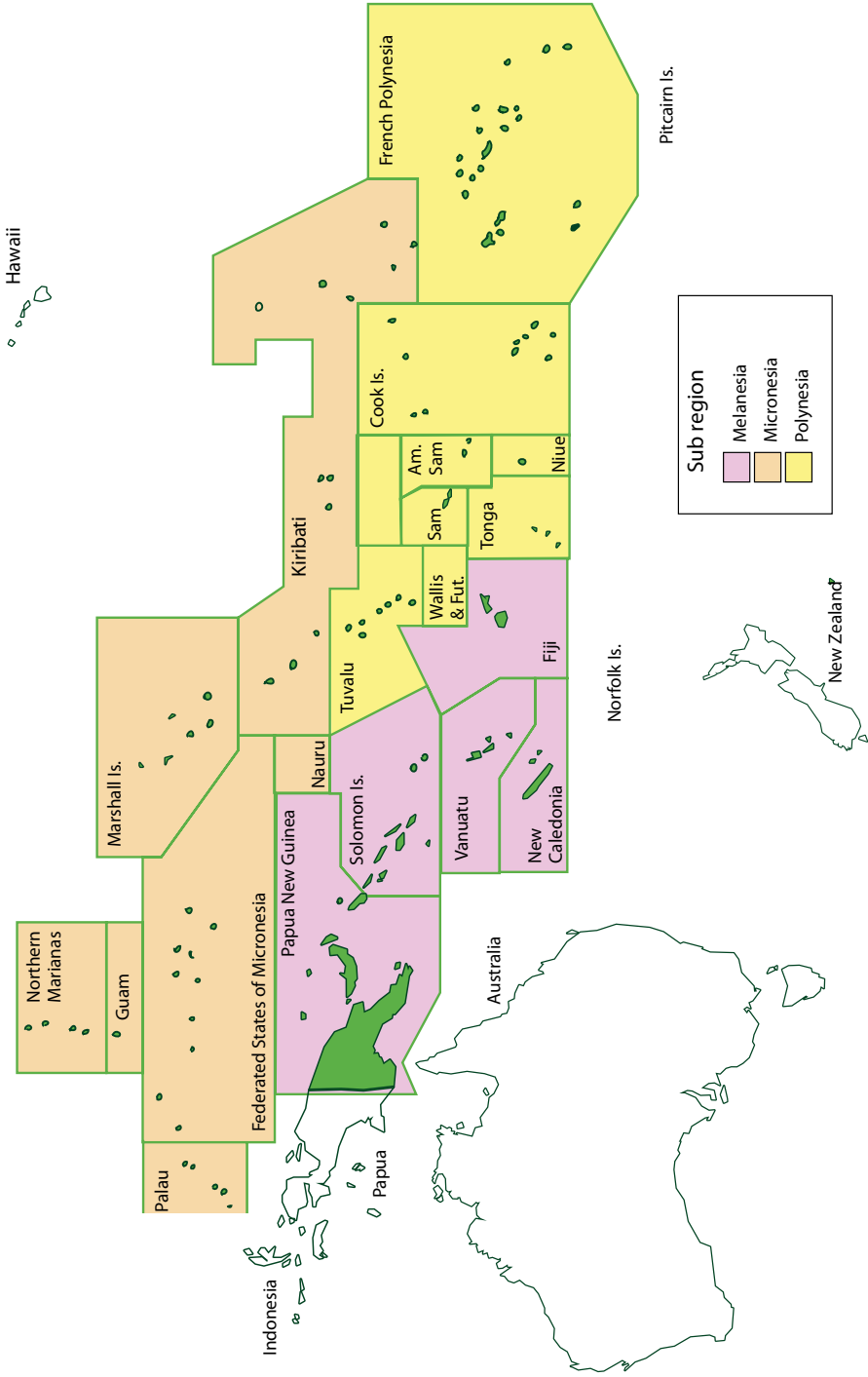
ADB	Asian Development Bank
AFAO	Australian Federation of AIDS Organizations
ANC	Antenatal clinic
ART	Antiretroviral therapy
ATFF	AIDS Task Force of Fiji
AusAID	Australian Agency for International Development
BAHA	PNG Business Coalition Against HIV and AIDS
BSS	Behavioural Surveillance Survey
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control (United States)
CNMI	Commonwealth of the Northern Mariana Islands
CSEC	Commercial sexual exploitation of children
CSO	Civil society organization
CSW	Commercial sex worker
DHS	Demographic and Health Survey
EU	European Union
FSM	Federated States of Micronesia
GFATM	Global Fund for AIDS, Tuberculosis and Malaria (or the Global Fund)
GIPA	Greater involvement of people living with or affected by HIV/AIDS
HAMP	PNG HIV/AIDS Management and Protection Act
HAPRI	HIV/AIDS Pacific Regional Initiative
ICAAP	International Congress on AIDS in the Asia and the Pacific
IDU	Injecting drug user
ILO	International Labour Organization
IRG	Independent Review Group (PNG)
K	(PNG) kina
M&E	Monitoring and evaluation
MDGs	Millennium Development Goals
MSM	Men who have sex with men
NAC	National AIDS Council/Committee
NACS	National AIDS Council Secretariat (PNG)
NASFUND	National Superannuation Fund (PNG)

Abbreviations - continued

NCD	Non-communicable disease
NDOH	National Department of Health (PNG)
NZAID	New Zealand International Aid and Development Agency
ODA	Official development assistance
OECD	Organization for Economic Cooperation and Development
PACASO	Pacific Council of AIDS Service Organizations
PIAF	Pacific Islands AIDS Foundation
PIJAAG	Pacific Islands Jurisdictions AIDS Action Group
PIRCCM	Pacific Islands Regional Country Coordinating Mechanism
PLHIV	People living with HIV
PMGH	Port Moresby General Hospital (PNG)
PMTCT	Prevention of mother-to-child transmission
PNG	Papua New Guinea
PPAPD	Pacific Parliamentary Assembly on Population and Development
PRHP	Pacific Regional HIV Project
PRISP	Pacific Regional Strategy Implementation Plan, 2005–2008
PRISP II	Pacific Regional Strategy Implementation Plan, 2009–2013
RAMSI	Regional Assistance Mission to Solomon Islands
RH	Reproductive health
SGS	Second Generation Surveillance
SPATS	South Pacific Association of Theological Schools
SPC	Secretariat of the Pacific Community
SPS	Sexually Transmitted Infection Prevalence Survey
STI	Sexually transmitted infection
SWAN	Sex Workers Advocacy Network
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCCT	Voluntary counselling and confidential testing
WHO	World Health Organization



Map of the Pacific



Executive Summary

Introduction

The Pacific is a unique and vulnerable region. It spans a third of the world's surface and accounts for just 0.14% of the world's population—with a similar proportion of the global burden of HIV. **For Pacific countries, even a small number of people living with HIV can translate into high incidence and prevalence rates** that can have devastating impacts on individuals, families, communities and economies. These challenges demand greater global attention. Pacific countries are often included in broad Asia–Pacific regional groupings where the magnitude of the problem in Asian countries overshadows the challenges and needs of smaller Pacific countries.

The Pacific region is characterized by diversity—an evolving mixture of cultures, traditions, languages, political systems and living conditions. Even the more-developed countries of the region are not immune to significant challenges to human development, compounded in recent times by the global financial crisis. Countries in the Pacific are at various levels of achievement of the Millennium Development Goals (MDGs)—but it is unlikely that any will meet all the health targets by 2015.

These Pacific realities led to the constitution of the Commission on AIDS in the Pacific in October 2007 to examine the current scale of the HIV epidemic in the region. The Commission also examined how the Pacific's response has changed over the past decade and how this momentum can be strengthened. During consultations in Fiji, Papua New Guinea (PNG), Solomon Islands, Samoa and New Caledonia this process entailed reviewing over 500 documents; commissioning eight studies in a range of areas; undertaking two surveys of Pacific people's perceptions of and attitudes to HIV; and listening to people affected by HIV and those working with them. National, regional and global experts were enlisted to review the data informing the deliberations of the Commission.

The Commission found that early action taken at community, national and regional levels helped keep the epidemic at low levels in most countries, though Papua New Guinea is the notable, complex exception. HIV responses have benefited broader Pacific health systems with improved testing and laboratory services. More openness about human behaviours, particularly sexual, has forced recognition of social issues that had previously been consciously avoided. Multisectoral approaches to HIV have also demonstrated **the importance of involving the whole community** and not just the health sector.

The Commission considers that more—and more determined—action is required to reinvigorate this early response and meet the continuing significant challenges of preventing new infections and alleviating the impacts of HIV.

The dynamics of HIV in the Pacific

There have been 29,629 reported cases of people living with HIV in the Pacific, with 5,162 new HIV diagnoses reported in 2008. Notably, cases from Papua New Guinea make up an ever-increasing proportion of the total cases detected in the Pacific—from 21% in

1984–1989 to over 99% in 2008. Reported cases in Papua New Guinea total 28,294, but UNAIDS estimates that there are 54,000 people living with HIV. Levels of under-reporting in the rest of the Pacific are likely to be similar.

On the basis of the reported numbers of people living with HIV, the countries of the region fall into three clusters:

- Papua New Guinea—as the overwhelming locus of the Pacific epidemic;
- Fiji, French Polynesia, New Caledonia and Guam—with significant numbers of HIV cases; and
- other countries, including the smaller island states—with fewer known cases.

The Commission is concerned that in spite of two decades of responding to HIV in the region and the positive steps taken, **knowledge of the estimated levels and distribution of HIV is still limited because of poor surveillance and data collection and analysis.**

Countries with the largest number of reported infections have the most widespread voluntary counselling and testing facilities. It is not clear whether low HIV prevalence in other countries is a result of low levels of testing, their relative isolation and the late introduction of HIV, the presence of protective factors, or the absence of specific vulnerability and risk factors.

The Commission is concerned that **sexually transmitted infections (STIs), which offer increased opportunity for HIV transmission, are endemic in the region.** The data and information that do exist indicate that **the predominant means of HIV transmission is unprotected sex.** The numbers of HIV-positive young people are steadily increasing and young women are infected earlier than young men. New Caledonia, French Polynesia and Guam have identified unprotected male-to-male sex and injecting drug use as key drivers of their epidemics.

HIV estimates are undertaken in only a limited number of countries: the others—the majority—depend on reported cases for their planning of appropriate responses. Because of the lack of solid epidemiological surveillance (except in Papua New Guinea) it is difficult to predict with any certainty the future growth of HIV in the region.

Risks, vulnerability and impacts

The Pacific region has a potent mix of risks and vulnerabilities to HIV.

Gender inequality and gender-based violence are major drivers in the spread of HIV and STIs. Connections between alcohol, drugs, unsafe sex and HIV are evident across all countries. Commercial and transactional sex is a major source of HIV vulnerability. Male-to-male sex, also a key risk, is often hidden and denied. Many men who have sex with men often also have sex with women, thus greatly increasing the risk of HIV infection in the wider population. Mobility and migration within and beyond the region pose another significant vulnerability.

The rapid pace of social, economic and cultural change in the region intensifies these

vulnerabilities. Pacific cultures have, historically, relied on extended family and clan networks as the fundamental social safety systems to provide emotional support, health care and economic security to individuals and communities (including those living with HIV). **In contemporary Pacific society grappling with the impacts of globalization, these social safety networks are being significantly weakened.**

Stigma and discrimination

Stigma and discrimination have the greatest impact on all aspects of a country's HIV response. **The greater the level of stigma, the further HIV spreads. Responses based on compassion work better than those based on coercion.** The stigmatization associated with high-risk behaviours deters people from accessing critical services. Terms such as illicit sex or labels for sexual identities exacerbate stigma and discrimination.

Making unprotected sex and other high-risk behaviours—rather than population groups—the focus of prevention programmes ensures that HIV is better understood at all levels in Pacific societies.

The Pacific response

The Commission compliments Pacific leaders for acting early to support efforts to mitigate the risk and vulnerabilities and maintain low levels of infections across the region. Even Papua New Guinea, while still facing significant challenges, has not, despite earlier predictions, experienced the scale and intensity of the hyper-epidemics of some of the sub-Saharan African countries.

The Commission believes that if leaders across the region—including traditional, church and community leaders—become more actively engaged in the response to HIV, it will help to translate regional political commitments to more effective national action.

Many Pacific countries have inherited legislation that criminalizes high-risk behaviours. In spite of legislative review and reform in some countries, as in the case of Papua New Guinea's HIV AIDS Management and Protection Act, **most legal systems across the region still do not provide adequate protection of the rights of people living with HIV/AIDS.**

The Pacific region has developed an extensive range of HIV strategies. But **the emphasis has been on regional planning; insufficient attention has been paid to national ownership and implementation.** A “one size fits all” response does not suit the diversity of Pacific nations. Regional approaches are best at mobilizing political commitment and providing technical capacity and resource mobilization where economies of scale can be achieved. Prioritization under the Pacific Plan of the Pacific Regional Strategy on HIV and other STIs (2009–2013) adopts this approach, stressing two things: countries should focus on actually implementing programmes rather than just talking about them; and they should be accountable for their performance. **But where national HIV/STI strategic plans have been developed, the countries have not fully costed any of them.**

Specific national and subnational cultural and socioeconomic factors are important determinants of the progression of HIV epidemics and responses. Because the essence of Pacific life lies in family and church relationships, **any hope for success depends on integrating responses to HIV within these social structures.**

Coordination of multisectoral national responses in the region has followed the principles of the “*Three Ones*”: one framework, one coordinating mechanism and one monitoring and evaluation framework. But these principles do not in themselves require the establishment of stand-alone entities: in smaller island states, the **processes can be integrated into national development or health systems.**

National AIDS committees constituted under these principles have not been able to lead the multisectoral engagement and dynamic partnerships required between national governments, civil society (including faith-based organizations and people living with HIV), the private sector and donors. There are also institutions that operate outside of the “Three Ones” principles, including the Global Fund Country Coordinating Mechanisms.

Between 2001 and 2009 funding for HIV activities in the region increased more than fivefold and more than US\$ 77 million was available for HIV activities in 2008. **The cost of implementing HIV programmes in the Pacific is high** due to a number of factors, including the cultural and linguistic diversity, limited and expensive transport networks and poor communications infrastructure. Moreover, the challenges to providing quality health and social services are, if anything, increasing.

The vulnerability of Pacific countries will be exacerbated if the impact of the global financial crisis leads to reductions in donor funding. Conversely, over-reliance on external funding can undermine the national- and community-level engagement required for effective responses. The Commission believes that **more effective use of national and donor resources and improved aid effectiveness, including the strengthening of absorptive capacity at the country level, are critical.**

HIV has, in some cases, exposed the inadequacies of government service delivery, including surveillance. **The resources available for HIV can provide opportunities to strengthen broader health and social services, including through alternative systems.**

Empowering partnerships

Actively engaging all stakeholders in HIV programmes will support governments in combating the spread of HIV as well as create a demand for the better governance of HIV responses. In countries across the region the prime challenge is to improve government engagement at the decision-making level with civil society and other key stakeholders.

Civil society organizations have strengthened engagement with communities, particularly with groups of people most vulnerable to HIV. They are effective partners for governments because they can complement government health care

services by providing alternative service delivery mechanisms. In Papua New Guinea the churches are making significant contributions in treatment and care. More inclusive church-based approaches across the region will strengthen their role as valuable partners in the response to HIV. However, the Commission believes greater openness on matters of sexual behaviour and identities in Pacific societies will reduce HIV-related stigma and discrimination.

The Commission believes that the **greater involvement of people living with HIV in matters of policy making and programme delivery will strengthen the response, and governments, civil society and donors should support them.**

The Commission is concerned that the limited access to core and activity funding from governments and donors is restricting the involvement of civil society organizations in national planning and the delivery and monitoring of HIV programmes. **The absorptive capacity of these organizations needs to be strengthened through core funding and capacity-development support.**

Pacific workplaces should play a stronger role in establishing policies and implementing programmes to reduce the spread of HIV, and protect the rights of workers living with HIV and their families.

The media should be more actively and sensitively engaged, to play a more effective role in covering human rights issues and promoting HIV prevention and awareness in the region. Sporting and cultural organizations are also becoming strategic partners and have a greater potential to reach young people across the Pacific.

The way forward – an OPEN strategy

The essential ingredients for moving forward involve strengthening health systems; overcoming stigma and discrimination; strengthening community involvement and resilience; and aligning regional and international support with national priorities and national service delivery.

The way forward for the Pacific countries lies in their abilities to achieve:

- **OWNERSHIP** of the epidemic at all levels of society;
- **PARTNERSHIPS** to develop integrated responses;
- **EMPOWERING** and **ENABLING** environments; and
- **NETWORKING** to share experiences and outcomes.

The interrelationships between HIV and other social, cultural, political and economic indicators make the Pacific Plan and the MDGs important vehicles for responding to HIV at the national level. In this context, HIV cannot be managed in isolation; it should be considered in the overall development context of the region.

Recommendations

The Commission recommends that decisive steps should be taken to implement the following actions to protect Pacific societies, cultures and economies from HIV.

Leadership

1. **Political leadership** and commitment remain critical determinants driving HIV responses. Political leaders must continue to be effectively engaged

and commitments made at regional level must not be allowed to be mere lip service. They must flow on into normal and continuing national action through wholehearted across-the-board government initiatives and follow-up.

2. **Traditional, church and community leaders** must stay actively engaged in the HIV response.

Legislation and the enabling environment

3. Countries must provide **legislative protection and enforcement mechanisms** for people living with HIV and their families; their protection from human rights abuses is a matter of priority.
4. Countries must undertake progressive **legislative reform** to repeal legislation that criminalizes high-risk behaviour and promotes HIV-related discrimination. Changing the laws need not imply approval of the behaviour but would signal a greater concern for people.

Civil society

5. Governments and donors must be more proactive in engaging with and supporting civil society and civil society organizations (CSOs) in **decision-making mechanisms**. Countries can achieve this outcome by ensuring that:
 - donor grants, including from the Global Fund, are not restricted to service delivery but are available for core and operational support;
 - national AIDS coordinating authorities (NACs) or their equivalent strongly represent civil society and the private sector (including representatives from human rights organizations) to ensure accountability;
 - Global Fund Country Coordinating Mechanisms (CCMs) have strong representation of civil society, democratically elected from their constituencies; and
 - professional development is provided to CSO representatives to support their effective involvement in national decision-making processes.
6. Community-based programmes are best delivered by communities themselves. Support for civil society organizations must include **core and capacity-development funding**.

Strategic planning and implementation

7. Countries, regional organizations and donor partners must continue to work together to ensure that **realistic targets and time frames** are set and adequate

resources are available to implement the HIV response. It is time to progress to **implementation and action**, away from the focus on strategy development and designing new mechanisms and financing structures.

8. Coordinating **multisector national responses** must follow the principles of the “Three Ones” (one framework, one coordinating mechanism and one monitoring and evaluation framework). This does not require the establishment of stand-alone entities in all countries. In smaller island states, especially, these processes can be integrated within national health or development plans with appropriate monitoring and reporting.
9. In the spirit of the “Three Ones” principles, Global Fund Country Coordinating Mechanisms (CCMs) must be harmonized with National AIDS Coordinating Authorities (NACs), in those countries where they are established, with common membership for stronger and more effective **coordination** and management
10. As potential strategic partners, the **media** must be more actively and sensitively engaged to play a more effective role in covering human rights issues and promoting HIV prevention and awareness in the region.
11. **Workplaces** must play a stronger role in establishing policies and programmes to reduce the spread of HIV, and protect the rights of workers living with HIV and their families.
12. **National HIV plans** (or HIV components of health/development plans) must be:
 - costed and prioritized for maximum effectiveness and the full utilization of available resources;
 - based on an analysis of whether regional and/or subregional mechanisms are appropriate;
 - supported by implementation plans and monitoring and evaluation (M&E) frameworks; and
 - informed by the findings of surveillance and social research.
13. Strengthening **health care systems** is an essential component of an effective HIV response. Available funding for HIV must strengthen health care services to achieve economies of scale. Increased investment must be directed towards:
 - scaling-up of laboratory capacity;
 - treatment of opportunistic infections and STIs;
 - maintenance of HIV-qualified staff; and
 - the care and monitoring of AIDS patients.
14. Treatment for HIV, opportunistic infections and STIs and **prevention of mother-to-child transmission** (PMTCT) programmes must be integrated within a strengthened health care system.
15. **National priorities must drive regional mechanisms** and approaches. Regional action should focus on advocating regional political commitment and providing appropriate in-country technical capacity and resource mobilization. Countries must focus on implementation of programmes and be accountable for their performance.

16. Greater funding must be provided for **prevention activities** that address high-risk behaviours and produce maximum impact. These include:
 - focusing on HIV risk behaviours, not population groups, to avoid stigma and discrimination,
 - using, in prevention programmes, the language of the people most affected, and
 - reviewing the experience from other regions in implementing innovative prevention programmes that integrate HIV with other behaviour-change programs (such as drug and alcohol use, sexual and reproductive health and gender-based violence).
17. Mandatory testing in all forms, including provider-initiated testing and counselling, must be avoided since they give rise to concerns about confidentiality, gender-based violence and the lack of cost-effectiveness in low prevalence countries. Countries must endorse good-quality testing standards and protocols that focus on **voluntary counselling and confidential testing (VCCT)** offered in conjunction with other testing services, to improve access and avoid stigma.
18. **Gender inequality and gender-based violence** are major social drivers of the epidemics in the Pacific. Countries must assess their HIV policies and programmes so that they empower women and reduce their vulnerability to HIV.
19. **Young people** comprise 40% of the Pacific population and must be supported to engage actively in the design, implementation and monitoring of responses to address their needs. Countries must scale up their efforts to:
 - include culturally-sensitive and age-appropriate sex education in the curriculum at appropriate levels of the school system, including teacher training and improving the understanding of heads of institutions and community leaders;
 - revive and strengthen youth peer education programmes;
 - establish and expand youth-friendly facilities, to improve access to HIV prevention services and commodities and appropriate sexual and reproductive health services;
 - use opportunities where young people gather to promote safe sexual behaviour; and;
 - make use of innovative approaches, including peer-reviewed messages through Internet and mobile phones, to target young people, particularly out-of-school youth, in line with objectives of the Pacific Regional Digital Strategy.
20. Countries, CSOs and donors must be more actively engaged in supporting the involvement of **HIV-positive people** in decision-making and HIV responses, including as members of national AIDS coordinating authorities (NACs) and country coordinating mechanisms (CCMs). This will require capacity building and innovative approaches, including :
 - internships for HIV-positive people with UN and regional agencies;
 - twinning of PLHIV groups and individuals of different countries and;
 - initiatives such as the Pan-Pacific Gathering for HIV Positive People and the International Congress on AIDS in the Asia and the Pacific (ICAAP).

Strategic information, surveillance and monitoring

- 21.** National plans in the Pacific must be informed by a **strong evidence base**. The urgent strengthening of evidence-informed systems should include:
- establishing country surveillance plans—including first and second generation surveillance—supported by regional and international agencies as required; and
 - ensuring that national surveillance data are made open and transparent and put into the public domain.
- 22.** Countries' efforts to improve their monitoring and surveillance must be supported by:
- instituting second generation surveillance including: repeated cross-sectional biological and behavioural studies among population groups with high-risk behaviours; seroprevalence studies in consistent sites among pregnant women, and a population-based survey with measurement of HIV prevalence in Papua New Guinea;
 - developing **capacity-building** programmes to support improved surveillance, planning, implementation and monitoring of HIV responses. Simple and standardized surveillance training packages can be adapted at national level;
 - supporting the interagency **technical working group** of regional and international organizations (SPC, WHO, UNAIDS) to help countries improve HIV and STI surveillance, research and population-based surveys;
 - and integrating HIV and STI **surveillance** as part of national communicable disease surveillance.
 - modify second generation surveillance protocols, by the Secretariat of the Pacific Community (SPC) and World Health Organisation (WHO), to the scale and characteristics of Pacific countries. This may require the development of novel sampling approaches or standard methods combined with community education to combat stigma and discrimination. Behavioural surveillance surveys (BSS) should be complemented by ethnographic data.
- 23.** Pacific countries must initiate culturally-appropriate **research**, including:
- integrating HIV with other **behaviour-change programmes**, such as drug and alcohol use, gender-based violence and aspects of sexual and reproductive health;
 - engaging **men who have sex with men and those individuals of other culturally-constructed genders** in more high-quality and participatory operational research that can be translated into effective prevention programmes;
 - investigating **injecting drug use** in French Polynesia, New Caledonia and US territories, and in other countries in the region as the need becomes apparent;
 - evaluating the **effectiveness** of treatment and care;
 - understanding the **economic impacts** of HIV; and
 - reviewing **new global approaches** to HIV prevention (including addressing concurrent sexual partnerships) for appropriateness for the Pacific region.

Resourcing and aid effectiveness

- 24.** Given the global economic crisis and the uncertainty of sustained external funding, countries must ensure more efficient use of resources and improved aid effectiveness. Countries must progressively increase their commitment of domestic resources to HIV programmes in order to reduce dependence on external assistance.
- 25.** Countries and donors must ensure that disaggregated data on funding levels, allocations and expenditure on HIV programmes are put in the public domain and made accessible.
- 26.** Donors must strengthen aid **coordination and harmonization** through broader involvement with existing funding mechanisms and closer **alignment** with national HIV strategies and/or health sector plans.

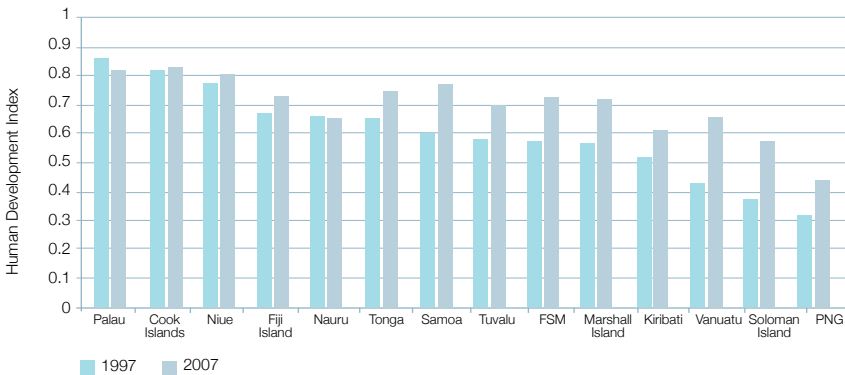
Chapter 1 The Pacific: a unique and diverse region

1.1 Introduction

The Pacific region comprises 22 independent countries and territories spread across 30 million square kilometres of the Pacific Ocean¹. Although it contains only 0.14% of the world's population, it is in many ways unique and one of the world's most diverse regions—a montage of different cultures, traditions, languages, political systems, lifestyles and living conditions. While Pacific people tend to identify themselves as from a specific village, island or country, broad cultural, economic and geographical similarities have seemed to allow a general delineation of three subregions: Melanesia, Micronesia and Polynesia. Populations range from 6.5 million in Papua New Guinea (PNG), around two-thirds of the total region, to fewer than 10,000 in the five microstates of Tuvalu, Nauru, Niue, Pitcairn Islands and Tokelau.

This diversity is also evident in living standards, levels of development (Figure 1), and the political stability of different countries. Even the more-developed of the countries experience significant challenges to human development. These include: low economic growth; increasing poverty; vulnerability to natural disasters, external economic shocks and climate change; and rising population and unemployment figures². Most people live in rural areas and outer islands but the towns and cities of the region are growing rapidly.

Figure 1: Pacific countries ranked by the Human Development Index (HDI), 1997 and 2007



Source: UNDP, 2009. The HDI is a measurement of human progress that combines indicators of life expectancy at birth, adult literacy rate and mean years of schooling, and income measured by real gross domestic product per capita.

Over the past decade political instability and low economic growth in some countries have disrupted economic and human development and contributed to the migration of skilled people to more stable and prosperous countries. Even before the current global

1 For the purpose of this report Pacific Island countries and territories (PICTs) are referred to as "Pacific countries".

2 UNDP, 2009. Pacific Human Development Report 2009: Improving services and living conditions through better governance. ADB, 2006, Socioeconomic Implications of HIV/AIDS in the Pacific.

financial crisis, more households were experiencing greater hardship. The poorest and most vulnerable households are those that lack access to basic services, including water and sanitation, health and education. These inequalities are not new but are becoming more pronounced as the interface between tradition and modernity creates new challenges in the region, including the breakdown of traditional social safety networks³.

The Pacific Plan⁴ intends to address these mounting challenges through a focus on the four pillars: economic growth; sustainable development; good governance; and security. Driven by Pacific leaders, it focuses on upholding and reinforcing these four pillars through improved regional cooperation. Regional approaches to development are becoming more relevant in the Pacific, where success in achieving the Millennium Development Goals (MDGs) has been mixed⁵. While the region is meeting some targets, such as reducing tuberculosis, and is expected to achieve gender equality in secondary schools, achievement of other goals by 2015 is unlikely⁶. It seems worryingly possible that the effects of the global financial crisis may see resources for the MDGs become scarcer as governments seek cost-cutting measures in key MDG sectors such as education and health⁷.

In the health sector, increasing rates of communicable disease and a growing burden of noncommunicable or “lifestyle” diseases (NCDs) are challenging national health systems. NCDs, such as heart disease, cancer, diabetes, high blood pressure and chronic respiratory diseases, account for 75% of deaths across the region (except for Papua New Guinea, where NCDs account for around 58% of deaths)⁸. The links between HIV and TB coinfection are well known. Less has been documented about the connections between HIV and NCDs (particularly cardiovascular disease, diabetes and cancer). These include the long-term management and burden on health care systems, and specific vulnerability of marginalized groups to HIV, other STIs and NCDs.

1.2 The initial response to HIV

The HIV response in the Pacific over the past decade has brought benefits to broader health systems, including the development of rapid testing and improved laboratories, as well as more openness about human behaviour, particularly sexual behaviour. Multisectoral approaches to HIV have also demonstrated the importance of involving the whole community and not just the health sector.

More than a decade ago the 1996 UN report, *Time to Act: the Pacific Response to HIV and AIDS*, noted that although the onset of the HIV pandemic occurred in the Pacific

3 UNDP, 2009. Pacific Human Development Report 2009: Improving services and living conditions through better governance.

4 Endorsed by Forum Leaders at their Pacific Islands Forum Meeting in Port Moresby, October 2005.

5 UNESCAP, ADB & UNDP, 2007. The Millennium Development Goals: Progress in Asia and the Pacific 2007. Bangkok: ESCAP/ADB/UNDP.

6 SPC. 2004. The Pacific Islands Millennium Development Goals Report.

7 Wiseman, G., Pacific MDG Workshop: Taking Stock, Emerging Issues and Way Forward, Nadi, March 2009.

8 Tukuitonga, C., 2007. Population Health in the Pacific Region-A Situation Analysis.

relatively late, the risks were great⁹. The report advised that a moderate to severe HIV epidemic could reverse much of the progress in human development that had been made over previous decades.

The potential repercussions of slowing or reversing national economic growth would be felt most at the household level, in the form of social, financial and emotional stress¹⁰. The report noted that the stigma attached to HIV and the discrimination faced by people known to be HIV-positive intensifies the psychological, social and economic burden of HIV in the region.

Early action taken by Pacific communities and governments had helped keep the epidemic at low levels in most countries. This included public education, distributing information and condoms, strategies to remove stigma and discrimination, modifying laws, protecting human rights, and dismantling barriers against the social and economic advancement of women. However, the report noted that, as HIV and AIDS were primarily seen as medical issues only, most activities were coordinated through Ministries of Health with little involvement of other sectors of government and the community. More limited was understanding of the wider human development consequences of the epidemic or appreciation of the need for a multisectoral response. Although civil society organizations (CSOs) and other nongovernment organizations (NGOs) were increasingly providing information and support to communities, government or donor programmes at the time accorded them only limited involvement or support.

1.3 The Commission on AIDS in the Pacific

How much has changed in the region's response to HIV over the past decade and how this response can be further strengthened are issues that underpin this report by the Commission on AIDS in the Pacific. UNAIDS constituted the Commission in 2007 as an independent body of experts from various disciplines. It is not a review body to evaluate national and regional responses and has relied on existing documentation on the effectiveness of current plans, strategies and programmes. It has investigated the impacts of and responses to HIV in the Pacific region and recommends ways that governments, civil society, regional institutions and development partners can help to reverse the epidemic and minimize the adverse impacts of HIV on individuals, communities and national economies.

The Commission has attempted to strengthen the evidence base on the status of HIV in region and future options by sponsoring a number of research studies. These include: the current status, trends and future projections of the spread of HIV in the Pacific¹¹; the effectiveness of aid coordination in responding to the epidemic¹²; the involvement of

9 United Nations, 1996. Time to Act: The Pacific Response to HIV and AIDS.

10 United Nations, 1996. Time to Act: The Pacific Response to HIV and AIDS.

11 Burnet Institute, 2009. HIV in the Pacific, 1984–2007.

12 UNSW Global, 2009. The Effectiveness of Financing and Aid Coordination in Responding to the HIV Epidemic in the Pacific Region.

churches in Papua New Guinea in the national response to HIV¹³; the impact of HIV on the health sector in Papua New Guinea¹⁴; profiles of people living with HIV and their carers¹⁵; and the economic impacts of HIV on superannuation fund programmes in Papua New Guinea. Two surveys were also undertaken, one across the Pacific on how people felt about HIV as a development challenge, stigma and discrimination, political commitment and the effectiveness of regional agencies¹⁶; and one in conjunction with the Papua New Guinea Business Coalition Against HIV and AIDS (BAHA) on perceptions of the impacts of HIV and AIDS in workplaces in Papua New Guinea¹⁷. The Commission also undertook field visits to Papua New Guinea, Solomon Islands, Samoa, New Caledonia and Fiji to meet with communities, government and development partners.

Chapter 2 of the report outlines the current information on the characteristics of the HIV epidemics in the region. Chapter 3 summarizes what is known about the vulnerability and risks to HIV within the Pacific and the current and potential impacts. Chapter 4 describes the response to the epidemics through programmes, plans and funding, and efforts required to increase the efficiency of aid and improve its coordination. Chapter 5 comments on the partnerships among community organizations (including people living with HIV, churches and faith-based organizations), the private sector, Pacific workplaces and the media in the HIV response. Chapter 6 summarizes the findings and recommendations of the report and suggests possible ways forward. The full research studies on which this report is based are published separately.

13 Hammar, L., 2009b. There wouldn't even be a response without them.

14 Lavu, E., 2009. Analysis of the Impact of HIV and AIDS on the Health Sector in Papua New Guinea 2004–2008.

15 Renagi Taukaral, Pacific Islands AIDS Foundation (PIAF), and Rei Frank.

16 Commission Secretariat, Australian Research Centre in Sex, Health and Society, La Trobe University and USP.

17 BAHA, 2009. Survey on perceptions and evidence in the private sector of the current and potential impacts of HIV.

Chapter 2 The dynamics of HIV epidemics in the Pacific

Key Findings

- After two decades of responding to HIV in the region, we still do not have consistent and reliable information about estimated levels and distribution of HIV, due to continuing poor surveillance and inadequate epidemiological data. The absence of biological and behavioural surveillance surveys among specific groups limits understanding of who is at risk of HIV infection and the ability to target appropriate prevention strategies.
- Outside of Papua New Guinea, New Caledonia, French Polynesia, Guam and perhaps Fiji, the low number of reported cases makes it difficult to predict with any certainty the future growth of HIV in the region. Only a limited number of countries (most notably Papua New Guinea) undertake HIV estimates; most of the countries depend on reported cases for the planning of their national responses.
- There have been 29,629 reported cases of people living with HIV in the Pacific; 5,162 new HIV diagnoses were reported in 2008. Cases from Papua New Guinea make up over 99% of reported cases in 2008. In Papua New Guinea there are 28,294 reported cases but UNAIDS estimates that the number of people living with HIV is 54,000. A similar level of under-reporting in the rest of the Pacific seems likely.
- In small populations even a small number of people living with HIV can translate into high incidence and prevalence rates and can have devastating impact.
- On the basis of the reported numbers of people living with HIV, the region can be categorized as follows: Papua New Guinea—the overwhelming locus of the Pacific epidemic; Fiji, French Polynesia, New Caledonia and Guam—with significant HIV cases; and other countries, including the smaller island states—where known cases are fewer.
- The predominant mode of reported transmission is unprotected sex: 90.7% across all Pacific countries and 83% when Papua New Guinea is excluded. In New Caledonia, French Polynesia and Guam a significant proportion of infections are attributed to unprotected male-to-male sex and injecting drug use.
- Across the whole Pacific region, women comprise the majority of reported cases. When Papua New Guinea is excluded, almost half of all reported HIV cases are women. In Papua New Guinea more women than men were diagnosed with HIV for the first time in 2005 and in 2007, 60% of all notifications in Papua New Guinea were women. Papua New Guinea now has more women diagnosed (14,598) than men (12,432).
- STIs are endemic across the region, with some countries reporting 18% incidence of Chlamydia in pregnant women.

2.1 Introduction

HIV strategies, planning and programmes should be informed by a strong evidence base. A major weakness across the region has been the absence, to date, of country reporting and surveillance programmes, so establishing them is a necessity: capacity constraints and a lack of appropriate research severely limit countries' efforts to improve their monitoring and surveillance. This chapter, based on current epidemiological and surveillance data, summarizes what is known of the dynamics of HIV epidemics in the Pacific.

2.2 Reporting and surveillance systems

The documented distribution of HIV in the Pacific may relate almost as much to the expansion and acceptance of HIV testing as it does to the movement of HIV across the region. **There is concern that the known numbers of HIV-positive people may obscure a higher level of infection by reflecting limited testing rather than absence of infection.**

Papua New Guinea appears to be the only country with a fully-functioning and recurrent reporting system with data from a substantial number of fixed sites where HIV tests are routinely or periodically collated (from antenatal clinics, STI clinics, patients diagnosed with tuberculosis (TB), voluntary counselling and testing centres). However, while data have been slowly improving since 2001, problems continue. In 2006, nine per cent of newly-notified cases of HIV failed to record the sex of the person tested, 18% the age, 55% the province of origin, and 53% the means of exposure¹⁸. Information about HIV-related deaths can be poorly captured, because death reports often do not record HIV or AIDS as an underlying condition, often to circumvent stigma and confidentiality issues¹⁹.

Knowledge of the levels of HIV infection is also constrained by restricted access to HIV testing and poor HIV case diagnosis and reporting (Attachment 1). Even where testing exists, poor-quality services are all too often the result of difficulties in retaining skilled health workers, heavy workloads, rapid turnover of staff trained in HIV and STI surveillance, and shortages of qualified counsellors, epidemiologists, health statisticians and laboratory technicians. Concerns about confidentiality of test results are more acute in smaller countries and communities. All these issues can underlie people's movement from their homes to other districts, provinces or even countries for HIV testing and treatment.

An analysis of testing sites in selected provinces in Papua New Guinea demonstrates the movement of people between provinces to access testing and treatment services. Madang has reported 225 HIV cases, but has 311 people registered for treatment; Southern Highlands has reported 528 HIV cases, but has 1,304 people registered for treatment; and National Capital District has reported 11,945 HIV cases, but has 1,594

18 Papua New Guinea National AIDS Council Secretariat and National Department of Health, 2007. The 2007 Estimation Report on the HIV epidemic in Papua New Guinea.

19 Burnet Institute, 2009. HIV in the Pacific, 1984–2007, p 45.

people registered for treatment²⁰. These figures also reflect the return of HIV-positive people to their families and villages for treatment and care. The regional HIV Testing and STI Working Group for the Pacific concluded that a more coherent and collaborative approach to STI and HIV testing and reporting was essential for improving surveillance throughout the region²¹. Data collection and reporting systems are being refined, along with case definitions for STI and HIV. **In most countries, the World Health Organization (WHO) in partnership with the Secretariat of the Pacific Community (SPC) has developed and distributed a national voluntary counselling and confidential testing (VCCT) protocol. However, countries' sense of ownership of these protocols is, reportedly, limited²².** Some VCCT sites do not have copies and protocols need further amendment where they are too generic, do not provide clear directions, or are not well-aligned with the country's needs. HIV testing protocols are being revised to allow for rapid testing and reproductive health nurses are being trained to provide VCCT, to expand the testing range. **Provider-initiated testing (including mandatory testing) and counselling, have caused anxiety about possible breaching of confidentiality, the potential for gender-based violence, and the lack of cost-effectiveness, especially in low prevalence countries²³.**

A lack of uniformity in the case definitions for STIs has made it difficult to compare trends over time within and between countries. Most of the STI data sourced were not disaggregated by age and other demographic features. In addition, the one country with seemingly good temporal data for STIs (New Caledonia) reports that trends cannot be interpreted because of ongoing adjustments to the surveillance system itself. These factors combine to limit accurate characterizations of epidemiological trends and impede triangulation of STI surveillance data with data from behavioural surveys²⁴.

Second generation surveillance

Behavioural surveillance surveys (BSS) have largely been conducted in the absence of long-term, coordinated plans; without reference to the findings of serosurveillance (and other information); and using different methods and different indicators (Attachment 2). With the exception of Papua New Guinea, the other four countries with relatively high case loads have inadequate behavioural data for populations at high risk. French Polynesia has no information on youth and Fiji has not conducted a youth survey since 1996. There are no studies of injecting drug users or men who have sex with men (MSM) in Guam, French Polynesia or New Caledonia. Only Papua New Guinea and Vanuatu have surveyed female sex workers, and only Fiji,

20 Data collated by the UNAIDS Country Office in Papua New Guinea as part of the preparation for the GFATM Round 9 proposal.

21 Joint Meeting for Consultation on HIV Testing and STI Working Group for the Pacific 2005–2008. May 2008, Pago Pago, American Samoa.

22 Papua New Guinea has developed its own protocols.

23 WHO, UNICEF, UNAIDS, 2007. Joint WHO/UNICEF/UNAIDS Technical Consultation on Scaling Up Testing and Counselling in Asia and the Pacific. Phnom Penh, Cambodia, 4–6 June 2007. Conclusions and Recommendations; Bradley, C. 2007. Introduction of PICT for PMTCT: possible negative impacts on women, Paper produced for the Papua New Guinea National Department of Health.

24 Burnet Institute, 2009. HIV in the Pacific, 1984–2007, p 11.

Vanuatu and Samoa have surveyed people attending sexually transmitted infection (STI) clinics. Lack of data on concurrent (multipartner) sex among men and women is critical missing information. **Even when BSS are conducted, the Secretariat of the Pacific Community (SPC), which attempts to collate regional HIV data, reports that findings are rarely integrated into HIV programmes.**

Other research has been conducted, particularly in Melanesia (much of which is listed in the bibliography of this report) but most of these projects have not used representative sampling methods and are essentially incomparable.

2.3 The spread of HIV through the region

In Melanesia, the first countries to report HIV cases were Papua New Guinea, New Caledonia and Fiji. Infections were confirmed much later in Solomon Islands and Vanuatu. HIV appears to have moved more quickly in Micronesia; by 1996, all Micronesian states had diagnosed at least one case of HIV infection²⁵. The spread of HIV through Polynesia appears to have been relatively slower, but HIV infections have been reported in all the countries and territories of the region except for Niue, Pitcairn Islands and Tokelau.²⁶ The extent to which countries have been affected by HIV varies greatly. **Five countries account for over 99% of all reported cases: Papua New Guinea, New Caledonia, French Polynesia, Fiji and Guam. The magnitude of the HIV burden in Papua New Guinea outstrips that in other countries.** Cases from Papua New Guinea comprise an ever-increasing proportion of the total cases detected in the Pacific—from 21% in 1984–1989 to over 98% in 2005–2007 (Table 2). In 2008 alone Papua New Guinea reported over three times the number of infections that were reported in all other Pacific countries during the 23 years since HIV was first detected in the region.

Table 1 Year that first HIV case was detected

1984	Marshall Islands	1993	Palau
1985	Fr. Polynesia	1994	Wallis and Futuna
1985	Guam	1995	Solomon Islands
1985	Northern Marianas	1995	Tuvalu
1986	New Caledonia	1996	Nauru
1987	Papua New Guinea	1997	Cook Islands
1987	Tonga	2002	Vanuatu
1989	FSM	2001	American Samoa
1989	Fiji	No case	Niue
1990	Samoa	No case	Pitcairn Islands
1991	Kiribati	No case	Tokelau

Source: Burnet Institute, 2009. *HIV in the Pacific, 1984–2007*, p 28.

25 Nauru has not yet officially reported a case of HIV in a local person; the few cases detected have all been foreigners living or working there.

26 There are, however, HIV-positive citizens from Niue and Tokelau residing in New Zealand.

The number of new HIV diagnoses in the region, excluding Papua New Guinea, was 87 in 2007 and 85 in 2008. The number of reported HIV infections continues to rise rapidly in Papua New Guinea and slowly elsewhere in the region. It is likely that HIV is under reported, with a larger population of people living with HIV (PLHIV) across the Pacific, reflecting the limited availability of HIV testing (see table 2). UNAIDS estimates that there are currently 54,000 people living with HIV in Papua New Guinea and fewer than 500 in Fiji. But the low levels of confirmed cases and lack of surveillance in other countries preclude estimations in other countries in the Pacific²⁷.

By global standards, the numbers of PLHIV are low — as, indeed, are population figures — but a matter of considerable concern for the small Pacific populations, where even a few cases can make a large difference to the incidence and prevalence rate and can have devastating impact. By the end of 2008, only 11 people in Tuvalu had been diagnosed with HIV but with a population of only 9,700, the known incidence of infection is similar to those of Guam and French Polynesia. Kiribati is only slightly behind. The 36 known cases in Federated States of Micronesia (FSM), 290 in Fiji, 19 in Marshall Islands and two in Nauru produce similar incidence rates.

27 UNAIDS, 2008. Report on the Global AIDS epidemic, p 219.

Table 2 Cumulative reported HIV, AIDS and AIDS deaths: cases, incidence rates and gender plus cases with missing details: all Pacific island countries and territories, to December 2008

Country	Mid-year population 2008	New cases 2008	Cumulative cases			HIV cumulative incidence per 100,000	HIV M	HIV F	Unknown
			HIV including AIDS	AIDS including deaths	AIDS related deaths				
MELANESIA	8,312,417	5,132	28,932	2,932	429	286.9	12,846	14,820	1,266
MELANESIA excl Papua New Guinea	1,884,011	48	638	162	76	34.6	414	222	2
Fiji Islands	843,888	31	290	34	11	34.4	162	128	0
New Caledonia	246,598	15	331	118	59	134.2	246	83	2
Papua New Guinea	6,468,405	5084	28,294	2,770	353	70	12,432	14,598	1,264
Solomon Islands	520,617	2	12	5	4	2.3	4	8	0
Vanuatu 232,908	0	5	5	2	2.1	2	3	0	
MICRONESIA	531,802	15	343	187	151	64	248	78	15
Federated States of Micronesia	110,445	1	36	28	28	32.6	24	12	0
Guam	177,290	5	192	109	82	108.3	164	28	0
Kiribati	97,201	2	52	28	23	57.6	30	16	10
Marshall Islands	53,889	5	19	5	4	24.1	4	5	4
Nauru	9,570	0	2	1	1	20.9	2	0	0
Northern Marianas	63,130	1	33	12	10	52.3	19	14	0
Palau	20,278	1	9	4	3	44.4	5	3	1
POLYNESIA	655,017	22	356	131	83	54.3	250	105	1
American Samoa	64,337	0	3	1	0	4.7	2	1	0
Cook Islands	15,564	0	2	0	12.8	1	1	1	0
French Polynesia	262,497	16	302	107	63	115.0	215	87	0
Niue	1,550	0	0	0	0	0.0	0	0	0
Pitcairn	66	0	0	0	0	0.0	0	0	0
Samoa	181,964	3	19	8	8	10.4	13	6	0
Tokelau Islands	1,168	0	0	0	0	0.0	0	0	0
Tonga	102,652	2	17	10	9	16.6	9	8	0
Tuvalu	11,035	1	11	4	3	99.7	9	1	1
Wallis & Futuna	14,183	0	2	1	0	14.1	1	1	0
ALL COUNTRIES	9,499,236	5,162	29,631	3,250	663	258.4	13,344	15,003	1,282
ALL excl Papua New Guinea	3,030,831	85	1,337	480	310	44.0	912	405	18

Source: SPC, 2009d and Government of Papua New Guinea, 2008. Surveillance Report (in draft – data provided by UNAIDS Country Office Papua New Guinea).

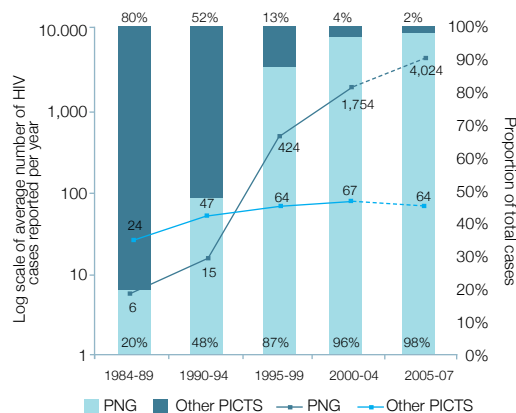
Despite small numbers of infections in several countries, the estimated doubling of annual growth rates in some countries are significant (Table 3).

Table 3: Implied annual compound growth rates for the decade to 2007

Country	Year of first HIV confirmation	Cumulative total cases 1997	Cumulative total cases 2007	Average growth rate per year	Double Times (Yrs) from 2007
Papua New Guinea	1987	918	23,210	38.13	2 years 1 month
Federated States of Micronesia	1989	2	35	33.15	2 years 5 months
Commonwealth of the Northern Marianas	1985	3	32	26.72	2 years 11 months
Solomon Islands	1995	1	10	25.9	3 years 1 months
Palau	1993	1	8	23.12	3 years 4 months
Fiji	1989	39	259	20.85	3 years 8 months
Tuvalu	1995	2	10	17.45	4 years 3 months
French Polynesia	1985	73	275	14.19	5 years 2 months
Kiribati	1991	21	54	9.89	7 years 4 months
Samoa	1990	7	16	8.65	8 years 4 months
Wallis and Futuna	1994	1	2	7.4	9 years 8 months
New Caledonia	1986	161	316	6.98	10 years 3 months
Tonga	1987	8	15	6.48	11 years
Guam	1985	115	187	4.98	14 years 3 months
Marshall Islands	1984	9	12	2.88	24 years 5 months

Source: UNAIDS Country Offices Fiji and Papua New Guinea, 2009. Note: Figures are based on the assumption that an HIV epidemic grows in a linear progression and does not alter over time, which allows the use of the average growth rate as a multiplier.

Nonetheless, the trend based on case reports to the end of 2007 for Pacific countries (excluding Papua New Guinea) has been a slowing pace of the epidemic (Figure 2). While 79 cases were reported from Pacific countries other than Papua New Guinea in 2005, 71 were reported in 2006 and just 48 in 2007. Thirteen countries reported no new cases in 2006 and eleven in 2007. However, in the absence of appropriate scientific data and surveillance it would be misleading to say that the HIV epidemic in the Pacific outside of Papua New Guinea has started to decline.

Figure 2: Average annual number of new notifications and proportional HIV case-load in Papua New Guinea compared to all other Pacific countries, 1985–2006

Source: Burnet Institute, 2009. HIV in the Pacific, 1984–2007, p 33. Note that the last bar is a two-year, not a five-year, period.

2.4 Molecular epidemiology

New molecular epidemiological tools are helping to clarify the origins and movement of HIV into and within the region. Phylogenetic analysis of viruses from Papua New Guinea (that is, the relationships between different groups of organisms) shows that the predominant subtype (C) is most closely related to East African strains and not those in Indonesia, other near Asian countries, Australia and New Zealand. **This suggests that HIV in Papua New Guinea originated from very few viruses—possibly even a single one—from East Africa, and has been present in Papua New Guinea for some time, well before the first case was reported in 1987²⁸.** Initially, it was assumed that HIV was primarily an urban phenomenon as most early HIV cases were detected in towns²⁹. But as testing facilities spread across the country into rural areas it became apparent that the epidemic was almost everywhere (and projections suggest that HIV will continue to be a rural phenomenon). This also suggests that the distribution of subtype (C) virus within Papua New Guinea matches the pattern of a highly mobile domestic population³⁰.

In Fiji, HIV subtype (C) viruses have been found to be genetically distinct from those in Papua New Guinea and are more closely related to strains from India³¹.

This suggests that the Papua New Guinea and Fiji epidemics are separate. Since it arrived in the Pacific, specific forms of HIV may have been distributed by increasing migration flows through the region but no information is available about the present distribution³².

2.5 Characteristics of people diagnosed with HIV in the Pacific

Male to female ratio

The Pacific region follows global trends with males initially making up the majority of diagnosed infections and with a steadily increasing proportion of women. For all Pacific countries, excluding Papua New Guinea, there have been 912 men diagnosed with HIV and 405 women³³. When Papua New Guinea is added, women comprise the majority of reported cases. **In Papua New Guinea more women than men were diagnosed with HIV for the first time in 2005 and in 2007, 60% of all notifications in Papua New Guinea were women³⁴.** Papua New Guinea now has more women diagnosed (14,598) than men (12,432) with a high level of cases where sex was not recorded (1,264)³⁵.

In New Caledonia, French Polynesia and in particular Guam, the male: female ratio remains well above 1:1 in 2006, which may reflect the difference in patterns of exposure to HIV in these countries³⁶.

28 Burnet Institute, 2009. HIV in the Pacific, 1984–2007, p 49.

29 Caldwell, J. and G. Isaac-Toua, 2002. AIDS in Papua New Guinea: Situation in the Pacific. *Journal of Health, Population and Nutrition* 20(2): 104–111.

30 The small size of the sample may weaken this conclusion.

31 Burnet Institute, 2009. HIV in the Pacific, 1984–2007, p 49.

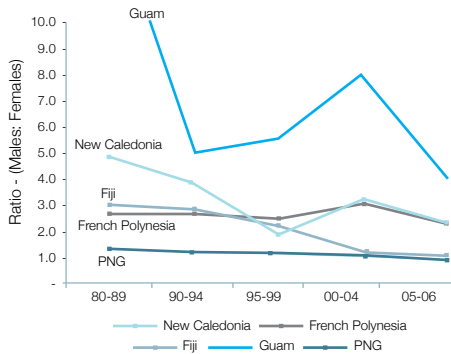
32 UNDP 2009. Migration, Mobility and HIV/STI Vulnerability in the Pacific.

33 Refer Table 2, this report.

34 Burnet Institute, 2009. HIV in the Pacific, 1984–2007, p 35.

35 Refer Table 2, this report.

36 Burnet Institute, 2009. HIV in the Pacific, 1984–2007, p 34.

Figure 3: Ratio of men to women infected with HIV over time

Age

The epidemiological data available show that the majority of people diagnosed with HIV are young people and young adults aged between 15 and 34. In Polynesia the concentration of infection in those between 15 and 29 years is higher than in Melanesia and Micronesia. Micronesia has had more people diagnosed with HIV in the 30–34 and over 35 age groups³⁷.

Source: Burnet Institute, 2009. *HIV in the Pacific, 1984–2007*, p 34.

Despite these reports, data on age are limited and, for most countries, these were available only as age groups rather than specific ages (a deliberate measure in some countries to minimize the risk of identifying people) and were presented as cumulative cases rather than cases per year. **The average age at HIV diagnosis for all cases reported in the Pacific from 1984 to 2006 was estimated to be 30.1 years.** This rises a little to 31.5 years if Papua New Guinea is excluded. In Papua New Guinea the average age for those people newly identified as being infected with HIV is 29.9 years (although age was not recorded for almost one in five cases identified during 2006).

In Papua New Guinea, 33% of all cases among women in 2007 were aged 15–24 years, while 14% of all HIV-positive males were in this age group.

This corresponds with social research that reports that male sexual partners of women are often 5–10 years older³⁸.

However, the routine testing of women attending antenatal clinics and the absence of an equivalent population of men who are regularly tested may bias this statistic. Across the region women tend to be slightly younger than men when they are diagnosed with HIV³⁹.

37 Burnet Institute, 2009. *HIV in the Pacific, 1984–2007*, p 36.

38 Burnet Institute, 2009. *HIV in the Pacific, 1984–2007*, p 45, citing Jenkins C and Buchanan-Aruwafu, H., 2007. *Cultures and Contexts Matter: Understanding and Preventing HIV in the Pacific*.

39 Burnet Institute, 2009. *HIV in the Pacific, 1984–2007*, p 36.

Figure 4a: Male HIV cases by age group in each subregion, 1984–2006 (excludes cases where age was not recorded)

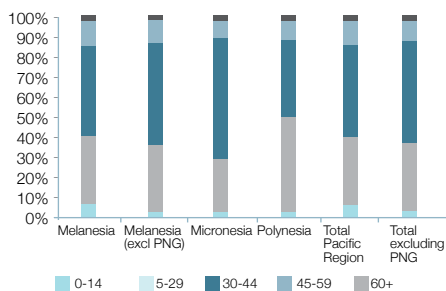
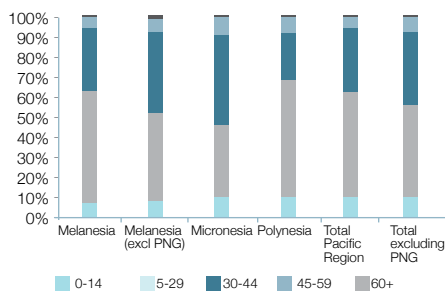


Figure 4b: Female HIV cases by age group in each subregion, 1984–2006 (excludes cases where age was not recorded)



Source: Burnet Institute, 2009. *HIV in the Pacific, 1984–2007*, p 36.

In any case, the apparent conclusion is that the proportion of HIV cases among young people (aged 15–24 years) in all Pacific countries, excluding Papua New Guinea, has been steadily increasing: from about one in five cases (19.5%) reported during the 1980s, to over one in four cases (26.5%) reported in 2000–2004⁴⁰. This may be related to an increase in the availability of testing (particularly for younger age groups), demographic shifts, or changes in high-risk behaviours.

Children

It is estimated that there were 1,727 children aged under 14 years living with HIV in Papua New Guinea in 2007, including 954 new cases diagnosed in that year⁴¹. Though 636 children are in need of antiretroviral therapy, only 185 are able to access this treatment⁴².

In Papua New Guinea, there were 3,621 HIV-positive pregnant women recorded in 2007 but coverage of services to prevent HIV transmission to their babies during pregnancy and during and after childbirth has fallen from 3.48% in 2006 to 2.32% in 2007⁴³. Across the Pacific, perinatal transmission was the recorded cause of transmission for 5.1% of infections up to the end of December 2005⁴⁴. Twenty-five perinatal cases of HIV were identified in Papua New Guinea during 2006. Some of the children were older than would normally be expected if HIV was acquired from their mother during pregnancy or after birth, which may suggest that the transmission could be related to child sexual abuse⁴⁵. Sexual abuse, including incest, has been documented⁴⁶.

40 Sladden, T., 2006. Twenty years of HIV surveillance in the Pacific – what do the data tell us and what do we still need to know? cited in Burnet Institute, 2009. *HIV in the Pacific, 1984–2007*, p 35.

41 Papua New Guinea NAC and NDoH, 2007. The 2007 estimation report on the HIV epidemic in Papua New Guinea, p 31.

42 Government of Papua New Guinea, 2008; UNGASS, 2008. Country Progress Report, p 39.

43 Government of Papua New Guinea, 2008; UNGASS, 2008. Country Progress Report, p 42.

44 SPC, 2009. The Pacific Regional Strategy on HIV and STIs 2009–2013, p 6.

45 Burnet Institute, 2009. *HIV in the Pacific, 1984–2007*, p 41.

46 HELP Resources, 2005. A Situational Analysis of Child Sexual Abuse and the Commercial Exploitation of Children in Papua New Guinea.

It is believed that up to 1.3 million children in Papua New Guinea are living in violent households and nearly half of reported rape victims in the country were under the age of 15⁴⁷. Research with HIV-positive women in four provinces in Papua New Guinea found that 30% had been sexually abused as children, usually by relatives such as uncles and brothers⁴⁸.

Ethnic groups

In several countries, there is marked concentration of known HIV infections in a single ethnic group. In Fiji, over 80% of reported cases are among indigenous Fijians⁴⁹. In New Caledonia, young Kanaks are disproportionately affected by STIs, although most cases of HIV have been reported among Europeans⁵⁰. Indigenous Melanesian and Polynesian women are particularly disadvantaged in their access to reproductive health services, putting them at greater risk to HIV and STIs⁵¹.

2.6 Modes of transmission

The data collected seem to suggest heterosexual transmission as the main route of HIV infection in the Pacific. This finding needs to be qualified by mention of the cultural reticence in many countries about disclosing or reporting on male-to-male sex. In this context, **if Papua New Guinea is included, 91% of reported transmission is heterosexual; if it is excluded, just over half the reported HIV cases are heterosexual.**

Figure 5a: HIV notifications in all Pacific Island Countries and Territories (excluding PNG) to December 2005

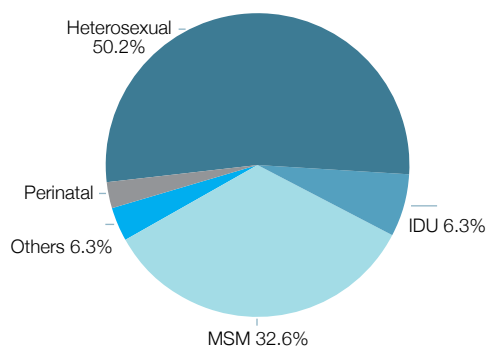
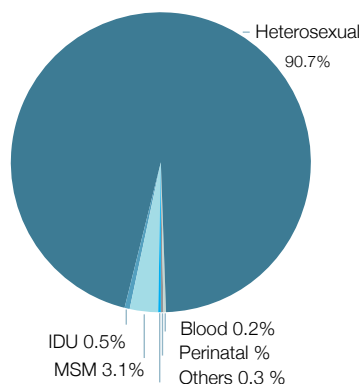


Figure 5b: HIV notifications in all Pacific Island Countries and Territories December 2005



Source: UNDP, 2009. *Gender and HIV in the Pacific Islands Region. A Review of Evidence, Policies and Strategies with Recommendations*

47 Hunter, S. Families and Children Affected by HIV/AIDS and Other Vulnerable Children in Papua New Guinea: A National Situational Analysis, March 2005. pp 30, 37.

48 Lewis et al. 2009. Final Report on Links between Violence Against Women and the Transmission of HIV in 4 Provinces of Papua New Guinea.

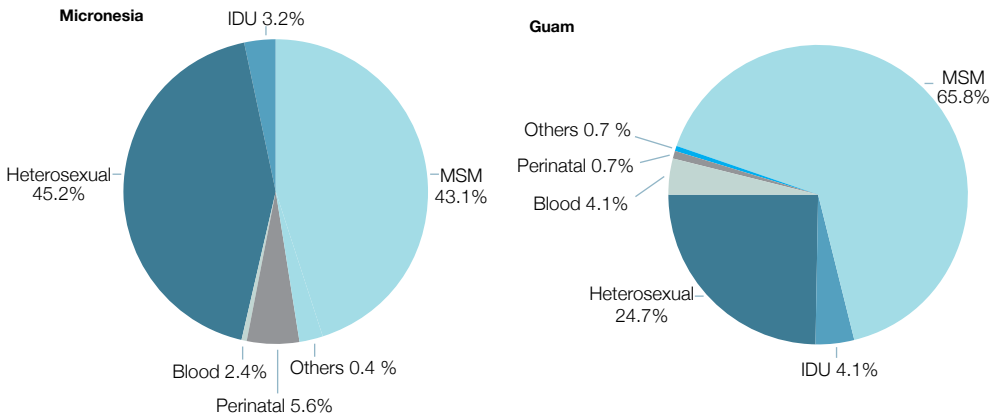
49 Fiji National Advisory Committee on AIDS, 2008. National HIV/AIDS Strategic Plan 2007–11 for the Republic of the Fiji Islands. Suva: 2007, p 13.

50 Salomon, C. and Hamelin, C. 2008. Why Kanak women are vulnerable than others to HIV

51 Salomon, C. et al, 2003. HIV protection and screening in women in New Caledonia

Despite the fact that since 2000 more heterosexual transmission of HIV has been recorded, Polynesian countries report a high number of infections among **men who have sex with men** (MSM). These countries also have a traditional cultural acceptance of transgender people—the *rae-rae* in French Polynesia, the *fa’afafine* in Samoa, and the *fakaleiti* (or *fakafefine*) in Tonga. However, detailed information about MSM and transgender people is not available, and it remains unclear if these groups have been disproportionately affected with HIV, or whether greater levels of social acceptance have resulted in a higher likelihood of their testing and reporting. Guam has the highest proportion in the Pacific of MSM who are known to be HIV-positive (although this could reflect difficulties in collecting MSM data in other parts of the region).

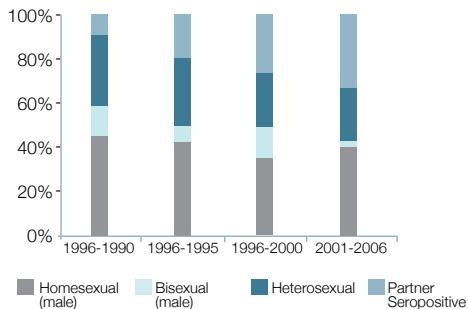
Figure 6a-b: Proportion of HIV cases by reported exposure in Micronesia and Guam



Source: Burnet Institute, 2009. *HIV in the Pacific, 1984–2007*, p 40.

Consistent time series data from New Caledonia allow an analysis of the maturing of the HIV epidemic. Most cases of HIV were initially identified among men who reported having sex with other men. There has been a decline among those reporting heterosexual and bisexual exposures (although these data were not disaggregated by sex) and a corresponding increase in those who stated their partner was infected with HIV (the risk behaviour of the latter group was not reported.) Combined with the change in the male:female ratio over time in New Caledonia, these data could suggest that women are being infected by men who acquired HIV at any earlier point in the country’s epidemic.

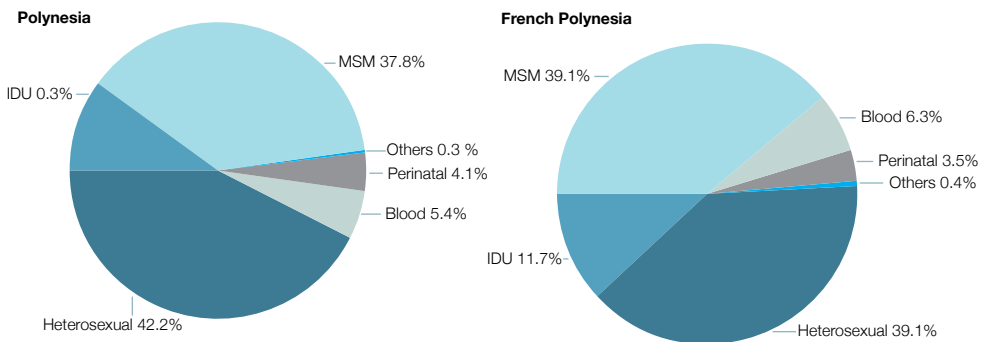
Figure 7: Proportion of cases by reported exposure in New Caledonia



Source: Burnet Institute, 2009. *HIV in the Pacific, 1984–2007*, p 39.

Injecting drug use appears to be relatively rare in Papua New Guinea, Fiji, Solomon Islands and Vanuatu⁵². Although almost all intravenous drug use exposures reported in Melanesia are from cases detected in New Caledonia, indications are that drug use is on the rise across the region.

Figure 8a–b: Proportion of HIV cases by reported exposure in Polynesia and French Polynesia



Source: Burnet Institute, 2009. *HIV in the Pacific, 1984–2007*, p 39.

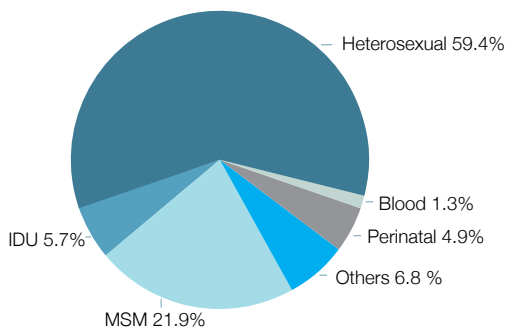
French Polynesia has the highest proportion of HIV cases in the Pacific attributable to injecting drug use, although there have been no specific studies investigating the nature and circumstances of this high risk exposure. **Injecting practices need to be a core focus of surveillance in all countries.**

The figures and discussion clearly demonstrate that reported modes of transmission vary considerably between countries. This highlights how important it is for each country to understand the specific nature of its epidemic and tailor its response accordingly.

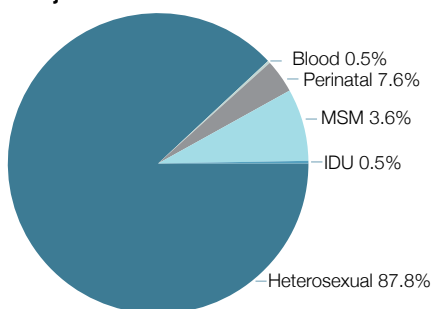
52 Millan J, et al 2007 Report of the HIV/AIDS behavioural surveillance survey within high-risk settings; WHO 2006. Second Generation Surveillance of HIV, other STIs and Risk Behaviours in Six Pacific Island Countries.

Figure 9a–d: Proportion of HIV cases by exposure in Melanesia, New Caledonia, Fiji and Papua New Guinea

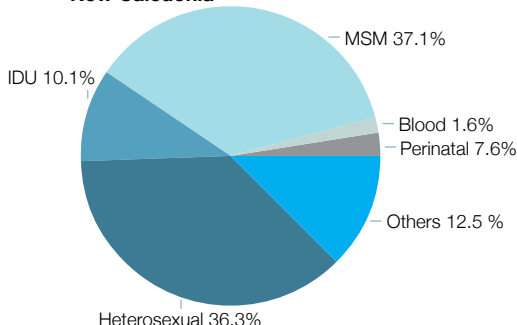
Melanesia (excl. PNG)



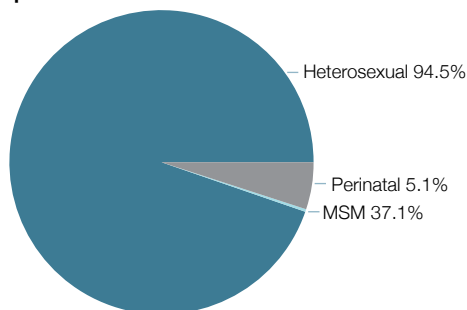
Fiji



New Caledonia



Papua New Guinea



Co-infections

Untreated sexually transmitted infections (STIs) increase the probability of HIV being transmitted during unprotected sex. Reporting of STI generally remains poor and inconsistent, but information points to high STI rates throughout the region⁵³ (Attachment 3) and STIs appear to be endemic throughout the region⁵⁴. Few surveys of young people have recorded their histories of STI symptoms and few young people have been tested for them. **Surveys, conducted in 2005 in six Pacific countries, of pregnant women—generally considered to be a low-risk group—found 18% were infected with chlamydia, three per cent with syphilis and 1.7% with gonorrhoea⁵⁵.** Papua New Guinea has the highest prevalence of gonorrhoea, trichomoniasis and genital chlamydia,

53 Burnet Institute, 2009. HIV in the Pacific, 1984–2007.

54 WHO, Ministry of Health, Kiribati and the University of New South Wales, 2004. STI/HIV Prevalence Surveys of Sexually Transmitted Infections among Seafarers and Women Attending Antenatal Clinics in Kiribati, 2002–2003. Manila: WHO Regional Office for the Western Pacific. p6.

55 WHO, 2006. Second Generation Surveillance Surveys of HIV, Other STIs and Risk Behaviours in 6 Pacific Island Countries.

56 Papua New Guinea NAC and NDoH, 2007. The 2007 estimation report on the HIV epidemic in Papua New Guinea. p 10.

and the second highest prevalence of syphilis, in the Asia–Pacific region⁵⁶. WHO warns that the low HIV prevalence rates in most of the region may rapidly change unless urgent measures are taken to control other STIs⁵⁷.

The Pacific region has an estimated 1,600 new tuberculosis (TB) cases every year. Case notification rates vary across Pacific island countries. Case notification rates for all forms of TB were highest in Kiribati (351 per 100 000 population) and lowest in American Samoa (4 per 100 000 population). Case notification rates for smear-positive cases were highest in Tuvalu (114 per 100 000 population) and lowest in Guam (3 per 100 000 population)⁵⁸. **The emergence of multidrug-resistant TB and the increasing number of TB–HIV cases in several countries continue to make TB control a priority in the Pacific**⁵⁹.

In all countries and areas in the Pacific region, HIV prevalence in new TB cases is consistently higher than the prevalence of HIV in the adult population—in Fiji 2% of TB patients are HIV-positive and in Papua New Guinea this is 18.5%, which is the highest level in the WHO’s Western Pacific region⁶⁰.

Table 4: TB–HIV co-infection in adults in Port Moresby General Hospital, 2006–2008

Year	Total TB patients	HIV positive	Proportion HIV–TB co-infection (%)	Overall Mortality %
2006	994	85	8.5	7.4
2007	1002	126	12.6	11.4
2008	930	156	16.8	14.8

Source: Lavu, E, 2009. Analysis of the Impact of HIV and AIDS on the Health Sector in Papua New Guinea 2004–2008, p 14.

2.7 Projecting the Pacific epidemic

The lack of time-series surveillance data and basic demography for relevant populations or national epidemics is coupled with inadequate data on sexual risk behaviour for relevant populations in most Pacific countries. Only the simplest projection methods can be applied in Papua New Guinea, Fiji, New Caledonia, Guam and French Polynesia⁶¹. Other Pacific countries lack the basic information about the structure of their HIV epidemic and the size and characteristics of people who engage in high-risk behaviours to justify even this most cautious modelling.

57 Dr Seng Sopheap, submission to the AIDS Commission meeting, November 2007.

58 WHO, 2009. Tuberculosis Control in the Western Pacific Region, p 46.

59 One-quarter (25%) of 60 bacteriologically confirmed cases of TB identified among villagers in the Western Province of Papua New Guinea presenting to clinics in the islands in Torres Strait were found to have multidrug-resistant TB. Nationally, 3% of new cases and 20% of previously treated patients have MDR TB (WHO, 2009. Tuberculosis Control in the Western Pacific Region, p10.

60 WHO, 2009. Tuberculosis Control in the Western Pacific Region, p 11.

61 Burnet Institute, 2009. HIV in the Pacific, 1984–2007, p 26.

That most of these countries depend on reported cases for planning serves to highlight the need for research and systems to establish data on both new and cumulative HIV cases.

Papua New Guinea is the only country that has projected the course of the HIV epidemic⁶²—and then only until 2012 using the 2007 Estimation and Projection Package (EPP) at the current level of response. The estimate is that by 2012, Papua New Guinea will have a national prevalence rate of 5.07%; a total of 208,714 people will have been infected with HIV, given the current level of response. However the Government warns that: “Although the actual estimates are considered by the national government as the most valid estimates available to date, they are taken with the necessary caution in consideration of the quality of the data used for them”⁶³. An apparent sharp increase in HIV cases in rural areas does not necessarily mean that the epidemic is increasing most rapidly there, as the data also reflect the expansion of testing sites from 2006.

The majority of Pacific countries lack basic information regarding epidemic structure and risk-group characteristics to justify even the most cautious modelling approach. The review also notes that prior to applying any model in any Pacific country, a detailed assessment of the quality and representativeness of surveillance data should be undertaken to ensure that data points are valid and/or are accounted for. Ideally, country-level models should be applied wherever possible, given the different features of national epidemics observed even within the same subregion.

Samantha’s story

Twenty-four year old Samantha lives in a village on the outskirts of Suva with her two young children. She was diagnosed HIV-positive in January 2007 when she was seven months pregnant with her youngest child. “My husband’s a rugby player so he travels around. His own family used to come and tell me that he was cheating on me and sleeping with other girls. I knew this was going on because sometimes he would get drunk with his friends and not come home until the next day,” she says.

“When the doctor told me my results, all I wanted to do was kill myself,” Samantha reflects. “I knew I got it from my husband. He was the first and only guy I had slept with.” Samantha hid her status from her family for the last two months of her pregnancy. “I told my husband about my HIV test results. He wasn’t even surprised. He just told me to ‘pray hard’ and ‘don’t think about it’. Then I asked him to go for a test and he said no. That’s when I knew that he already knew his status, and that he knew he was the one who had infected me.”

Samantha gave birth to a healthy baby boy who is HIV-negative. After a few months, she told her family about her HIV status - but only after rumours starting spreading. “At first, the village people didn’t want to talk to me or come near me. So I kept to myself and just

62 The Government of Fiji and WHO are also working on projections.

63 Papua New Guinea NAC and NDoH, 2007. The 2007 estimation report on the HIV epidemic in Papua New Guinea. Port Moresby. p27.



cried inside. When my mother asked me if the stories were true, I denied it at first but she knew. It was when I saw that she still would love me and support me that I broke down and told her everything.” Now the whole village knows and supports her, after they also learnt how HIV is transmitted.

Samantha separated from her husband a few months later. “When I started to talk about the virus, he’d tell me not to bring it up and to shut up,” she said. “He beat me up and burned all my clothes and my daughter’s clothes.” Samantha now lives with her mother and children in the village. She goes fishing and sells the fish to feed her family. And she believes she has changed for the better. “Before, I was very stubborn and carefree. Now I have learnt to listen to others and have a heart, and not judge them.”

Source: Renagi Taukarai, PIAF

Chapter 3 Risks, vulnerabilities and impacts

Key findings

- **Stigma and discrimination have a major impact on all aspects of a country's response to HIV, particularly in small Pacific communities. Terms such as illicit sex (commercial and transactional) or labels for sexual identities (homosexual, transgender, sex worker) can lead to stigmatization of individuals and vulnerable populations.**
- **Major sources of risk and vulnerability to HIV include:**
 - gender inequality and gender-based violence;
 - concurrent sexual partnerships;
 - commercial and transactional sex;
 - male-to-male sex, which is often hidden and denied. Many men who have sex with men often also have sex with women. This greatly enhances the risk of HIV infection in the wider population;
 - connections between alcohol, drugs, unsafe sex;
 - unprotected sex by young people—the fastest growing age group in the region—starting at a young age and involving multiple partners; and
 - mobility and migration within and beyond the region.
- **HIV-related sickness and mortality in the formal workforce are already having a negative economic impact in Papua New Guinea.**
- **The fundamental social safety networks across the region (including for HIV care), traditional extended family and clan networks are being weakened by the rapid pace of socioeconomic and cultural change.**

3.1 Introduction

Stigma and discrimination have a major impact on all aspects of a country's response to HIV, particularly in small communities. The prejudice and discrimination directed at people living with HIV (PLHIV) and the groups and communities that they are associated with can result in their rejection by their community. They may find themselves shunned, discriminated against or even physically hurt. Fearful expectation of HIV-related stigma can make people reluctant to access HIV testing, treatment and care, and can deter governments from taking fast, effective action.

3.2 Stigma and discrimination

People living with HIV in the Pacific are known to experience stigma and discrimination yet little information exists about the impact or the extent. Between 2007 and 2009, the Pacific Islands AIDS Foundation (PIAF) undertook the first study of HIV-related stigma and discrimination in the region, to address the current lack of understanding by examining the experiences and perceptions of people living with HIV (PLHIV)⁶⁴.

Encouragingly, the personal experiences of PLHIV indicate positive change over the past decade as people understand more about HIV. Although fear, illness and tragic family losses still exist, many HIV-positive people, supported by networks of PLHIV and often employed by civil society organizations (CSOs), report constructive testing, treatment and counselling experiences that have helped them find meaningful lives. Similarly, groups that represent vulnerable populations are gaining strength to express themselves through growing recognition of their needs and increased support. A prime example is the Pacific Sexual Diversity Network (PSDN) a regional network working with men who have sex with men (MSM) and transgender people in the Pacific, especially in relation to HIV and AIDS. A number of countries in the region also have sex worker networks.

Participants in the PIAF study identified CSOs as a key means of support by providing emergency funds, establishing HIV support groups and engaging PLHIV in community education. Some participants found that public disclosure of their status was an empowering experience, moving them from feeling defeated by their HIV-positive status to living positively with HIV and taking an active role in helping to reduce stigma and discrimination. Some, however, regretted “going public” as they felt they did not receive adequate and continued support.

While people's attitudes have improved markedly, significant barriers still remain. The PIAF study found that HIV-related stigma has a powerful impact on how people react to being diagnosed HIV-positive. Many of the respondents were plunged into shock, grief, shame and guilt after their diagnosis, sometimes leading to depression and contemplation of suicide. Participants described how HIV-related discrimination occurs in several different facets of their lives.

64. PIAF, 2009. Report on People living with HIV in the Pacific: A Qualitative Study of HIV and AIDS-related Stigma and Discrimination.

One described how she was forced to leave her village, while another was unable to use public transportation services. In some instances, discrimination is imposed by friends and family and ranges from outright rejection to subtle social isolation. **The church has been noted as a major force in maintaining negative attitudes and discrimination. Breaches of confidentiality were experienced by a majority of the participants and deterred HIV-positive people from accessing health services. Discrimination was also experienced at workplaces and by those seeking employment.**

Stigma and discrimination are linked to social inequalities that serve to exacerbate existing forms of social exclusion such as poverty and gender inequality. Many of the research participants described how being poor and HIV-positive made it difficult to find housing, employment, food and a means to support their families. Several described how the difficulties imposed by poverty made it a struggle to get by day-to-day, which in turn had a direct impact on their ability to maintain their health. Many HIV-positive women described how stigmatization isolates them, making even more difficult their struggle to support their children and maintain their households.

It is now widely accepted that the greater the level of stigma, the further HIV will spread. Encouragingly, awareness that responses based on compassion work better than those based on coercion is also gaining ground⁶⁵. The PIAF research recommends a variety of ways to reduce discrimination in HIV responses. These include:

- bringing Pacific communal values to bear on improving understanding of the consequences of marginalization and the benefits of inclusiveness;
- making unprotected sex and high-risk behaviour, rather than population groups, the focus of prevention programmes. This will help ensure that risks of HIV are better understood at all levels in Pacific societies;
- expanding voluntary counselling and testing (VCCT) services so that they can train and employ PLHIV as counsellors to provide peer support, which should also be offered to the partners and families of HIV-positive people;
- enhancing the anti-stigma and anti-discrimination components of HIV information and education programmes, instead of focusing solely upon transmission of HIV;
- for Pacific churches, working toward ideals set out within the 2004 Nadi Declaration, which promotes ideals of care and compassion toward positive people and nonjudgmental pastoral counselling;
- providing training for all health service workers, covering the importance of confidentiality, how it is to be provided and guaranteed to patients, and the consequences for breaches of confidentiality;
- for policy and law-makers, taking a more active role in ensuring and enforcing legislation and policies that protect PLHIV from experiencing discrimination in the workplace;
- increasing the support for HIV-positive people facing poverty, including: provision of healthy meals, assistance in finding housing, increasing people's skills and capacities for employment, and providing emergency financial support;
- developing and strengthening partnerships between women's organizations and HIV

65 Kirby, M, 1995. Facing up to the AIDS Paradox, 3rd International Conference on AIDS in the Asia-Pacific,

- organizations so that they can simultaneously address gender inequality and the distinct ways in which women face HIV-related stigma and discrimination; and for CSOs, continuing to provide and expand educational training programmes that focus on developing skills and expanding employment opportunities. They should also continue to support people who choose to “go public”.

Sione's story

Sione learnt he had HIV three years ago and began ARV treatment. He began to feel and look better. But then the stories started. “The rumours started to circulate that there was a Tokelauan guy in Samoa who had this AIDS. The rumours were from other Tokelau Islanders here.” Sione felt embarrassed and stigmatised. “One day, I went to my office and I asked someone from my island if there was any story about me back home. He said yes. I asked him what kind of story? He told me he'd heard that I got AIDS. At that time, I didn't know what I would do because people were talking about me.”

Worse was to come. “I walked into my office one day, you know I'm a hard worker and do very well in my job. But my boss called me in and told me: ‘Sorry, there is no more job for you.’ I asked him why and he said: ‘Because there is a virus in your body, you cannot work anymore.’”

Sione was fortunate in the support of his wife and both their families. He now has his own small business and describes himself as having no problems. ‘I'm very happy to talk to people, not to talk about the disease, but just socialise and interact with people and my family,’ he says. Asked if he plans to publicly disclose his status and do advocacy work, Sione laughs “No that's not for me. I am a weak person, but who knows, maybe later”.

Source: Renagi Taukarai, PIAF

3.3 Gender inequality and gender-based violence

In the Pacific, women generally have unequal rights to property, experience a high degree of sexual and domestic violence and are underrepresented in decision-making at community and political levels⁶⁶. Key indicators for women in relation to literacy, education, employment and poverty also highlight the inequalities between men and women.

Traditional cultural ideas about gender vary across the region and have changed over time. **Studies of Pacific attitudes to sex show that, while fidelity is expected of women, most live with (rather than tolerate) male promiscuity, adultery and irresponsible sexual behaviour, especially by young men.** This is a major factor in the spread of HIV and STI⁶⁷. Traditional attitudes to premarital sexual activity vary, and even where it was once frowned upon, attitudes are changing. Globally, it is recognized that concurrent (or following closely after one another) sexual partnerships pose a greater risk to the spread of HIV than sequential partnerships⁶⁸. While there has been little research in this area, **the**

66 Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches. p 35.

67 UNDP, 2009. Wardlow, H., 2007. Men's extramarital sexuality in rural Papua New Guinea.

68 Shelton, J. D., 2007. Ten myths and one truth about generalised HIV epidemics.

number of young people who reported having more than two sexual partners in the last year ranged from 12.7% (Samoa) and 21.9% (Solomon Islands) to 43.3% (Vanuatu). Consistent condom use within these casual partnerships was very low; 5.2%, 7.6% and 15.7% respectively⁶⁹. Results from behavioural surveillance surveys (BSS) in Papua New Guinea indicate the prevalence of early sexual debut, and multiple premarital and extramarital sex partners, including some polygamy⁷⁰.

Women can be at risk of HIV infection through their own sexual practices but they are primarily vulnerable to and at risk from the sexual relationships of their male partners; and from violence that occurs outside of and within marriages, including rape and forced sex⁷¹. In Papua New Guinea, marriage has been identified as a significant risk factor for HIV infection for women⁷².

Violence against women is a driving factor in the spread of HIV in the region, partly by contributing to the prevalence of unprotected sex. Gender-based violence can be supported by cultural norms where people believe it is a personal and private matter or even an acceptable “tradition”. Social change throughout the region is affecting family structures as well as increasing the risks of spousal violence and other social problems. A 2003 study in Samoa, for example, found that 46% of women interviewed had experienced some form of partner abuse—38% was physical abuse, 19% emotional abuse, and 20% sexual abuse⁷³. In other parts of the region, particularly Papua New Guinea and Fiji, “line-ups” or multiple rapes sometimes occur.

Gender-based violence is increasingly recognized as having become a serious sociocultural and public health concern in many parts of the region and efforts are being made to place this issue more firmly onto the political agenda⁷⁴. National surveys conducted by SPC in Kiribati, Solomon Islands and Samoa have aimed to draw attention to the social, economic and health consequences of violence against women and girls in Pacific communities. Mapusaga O Aiga and Victim Support (Samoa), the Fiji Women’s Crisis Centre and the Vanuatu Women’s Centre are some of the civil society organizations across the Pacific that are responding to this issue.

69 WHO, 2006. Second Generation Surveillance of HIV, other STIs and Risk Behaviours in Six Pacific Island Countries.

70 Papua New Guinea NAC, 2008. UNGASS 2008 Papua New Guinea Country Progress Report 2006–2008, p 25.

71 AusAID, 2008a. Violence against Women in Melanesia and East Timor: Building on Global and Regional Promising Approaches; Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches; Fiji Women’s Crisis Centre, 2001. The Incidence, Prevalence and Nature of Domestic Violence and Sexual Assault in Fiji.

72 Hammar, L., 2006. “It’s in Every Corner Now”: results from a nationwide study of HIV, AIDS, STDs and sexual health”.

73 SPC, 2003. Samoa Family Health and Safety Study; see also WHO, 2005. Multi-country Study on Women’s Health and Domestic Violence against Women. Initial results on prevalence, health outcomes and women’s responses, Geneva: World Health Organization.

74 UNIFEM, the Commonwealth Secretariat, the Fiji Women’s Crisis Centre in its regional capacity as Secretariat for the Violence Against Women (VAW) Network, the Pacific Island Forum Secretariat, and SPC’s Women’s Bureau are currently working on this.

Analysis of the interface between tradition and modernity and the impact of the different rates of social change can add to these efforts. Traditional protective customs for women and girls have been eroded, creating or intensifying conditions of vulnerability. It is important that young people and society in general become more critically aware of social change, their role as agents and the need to adapt attitudes and behaviours to lessen the negative impact of this change.

Gender inequality in Papua New Guinea

Research in PNG with 415 women from four provinces found that:

- 27.5% had been sexually abused under the age of 16 years
- 58.2% reported physical abuse in relationships
- 44.6% reported sexual abuse in relationships
- 75% had never accessed social services

Women who reported child sexual abuse were twice as likely to be HIV-positive. They also had their first sexual experience at a younger age, were at least seven times more likely to be involved in transactional sex, were more likely to be in a violent relationship as an adult and had a higher number of concurrent sexual partners. Women's level of education and paid employment were not protective factors against violence in their relationship. Their partners' level of education was also not found to influence levels of abuse.

Source: Lewis et al 2009 Final Report on Links Between Violence Against Women and the Transmission of HIV in 4 Provinces of PNG

3.4 Commercial and transactional sex

Unprotected commercial and transactional sex is cited as a major source of HIV vulnerability within the Pacific, as the purchasing of sex is a common practice in some countries and in some population groups. **Seventy per cent of truck drivers, 61% of military personnel and 33% of port workers reported paying women for sex in the last 12 months in Papua New Guinea.** While reported condom use was high during the majority of men's most recent commercial sex (62–91%), consistent condom use with sex workers during the last 12 months was less and varied from a low of 33% among truck drivers to 69% for Ramu Sugar workers⁷⁵.

Commercial and transactional sex can often result from economic disadvantage and limited opportunities. Commercial sex (by people who support themselves through the sale of sex for agreed prices) is usually illegal and not blatant in Pacific communities. It is most visible and organized in the largest towns and cities (including at sporting and cultural events) and around rural industries with mobile male populations (such as mines and logging camps in Papua New Guinea and Solomon Islands). Foreign sex workers are becoming more numerous in Fiji, where they also often work in local factories, and in the Marshall Islands⁷⁶.

⁷⁵ Papua New Guinea NAC, 2008; UNGASS, 2008 Papua New Guinea Country Progress Report 2006–2008. p 25.

⁷⁶ Yunisea, 2006 The tuna fishing industry and its side effects; Burnet Institute, 2009. HIV in the Pacific, 1984-2007, p 57

Police are reported in some cases to exploit their illegal status by subjecting sex workers to violence or rape and extortion⁷⁷.

During the vanilla boom in 2003–2004 in Papua New Guinea, levels of reported STIs soared and commercial sexual activity and sexual abuse increased.

Much less visible, but more widespread, is unorganized, transactional sex - namely sex exchanged for food, clothing or other resources, or for a 'good time' or the attentions of a 'boyfriend'. Anecdotal evidence suggests that many women and some men exchange sex for money or gifts in all Pacific countries.⁷⁸ **Studies in PNG, particularly, have found some women partly or fully support themselves and their families by selling sex but do not identify themselves as sex workers.**⁷⁹

Targeted prevention programmes are being shown to succeed. In surveys done in 2005 and 2007 as part of the Porot Support Project in Papua New Guinea, sex workers reported increases in condom use both at last sex and consistently with non-paying partners. Consistent condom use increased in Port Moresby from 53% to 88% and in Goroka from 20% to 35%. Consistent condom use over the past month with clients also increased from 63% to 88% in Port Moresby and 30% to 44% in Goroka⁸⁰.

Young gay prostitutes in Fiji

Many young men end up on the streets because of their sexual orientation, disowned by their family for being a homosexual, or finding few other doors open because they are inadequately educated. One young man said: "I am 23-years old. I started doing this when I was 17. I have three sisters and two brothers and my family did not accept what I was becoming. I left home because I could not be myself, could not express myself and do things I was comfortable with. This job that I have guarantees that I pay my rent and buy my food. Sadly, now that I am on the streets, I am not being accepted by my family. But this is what I do now and I intend to do this for a while. These earnings also allow me to help my family during emergencies."

While money is the driving force, some young men are there by choice, such as the son of a senior civil servant. In his home, homosexuality is abhorred. Selling sex is the only way he can find male partners. "I don't know what they will do if I get seen out here. They give me money but I also want to enjoy myself," he said. And as if to justify his actions, he said, "Well, we also have students here, high school students who come to make money to pay for school fees."

Source: *Fiji Times*, 16 Nov 2008.

77 Human Rights Watch (HRW). 2005. 'Making Their Own Rules': police abuses and HIV/AIDS

78 Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches, pp21-27; Burnet Institute, 2009. HIV in the Pacific, 1984-2007, p 57

79 Government of PNG 2008 UNGASS 2008 Country Progress Report, P 26.

80 Government of Papua New Guinea 2008 UNGASS 2008 Country Progress Report, P 27

3.5 Male-to-male sex

The extent to which HIV is transmitted by sex between men in the Pacific is not known. Only New Caledonia, French Polynesia and Guam have reported cases, but it is highly unlikely that these are the only countries where male-to-male transmission has occurred.

Since most sex between men in the Pacific is hidden, illegal and denied, it is not addressed appropriately in most national HIV plans. Where there is a visible “gay” or transgender community in the Pacific they have taken a lead in national responses to HIV, as they were aware of the epidemic in other countries since the 1980s. The Pacific has the opportunity to learn from the mistakes of other regions. The report of the Commission on AIDS in Asia noted that there had been a rapid rise in HIV prevalence among men who have sex with men in several Asia cities. The Commission also found that despite dramatic increases in resources available for HIV services, there continued to be a low coverage of services for MSM at only around 5%⁸¹.

Western constructs of homosexuality and gay identity do not fit comfortably with Pacific cultures. Traditions of transgender people in the region include the mahu of French Polynesia, the *fa'afafine* of Samoa and the *fakaleiti* (or the older term *fakafefine*) of Tonga. Many cultural groups in Papua New Guinea have traditions of male-to-male sex practised at certain stages of men's lives⁸².

Ethnographic studies confirm high rates of male bisexuality though the practice is rarely open and even less often acknowledged. Behavioural surveillance identifies male-to-male sex among youth in Solomon Islands, Vanuatu and Samoa, as well as police and military in Fiji Islands (15, 6.7%), STI clinic patients in Fiji Islands and Samoa (5, 7%), and seafarers in Kiribati in 2002–2003 (19, 5.6%) and 2004–2005 (3, 1%)⁸³.

Surveys in Papua New Guinea also reported male-to-male sex (often for payment) in many male-dominated situations, such as boys' school dormitories, prisons, the military, mining and logging camps and oil rigs⁸⁴. A survey of people defined as MSM in Port Moresby found that more than three-quarters had sex with both men and women and did not identify as being homosexual⁸⁵.

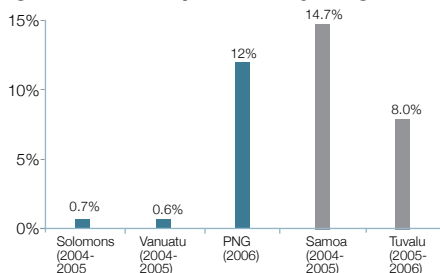
81 Commission on AIDS in Asia, 2008, pp 49 and 131.

82 PSDN, 2009. HIV/AIDS, men who have sex with men and transgender people in the Pacific: Recommendations for an improved response; Jenkins, C., 2007. HIV/AIDS, 'Culture, and Sexuality in Papua New Guinea', in Jenkins, C. and Buchanan-Aruwafu, H. Cultures and Contexts Matter: Understanding and Preventing HIV in the Pacific,

83 Buchanan-Aruwafu, 2002a; Solomon Islands Ministry of Health and Medical Services [SI-MHMS], 2005; WHO, 2006; WHO and Kiribati Ministry of Health, 2004) cited in Buchanan & Jenkins 2006, p 94.

84 Jenkins, C. & National Sex and Reproduction Research Team, 1994. National knowledge and study of Sexual and Reproductive Behaviour in Papua New Guinea

85 Papua New Guinea NAC & NDOH, 2007. The 2007 estimation report on the HIV epidemic in Papua New Guinea, p 18

Figure 10: Proportion of young male-to-male sex in the last 12 months

Source: Burnet Institute, 2009. *HIV in the Pacific, 1984–2007*

Note: Figures for Solomon Islands and Vanuatu may reflect under-reporting of males who have sex with males (MSM).

Some information emerges from more general surveys. A broader 2006 study in Solomon Islands among youth, sex workers and MSM found they often had multiple sex partners, low or inconsistent condom use, poor health practices for STIs, high levels of alcohol and some drug use, and engaged in sexual violence—all factors that contribute to the spread of STI and HIV⁸⁶. A better understanding of the particular vulnerability of MSM may soon emerge in Tonga, Cook Islands and Northern Mariana Islands from STI prevalence and behavioural surveys among MSM that are still in progress.

Despite the evident link between unprotected sex between men and relatively high rates of HIV infection in Papua New Guinea, Fiji, New Caledonia, French Polynesia and Guam, none of these countries has conducted recent behavioural surveillance surveys or qualitative studies about the characteristics of these men, or initiated targeted campaigns to encourage them to use safer sexual practices⁸⁷.

Major obstacles to making such campaigns effective remain, both with the social stigma and the illegal status of homosexual activity. Not only are men ashamed of or embarrassed about disclosing their sexual activity, they are also deterred from finding out what they need to know to reduce their risk or to buy condoms. Boys and men in institutionalized settings, notably prisons, are particularly vulnerable, as they have limited or no choice about safe ways to express their sexuality. Almost half of surveyed men who had sex with men reported facing stigma and discrimination in their workplace; one in five had been beaten because of sexual orientation and 60% had been raped⁸⁸.

Nevertheless, most countries already have grassroots initiatives that are well worth supporting. Men who have sex with other men are not hard to identify and can be reached with the information they need within their peer groups, including openly gay and transgender as well as underground bisexual communities. The Samoa AIDS Foundation

86 SCA Solomon Islands, 2006 HIV vulnerable groups research: a pre-intervention assessment

87 Nguyen, 1999. From 1991 to 1996, three studies were conducted in French Polynesia to assess the knowledge, attitudes and behaviour of transvestites, bar girls, and sex workers, but there has been no follow up of these studies. The single successful behavioural survey among MSM in the Pacific was conducted in Papua New Guinea. A survey of MSM in Palau in 2005–2006 failed to recruit enough male respondents.

88 Papua New Guinea NAC and NDoH, 2007. The 2007 estimation report on the HIV epidemic in Papua New Guinea, p 18.

(SAF) has undertaken some effective interventions for MSM that can provide lessons for other Pacific countries. SAF has adapted successful prevention approaches from gay communities elsewhere to the unique cultural contexts of Samoa and the Pacific.

Informal networking among sexual minorities in the Pacific has now been formalized with the launch of the Pacific Sexual Diversity Plan 2010–2013 at the 2009 Bali International Congress on AIDS in Asia and the Pacific (ICAAP). This provides a sound platform for the promotion of effective national policies and interventions to reduce HIV and STI risk among men who have sex with men.

To be effective, this strategic plan requires a clear commitment in national plans to targeted, peer-driven education; improved capacity and meaningful engagement of MSM and transgender people in national planning; improved knowledge and understanding of MSM and transgender sexual health; efforts to reduce stigma and discrimination; and removal of colonial era laws criminalizing sex between men.

3.6 Alcohol and drug use

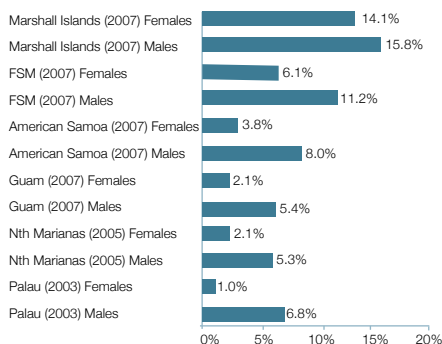
The connections between alcohol, drugs, unsafe sex (including decreased condom use) and vulnerability to HIV are evident across the region⁸⁹. **Recent surveys have found that around a third of all young people used alcohol and drugs before their last sexual encounter**⁹⁰. In a survey of young people in two communities in Port Moresby (Joyce Bay and Hanuabada) alcohol use was linked to forced sex with over forty percent of young men and young women reporting that they had been forced to have sex⁹¹.

While intravenous drug and methamphetamine use appears low, little is known about the groups who engage in these high-risk practices and further research to fill this gap in information should assume high priority. More attention should be paid to this possibly emerging trend, both as a health risk in itself and because of its potential to spread HIV (particularly in the sharing of needles). Increasing drug use has the potential to threaten already weakened social systems in many countries, particularly in urban areas.

89 Papua New Guinea NAC and NDoH, 2007. The 2007 estimation report on the HIV epidemic in Papua New Guinea, p 9; Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches, p 34.

90 Burnet Institute, 2009. HIV in the Pacific, 1984–2007, p 55.

91 Papua New Guinea NAC and NDoH, 2007. The 2007 estimation report on the HIV epidemic in Papua New Guinea, p 26.

Figure 11: Proportion of youth in US territories reported injecting drugs

Source: Burnet Institute, 2009. *HIV in the Pacific, 1984-2007*.

3.7 Young people

Forty per cent of the Pacific population is under the age of 15 and adolescents are the fastest-growing age group in the region. Employment and services are not keeping pace with their growing numbers. Improved access to education is less likely to open opportunities for paid employment. Pacific youth are at the forefront of rapid social change, including changes in sexual behaviour. Cultural identity is still important to young people in the Pacific, who typically have a strong sense of the importance of family expectations and their own obligations and status. But social change and disruption can expose young people's vulnerability to drug and alcohol abuse, mental health problems and suicide. All these reactions to the pressures of change are evident across the region: in some countries, recorded alcohol abuse and suicide rates are some of the highest in the world⁹².

In all Pacific countries, the proportion of HIV cases among youth has been increasing steadily, particularly for young women⁹³. More than 30 separate studies of youth—defined in most Pacific surveys as males and females aged between 15 and 24 years—have been conducted throughout the Pacific. Yet little information can be gleaned about the risk behaviours of young people, especially from Fiji and French Polynesia, two of the higher HIV incidence countries. **A Demographic and Health Survey in the Marshall Islands found that, as with many young people across the world, 73% of young men and 60% of young women had sex before they turned 18. But only 10% of men and 16% of women aged 15–24 reported having used a condom during their first sexual intercourse⁹⁴.** This pattern runs parallel to teenage fertility rates that are high in some countries⁹⁵. It is also roughly consistent with that of the median age of the first sexual experience, which is generally lowest in Melanesia and Micronesia⁹⁶.

92 Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches

93 Sladden, T., 2006. Twenty years of HIV surveillance in the Pacific – what do the data tell us and what do we still need to know?

94 Republic of the Marshall Islands, 2007. Demographic and Health Survey: Facts at Your Fingertips: HIV and AIDS. SPC: Noumea.

95 Burnet Institute, 2009. *HIV in the Pacific, 1984–2007* p 51.

96 Burnet Institute, 2009. *HIV in the Pacific, 1984–2007* p 51.

Young women are affected by changing social attitudes and sexual practices, which have generally increased the extent of premarital and extramarital sex, even while reproductive health services remain largely restricted to married women, especially in more conservative rural communities. But young women also often fear that carrying or asking for condoms will brand them as promiscuous⁹⁷.

As in many other parts of the world, many young people in the Pacific experience their first sexual encounter through force and coercion. Surveys in Samoa, Cook Islands and Kiribati found high levels of pressure and force involved in the first sexual experience of many young people⁹⁸.

Young people can also be involved in higher risk practices such as drug use, transactional sex and male-to-male sex. Many young men (especially in all-male environments such as boarding schools or young men's houses) engage in same-sex behaviour (which does not necessarily include penetrative sex) but do not identify as being bisexual or homosexual. Relatively few young people report having sex with sex workers but the level of transactional sex is high. There are serious gaps in information on what influences these behaviours, why condom use remains low, or the specific contexts in which transactional sex and sexual violence occur⁹⁹. Clearly it is desirable that all countries should focus on carrying out systematic and repeated research studies of young people's behaviours, knowledge and the barriers to putting what they do know into practice.

Youth sex in Solomon Islands and Vanuatu

Surveys conducted in Honiara in 2004-2005 found that around one fifth of students questioned reported that they had exchanged sex for money or goods in the previous year. When young people who had left school were included, the figure rose to more than one quarter. The exchange of sex for money or goods involved children as young as 11 years. Few young people used condoms consistently or at all. In Vanuatu, two fifths of youth out of school reported that they had exchanged sex for money or goods in the previous year. Again, few reported consistent condom use.

Source: Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches.

3.8 People on the move

Limited employment opportunities in most Pacific countries result in high rates of internal and external mobility. Increasing urbanization, population growth and mobility from rural areas and islands to towns and cities are characteristic of the Pacific, with ensuing sociocultural problems presenting key risks for HIV infection. Internal mobility is high in Melanesian countries, especially Papua New Guinea. Studies show that in Solomon Islands and Kiribati, increased movement to urban centres has been linked to increased crime, drug and alcohol abuse, overcrowding, higher unemployment, increased teenage pregnancy, STIs, gender-based violence and sex work¹⁰⁰.

97 UNDP, 2009d. Gender and HIV in the Pacific Islands region: a literature review of evidence with recommendations

98 Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches, p 37.

99 UNDP, 2009d. Gender and HIV in the Pacific Islands region: a literature review of evidence with recommendations

100 Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches.

All Pacific countries have increasing numbers of people working abroad and remittances are an increasing—and important—source of income, especially in Polynesia and Micronesia. Mobile workers include: uniformed servicemen (such as the military, police, security officers and peacekeepers); seafarers (particularly in Kiribati and Tuvalu); short-term contract agricultural workers¹⁰¹; health workers; truck drivers; and port workers. Pacific students study around the globe. Senior business people, politicians, civil servants and sports people¹⁰² attend international conferences, workshops and sporting events. At the same time, the growing tourism industry brings into the region people from all parts of the world.

Pacific Mobility

Fiji: Military coups in 1987 and 2000, aimed at strengthening the political control of ethnic Fijians, caused a sharp upturn in emigration by Indo-Fijians including doctors, nurses and computer specialists, to Australia, Canada and New Zealand. Indigenous Fijians are longstanding participants in UN peacekeeping forces, and professional rugby players in Australia, New Zealand and Europe.

Kiribati: Internationally-certified I-Kiribati seafarers are employed on vessels operating worldwide. They normally obtain renewable one-year contracts.

Samoa and Tonga: Large communities from these countries have lived in New Zealand for many years. There are also sizeable numbers in Australia and the United States, primarily employed in construction, and agriculture. Numbers living abroad exceed the local population in both countries.

PNG, Solomon Islands and Vanuatu: Emigration from these three countries has been small since independence, notwithstanding relatively low growth and high unemployment rates over long periods. The reasons for this may include the small numbers of skilled citizens, less pronounced links than Samoa and Tonga with New Zealand, the high percentage of the population living in rural areas where knowledge of jobs abroad is minimal, and the continued importance of the ‘wontok’ system whereby a relatively high percentage of earnings would need to be widely shared with neighbors.

Marshall Islands and Micronesia: It is estimated that up to 20,000 Marshallese and 30,000 Micronesians could be resident in Guam, Hawaii and mainland US. These citizens do not require visas and there are no restrictions on working in the US. Increases in emigration have been associated with decreases in Compact funds, which have limited public sector employment.

Palau: Palauan citizens also have unrestricted access to live and work in the US .

Source: IMF Working Paper, Remittances in the Pacific Region, Browne and Aiko Mineshima, 2007

101 In 2007 New Zealand began a pilot scheme for seasonal horticultural workers from Kiribati, Samoa, Tonga, Tuvalu and Vanuatu, and Australia is planning to follow.

102 The Oceania National Olympic Committees (ONOC) is developing an HIV care and prevention programme for the sports community, with the aim of establishing partnerships between National AIDS Committees and National Olympic Committees to work together on HIV and the prevention of NCDs.

Each of these quite distinct mobile groups has particular types of vulnerability to HIV¹⁰³. Especially in industries that are of critical economic importance to local populations (such as logging, mining and fisheries) mobile workers are known to be at particular risk of acquiring HIV. **Many of the early HIV infections in Kiribati and Tuvalu occurred among seafarers and their wives; and in Fiji and Papua New Guinea among military personnel and their wives.** Studies of other mobile male groups have found that high-risk sexual behaviour is common, often associated with alcohol and drug use¹⁰⁴.

Efforts directed towards HIV prevention for mobile workers generally commenced too late, across the region. A survey of seafarers in Kiribati found that almost one-third had at least one STI and 3.4% had two concurrent infections. When hepatitis B was included, 44% had at least one infection and almost 8% had two concurrent infections. Forty per cent of seafarers reported sex with a casual partner, with one-third of those men using a condom, and one in five had sex with a commercial sex partner, with 40% of these men having used a condom.¹⁰⁵ A follow-up survey found that slightly fewer seafarers reported having had sex with a sex worker or casual partner and condom use had increased, although it was still low at between 30% and 40% during last sex¹⁰⁶.

The practices and risk of HIV infection for uniformed services in the Pacific (including the RAMSI forces in Solomon Islands) are not adequately researched or understood¹⁰⁷. However, some programmes targeting men in uniformed services have evidently had some effect. **Papua New Guinea soldiers often use commercial sex workers (61% in the latest survey) but have a high level of condom use at 91%. However, condom use with a non-regular non-commercial partner dropped to 14%¹⁰⁸.**

3.9 Traditional cultural practices

Traditional cultural practices and the use of traditional medicines or other products are more common in some parts of the Pacific than others and remain outside formal systems. Those that can also pose significant risk of HIV infection include skin cutting, circumcision, subincision, superincision, penile insertions, scarification, tattooing, piercing and vaginal cleaning practices¹⁰⁹.

103 UNDP, 2009. Migration, Mobility and HIV-STI Vulnerability in the Pacific.

104 Oriente, R., 2006. HIV/AIDS and Pacific Island Regional Fishers and Seafarers: Information, Education and Communications Needs and Available Resources at the Secretariat of the Pacific Community; Jenkins, 1994. Behavioral Risk Assessment for HIV/AIDS Among Workers in the Transport Industry ; Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches, p 37.

105 WHO, Ministry of Health Republic of Kiribati, and the University of New South Wales, 2004. Prevalence of surveys of sexually transmitted infections among seafarers and women attending antenatal clinics in Kiribati , 2002–2003. Manila: WHO Regional Office for the Western Pacific. p 18.

106 WHO, 2006. Second Generation Surveillance of HIV, other STIs and Risk Behaviours in Six Pacific Island Countries.

107 Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches p 17 (citing Anang and Jenkins, 1998; Blair, 2005b; MacDonald, 2006; Tupou, 2004).

108 Burnet Institute, 2009. HIV in the Pacific, 1984–2007, p 59.

109 Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches, p 41.

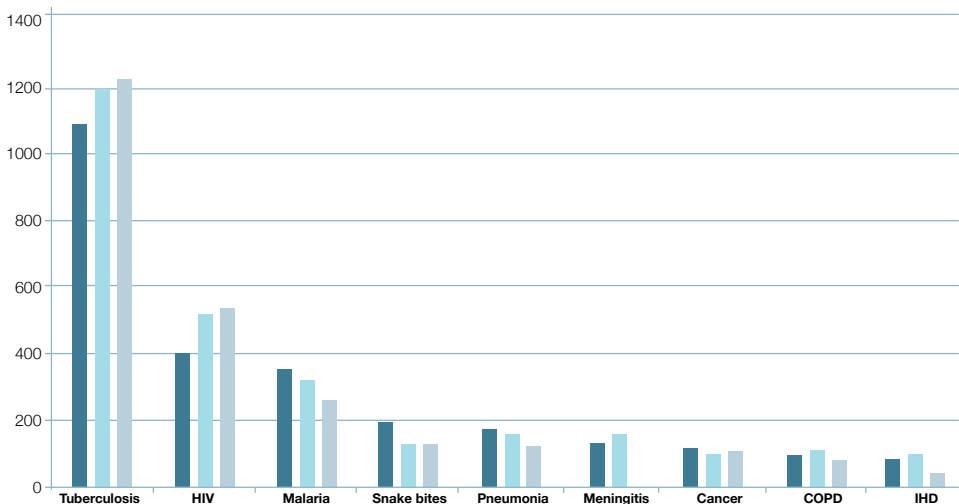
3.10 Impacts

To date little research has been undertaken to investigate the impacts of HIV and most of that work has been based on modelling¹¹⁰. Strong qualitative and quantitative research in this area is required, as a basis for general planning and the implementation of impact mitigation programmes.

Papua New Guinea's health system¹¹¹

An increasing proportion of hospital admissions in Papua New Guinea are HIV-related. **Between 2004 and 2008, the overall number of patients at Port Moresby General Hospital (PMGH) remained steady but the proportion with HIV-related illnesses increased from 9.3% to 12.9%**¹¹².

Figure 12: Port Moresby General Hospital Internal Medicine Common Causes of Admissions



Source: Lavu, E. 2009. *Analysis of the Impact of HIV and AIDS on the Health Sector in Papua New Guinea 2004–2008*, p 9.

HIV-related illnesses are contributing to rising hospital mortality rates, as is the extent of TB–HIV coinfection. **Between 2006 and 2008 the proportion of TB patients with HIV at PMGH almost doubled from 8.5% to 16.8%, as did their mortality (up from 7.4% to 14.8%)**. Meanwhile, the operational budget for the hospital has not increased over the past five years. Donors have funded additional staff but there has been no increase in space and patient facilities are overcrowded.

¹¹⁰ AusAID, 2002. *The Potential Economic Impact of AIDS in Asia and the Pacific*, prepared by the Centre for International Economics; AusAID, 2006c. *Impacts of HIV/AIDS 2005–2025 in Papua New Guinea, Indonesia and East Timor: Final Report of HIV Epidemiological Modelling and Impact Study*.

¹¹¹ Except where referenced, all health sector data comes from Lavu, E., 2009. *Analysis of the Impact of HIV and AIDS on the Health Sector in Papua New Guinea 2004–2008*.

¹¹² In the adult medical ward, the proportion of patients with HIV-related illnesses rose from 22.9% in 2006 to 26.9% in 2008.

Table 5: Patients with HIV-related illnesses in Port Moresby General Hospital

Year	Total Patients	AIDS-related	Percentage (%)
2004	4318	400	9.3
2005	4193	514	12.3
2006	4115	529	12.9
2006	1617	371	22.9
2007	1535	366	23.8
2008	1399	376	26.9

Source: Lavu E 2009 *Analysis of the Impact of HIV and AIDS on the Health Sector in Papua New Guinea 2004–2008*.

Note: 2006–2008, Ward B only.

Qualified staff remains in short supply. Many have left because of poor pay. The greater range of services, especially the increased number of blood tests conducted and counseling required, is demanding much more of rural nursing staff. Staff 'burn out' has become apparent at some clinics. **One obstetrician estimated that HIV had increased the antenatal clinic workloads by a factor of 10 because of the complexity of counseling, testing and prevention interventions.**¹¹³

The co-location of HIV and STI testing and treatment services is tending to crowd-out STI services. For example, the number of STI cases treated at the main STI centre – Heduru Clinic at Port Moresby General Hospital (PMGH) – dropped by almost half between 2003 and 2007. As ART treatment became available, staff cut back on the number of days that STI services were available.

Other hospitals in Papua New Guinea are experiencing similar problems. HIV services were added to the STI clinic at Mt Hagen Hospital in 2005. The clinic integrated antiretroviral therapy (ART) and voluntary counselling and confidential testing (VCCT) in 2006, prevention of parent-to-child transmission (PPTCT) services in 2007, and supervision of home based care (HBC) for ART patients in 2008. The clinic's staff supervises seven other HIV service centres throughout the province. The number of registered HIV patients has steadily increased. Over 800 people are now registered for ART. However, the only additions to clinic staff have been one medical officer (taking the total to two), one counsellor (taking the total to two), and four nurses (taking the total to six). St Joseph Migende Rural Hospital has also seen a marked increase in HIV-related admissions over the past five years, although HIV does not yet rank among the ten top causes of admission. HIV-related services have been increased to include prevention of mother-to-child transmission (PMTCT) and ART services. **Between 2006 and 2008, the number of VCCT clients rose almost 30% and antenatal VCCT rose by 43%. The introduction of PMTCT has improved the levels of supervised delivery to over 90%, helping to reduce maternal and infant mortality.** However, the few qualified staff struggle with the increased workload. Some trained nurses have left.

113 Duke 2008 "HIV in Papua New Guinea: The need for practical action, and a focus on human resources and health systems for women and children"

Table 6: New HIV-positive registration, Mt Hagen Hospital

Year	2006		2007		2008		Total
	Male	Female	Male	Female	Male	Female	
	182	152	198	235	181	267	1215

Source: Lavu, E. 2009. *Analysis of the Impact of HIV and AIDS on the Health Sector in Papua New Guinea 2004–2008*.

While the growing demand for HIV testing and treatment has highlighted problems in PNG's health system, the flow of funding to address HIV is also providing opportunities to address wider health system challenges. **Prevention of parent to child transmission (PPTCT) and ART treatment programs, for example, are helping to develop holistic maternal and child health programs.**¹¹⁴ Increased funding to health centres is generally improving the quality of services in some respects. More people are attending rural health centres, both with and without HIV-related conditions.

Formal employment

Absences, illnesses and deaths due to HIV can have profound implications for employment and the formal workforce. Research on these issues in the Pacific has been limited, other than in Papua New Guinea, which can provide vital lessons for the broader region.

Although no formal surveys have been undertaken in Papua New Guinea to assess the impact of HIV-related mortality on the public sector, anecdotal reporting suggests that it is taking its toll. **The education sector is claiming to have exhausted its repatriation budget in the first fiscal quarter due to an increase in employee mortality**¹¹⁵. Given that the greatest number of these HIV infections is in the most productive age group, it is likely that important skills and experience will continue to be lost.

Most mining companies have recognized the benefits of protecting the health of their workers and are playing an important role in HIV prevention and care. In 2004, all major private sector employment associations endorsed the Papua New Guinea application to the Global Fund to support the national HIV programme¹¹⁶. Assisted by the Papua New Guinea Business Coalition Against AIDS (BAHA) and UNDP, many private sector organizations have now developed workplace HIV policies.

One indication of the loss of workers to HIV is the increase in claims on both public and private sector worker superannuation schemes. An upsurge in early adult deaths can strain the budgets of these schemes. Papua New Guinea's superannuation fund NASFUND, the largest private sector superannuation fund, has tracked the impact of HIV and analysed the claims relating to AIDS and AIDS-related illnesses by category of employee. From January 2005 to June 2008, a gradual increase was seen in death

¹¹⁴ Lavu E. 2009. *Analysis of the Impact of HIV and AIDS on the Health Sector in Papua New Guinea 2004–2008*

¹¹⁵ Butcher, K., 2007. HIV Mainstreaming in Papua New Guinea, and its role in supporting good governance, p 161.

¹¹⁶ This application did not succeed, but was successfully resubmitted with modification the following year.

or terminal illness payments recorded as being AIDS-related and these figures may be higher, given that some deaths or illnesses attributed to TB or malaria may be related to HIV. Recent studies on the employment categories of death and disability claims reveal a concentration among professional, technical and clerical workers.

Table 7: NASFUND: Employment categories of claimants for HIV and AIDS-related illnesses and deaths

	Initial records (%)	'Unknowns' attributed to employment categories (%)
Security Guards	21	21
Mining	3	6
Maritime	7	9
Airline	5	5
Casual/Unskilled/Rural	10	21
Professional/Technical/Clerical	28	37
Unknown	26	1

Source: Mitchell, R., 2008, *Tracking HIV mortality and sickness benefit claims among formal private sector workers.*

Records of the Nambawan Superannuation Scheme for public sector workers show fluctuating numbers of processed death claims, with some suggestion of rising numbers (Table 8). **Separate records of AIDS deaths among public servants between 2005 and 2008 show that 15 national or provincial government departments recorded AIDS deaths. AIDS-related deaths have accounted for between 25% and 55% of total deaths from 2003 to 2008 and between 25% and 35% over the last three years** (with no evident concentration among any group of workers).¹¹⁷

Table 8: Nambawan Superannuation Scheme: Death claims from AIDS and AIDS-related causes, 2003–2008

Year	Membership	% increase over previous year	Death claims processed	% increase over previous year
2003	75,863		12	
2004	78,101	2.95	11	
2005	81,657	4.5	57	70
2006	87,372	6.9	180	68.3
2007	87,511	0.16	170	-5
2008	87,075	-0.5	74	

Source: UNAIDS analysis of data provided by Nambawan.

* Not all claims for 2007 and 2008 have been processed.

In 2009 the Commission on AIDS, BAHA, and the ADB HIV/AIDS Prevention and Control in Rural Development Enclaves Project surveyed 107 companies in Papua New Guinea with a combined workforce of 49,873. Twenty-five per cent of employers reported

¹¹⁷ UNAIDS analysis of data provided by Nambawan.

that **HIV was having a negative impact on productivity; 22% attributed loss of productivity to personal or family illness related to HIV; and 31% reported losing staff from these causes.** Three-quarters of employers expected that HIV would affect their companies within the next five years with the loss of staff or reduction in productivity, increased costs of recruiting and training replacement staff, and a loss of customers.

Due to the low level of formal sector employment, persons who have jobs often support a large number of dependants. At the petroleum site in Papua New Guinea, 50% of workers had between 6 and 11 dependants and another quarter had between 12 and 30 people, with 5% having 30 or more dependants. The plantation sites reported fewer dependants, perhaps indicating the differences in salary base and living conditions. Close to half (46%) of the plantation workforce had 5 or fewer dependants, just over a quarter had 6 to 8 dependants, and over ten per cent had ten or more dependants, with around five per cent having between 13 and 30 dependants. These data indicate the degree of impact at household and village levels if a worker is not able to maintain a productive economic role because of HIV infection or having AIDS¹¹⁸.

The Papua New Guinea experience shows that if action is not taken early with appropriate responses, HIV will have profound effects on the national developmental agenda and the broader economy.

3.11 Vulnerability of families

The absence of one single set of indigenous traditions in the Pacific—cultural and linguistic diversity between nations, and within some nations, being the norm—makes development issues, including HIV, complex. One commonality for Pacific cultures is the overwhelming importance of extended family and clan networks. They are the fundamental social safety networks and, historically, have been central in providing emotional support, health care and economic security to individuals and communities. In contemporary Pacific society, the interface between tradition and modernity has become complex as societies adapted to missionaries' influence, colonization and, more recently, ever more explicit socioeconomic and cultural globalization. This complexity has weakened safety networks and there are signs that the HIV epidemic is aiding the breakdown. **Stigma associated with HIV is isolating those affected by the virus, abandoning them outside of clan support. Anecdotal evidence tells of women in Papua New Guinea being “sent home” on the death of their husbands to AIDS, where previously they and their children would have remained with the husbands' clans.**

In Papua New Guinea, the HIV epidemic is already seriously affecting health and social systems, the workforce, and potentially, the economy. Efforts to quantify this impact, a necessary first step in responding to it, have already begun. **There are believed to be 3,730 orphans from AIDS in Papua New Guinea¹¹⁹.**

118 Aruwafu et al., 2009a. Behavioral Surveillance Research with More at Risk Populations in Rural Development Enclaves in Papua New Guinea: A Study at Oil Search Limited; Aruwafu et al., 2009b. Behavioral Surveillance Research with More at Risk Populations in Rural Development Enclaves in Papua New Guinea: A Study at W R Carpenters.

119 Papua New Guinea NAC and NDoH, 2007. The 2007 estimation report on the HIV epidemic in Papua New Guinea.

In addition, carefully-structured and sensitively-facilitated “community conversations” and other user-friendly methodologies are emerging as an effective toolkit for prevention and care within communities. Monitoring of outcomes needs to be a continuous process, so other countries can learn from the experience.

However, the personal impacts at microlevel on the household and family safety network are not well documented. Because the human face of the impact of HIV is experienced with such devastation at family and community levels, more attention must be given to support systems that strengthen families affected by HIV.

Lessons from limited qualitative research point to the importance of family and community's being involved in and feeling a sense of ownership of the HIV epidemic and responses to it in all Pacific nations, and especially in the countries with limited access to public health systems. Meaningful engagement necessitates a shift from project-type interventions to a sustained programme approach (by both governments and civil society) that engages communities to identify and address the underlying drivers of the epidemic, such as power relations, stigma, gender-based violence, and alcohol and drug use.

Planning for effective responses must take into consideration family structures typical of most Pacific nations. The constraints that the typical hierarchical family power structures place on youth leadership need to be understood so that youth participation is inclusive rather than marginalized in the community. In addition, the expansive network of the extended family and clan should be embraced to ensure that home-based care can have maximum beneficial impact.

Geua's story from Papua New Guinea (see Box) illustrates the human face of the importance, and the increasing vulnerability, of the family in Pacific societies.



Geua's story

Guea is married with two children. For four years her older sister Kara and her husband Musau lived with Guea's family until they died last year from AIDS related illnesses.

"Before she got sick, Kara had a job. She provided for us. [After] they got sick ...every now and then someone would bring us some food or throw K10 our way. There was no family or village support. Sometimes I would put my pride aside and send the kids to beg for rice from relatives. If not, then we had nothing. Sometimes some village people would bring garden food and we could cook that to feed the sick ones."

"We would be fetching water all the time, to wash them and their clothes which would always be soiled. When their bodies were still strong we helped them to the toilet. After that, we opened up a slat in the floor and they would do their business. We would wash it with seawater or soapy water. No one came to give me or the family a helping hand."

"People are scared. There is no reason for this. When people get malaria, we look after them; when people get TB, we look after them. It is all the same. Someone is sick and we do what we can to make them better again."

Source: Dobi Kidu, in Commonwealth Secretariat's forthcoming publication "The Economics of Dignity"

Chapter 4 The Pacific response

Key findings

- Pacific leaders acted early to support efforts to mitigate risks and vulnerabilities and maintain low levels of infections across the region. Even Papua New Guinea, while facing significant challenges, has not, despite earlier predictions, experienced the hyper-epidemics of some sub-Saharan African countries.
- Outdated legislation that criminalizes behaviours such as anal sex and commercial sex constitutes a barrier to effective prevention.
- Although legislative review and reform has been undertaken in some countries, many legal systems still do not provide adequate protection of the rights of people living with HIV.
- Regional planning processes and institutions have been emphasized at the expense of national ownership, cultural diversity, the maintenance of relationships and country implementation.
- Effective approaches to HIV require strong partnerships between governments, community-sector organizations (CSOs), faith-based organizations (FBOs), the sports and creative arts communities, the private sector and donors—with a commitment to consultation and joint decision-making under the leadership of National AIDS Committees or equivalent.
- Poor quality health services across much of the region restrict the capacity for HIV and STI diagnosis, reporting and treatment. Resources available for HIV prevention, treatment and care can provide an opportunity to strengthen overall health systems.
- Multisector national responses following the principle of the “Three Ones” (one framework, one coordinating mechanism and one monitoring and evaluation framework) need not require the establishment of stand-alone entities. In smaller island states, especially, these principles can be integrated into health or development processes. Greater integration of HIV and STI programmes is especially needed as STIs pose significant risk of HIV transmission.
- The cost of implementing HIV programmes is high in the Pacific. The mobilization of significant levels of funding for HIV in the past five years has helped to maintain current levels of low prevalence.
- The reliance on external funds can undermine national-level engagement. More effective use of resources and improved aid effectiveness is critical to improving aid harmonization (between donors and regional organizations) and alignment (with national systems and priorities) to strengthen the effectiveness of aid, reduce duplication and significantly improve the use of available resources.
- Pacific countries are vulnerable to the global financial crisis—especially if it has a severe impact on donor funding levels—in light of the increasing challenges of providing adequate social services and meeting the needs of vulnerable groups.

4.1 Introduction

Previous chapters have highlighted the key challenges to addressing HIV in the Pacific. In this chapter the Commission has collected and analysed a range of national and regional information to examine whether the different responses across the Pacific to these significant challenges have been effective in making an impact on the epidemic. It also examines current funding levels for HIV, future funding needs and aid effectiveness.

PACIFIC RESPONSES

4.2 Leadership and accountability

Global experience shows that strong and effective leadership is critical if the HIV epidemic is to be stemmed. **Pacific leaders can be complimented for acting early to support efforts to maintain low levels of infections across the region.** Even Papua New Guinea, while still facing significant challenges, has not, despite earlier predictions, experienced the scale and intensity of the hyper-epidemics of some of the sub-Saharan African countries. **But it is essential for leaders across the region to be more actively engaged if they are to translate regional political commitments into more effective national action through enhancing public policy, strengthening the enabling environment and programming health and social services.** Varied responses across the region have seen some leaders acting early to keep HIV at low levels, while others have allowed the HIV epidemic to overtake the response.

In a survey of perceptions conducted by the Commission¹²⁰, less than nine per cent of respondents considered that there was a high level of political commitment to HIV. There were a number of perceived reasons: a lack of HIV awareness among various actors in governments; low levels of accountability of governments against previous HIV/AIDS commitments; insufficient capacity for governments to administer the HIV response; inability of CSOs to hold governments accountable; a perception that donors are driving and funding HIV programmes, obviating the necessity for national resources; and lack of personal leadership by politicians.

With exceptions, the perception is that some political leaders have been largely silent in protecting the rights of people most vulnerable to and affected by HIV. There are some signs that this is changing. In Papua New Guinea the establishment of Parliamentary networks—the Special Parliamentary Committee on HIV and AIDS in 2003 and the establishment of Papua New Guinea Parliamentarians on Population and Development (PPD) in 2008—is helping to sensitize politicians to the complexity and severity of the epidemic.

Pacific leaders have, however, demonstrated strong commitment at the regional level. They approved a regional strategy to combat HIV and AIDS in 2004 and re-committed to it through the Pacific Plan in 2006. More recently, the Pacific Parliamentary Assembly on

120 Commission on UNAIDS in the Pacific, 2009. A total of 124 responses were received from fifteen countries, the majority of them from Papua New Guinea and Fiji.

Population and Development (PPAPD) endorsed two Champions for HIV/AIDS advocacy work at regional and global levels¹²¹.

4.3 Legal frameworks

Many Pacific island countries have a legacy of legislation from their colonial pasts that criminalizes behaviours such as anal sex and commercial sex. Although legislative review and reform in some countries has improved, most legal systems in the region still do not provide adequate protection of the rights of people living with HIV.

Although unevenly applied, the existence of penal laws can lead to fear of prosecution and have the effect of deterring people from accessing HIV education and prevention services. Sex workers in Papua New Guinea, for example, are sometimes picked up by police and forced into sex under threat of prosecution, sometimes amounting to serious gang rape. The Three-Mile Guesthouse Raid is an extreme example of such police harassment¹²².

A legal framework review of fifteen Pacific Island Countries found that eleven criminalize male to male sex between consenting adults and that none of the countries of the region prohibit discrimination in employment based on sexual orientation or gender identity¹²³. Fear of stigmatization, discrimination and legal retribution reduce access for MSM to HIV prevention services, especially those specifically targeted towards them such as awareness campaigns regarding HIV, condom use and VCCT services¹²⁴. The creation of conducive and enabling legal environments throughout the Pacific will enable dissemination of MSM-friendly prevention messages and accessible treatment, care and support services¹²⁵.

Legislation across the region generally provides terms of imprisonment for people who intentionally cause the infection of another person with a notifiable disease (including HIV). All countries have a **Public Health Act (or equivalent)** that provides for the control of “infectious”, “contagious” or “notifiable” diseases (refer to Attachment 4 for country-specific details). Mostly drawn up in colonial times, **these Acts usually provide wide powers to public health authorities, impose heavy duties on infected people and others who must notify and take precautionary measures – but rarely give privacy to people who are subject to these provisions.** Most of these Acts require a degree of mandatory testing, especially for groups of people such as immigrants or non-citizen workers, workers recruited to overseas employment (such as seamen), prisoners, the

121 PPAPD, 2008. The Honiara Communique on Effective Governance and People-Centred Development.

122 Stewart, C. (2005). Sex, Gender and The Law in Papua New Guinea, p 3. In this case, there were mass arrests of almost everyone on the premises, who were then paraded through the streets of Boroko to the police station. The women were forced to chew and swallow condoms, blow them up, and wave them above their heads while a crowd of onlookers heckled them

123 Ottoson, D (2008). State sponsored homophobia: A world survey of laws prohibiting same sex activity between consenting adults. (Cook Islands, Kiribati, Nauru, Niue, Palau, Papua New Guinea, Solomon Islands, Tokelau, Tonga, Tuvalu, Samoa)

124 James, R (2008). Stigma and discrimination by health care workers towards people living with HIV and AIDS in developing country settings.

125 Kirby, M (2009). MSM: Action, Not more words. Speech given at the 9th International Congress on AIDS in Asia and the Pacific, 11 August 2009.

uniformed services, and people health officials suspect may have HIV. Antenatal women are also routinely tested.

Some governments enact wider legal powers. The Marshall Islands, for example, also includes mandatory testing for blood and organ donors, food handlers, all aliens, high school students, visitors who stay more than 30 days, and citizens who have been overseas for five years or more (though it is not clear whether this test is implemented). Such powers are seldom used as most public health officials view them as inappropriate, counterproductive and in conflict with constitutional rights. However, in many cases the legal qualifications on confidentiality fall short of international human rights standards.

Over the past decade legislation has gradually changed to bring the legal environment for HIV into better alignment with the rights enshrined in national constitutions and national HIV plans. In Fiji, for example, the Prisons and Corrections Act (2006) disallows mandatory HIV testing and segregation, and protects confidentiality for HIV-positive prisoners. **Papua New Guinea has the most comprehensive HIV-specific legislation in the region. The HIV/AIDS Management and Prevention Act (the HAMP Act):** includes a declaration that HIV is not a venereal disease (thereby excluding Public Health Act provisions relating to venereal disease); forbids HIV-related discrimination; ensures partner notification; forbids mandatory testing (except in emergency situations); requires that information about a person's HIV status be kept confidential; and guarantees access to protection from HIV infection (specifically including the use of condoms). However, as ordinary people find the court system difficult to access, the provisions under the HAMP Act have rarely been enforced and there has not been a successful case of prosecution under the Act¹²⁶.

4.4 Pacific health systems

Vulnerable and poor-quality health services across much of the region restrict the capacity for HIV and STI diagnosis, reporting and treatment¹²⁷. Service delivery is generally less effective in rural than in urban areas. Unreliable blood supplies, inadequate or expired stocks of condoms, limited access to HIV counselling and testing, information, drugs and other reproductive and sexual health services—these are common problems in rural and remote areas throughout the region¹²⁸.

In a region with high levels of communicable diseases and an increasing noncommunicable diseases burden, the urgent need for strengthening the health system means that consideration should be given to integrating health sector programming away from its current predominant focus on disease. Inevitably, this focus shift would involve trade-offs and choices in responding to different health priorities. Some of the significant opportunities

126 Howse, G., 2008. Accessing rights and protections under the HIV/AIDS Management and Prevention Act in Papua New Guinea: Making a case for granting a limited jurisdiction to the Village Courts. Personal communications with Commission members during their visit to Papua New Guinea.

127 Tukuitonga, C., 2007. Population Health in the Pacific Region – A Situation Analysis.

128 Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches: citing MOH Cook Islands, 2004; RMI Ministry of Health, 2006; Vanuatu Ministry of Health, 2004; SINAC et al., 2005; UNFPA, 2004; IRG, 2008.

for relatively high levels of HIV funding could be used to support strengthened health sector responses, through health worker training, refurbishing health centres, strengthening procurement and distribution systems and improving surveillance. Integration of HIV programmes is especially relevant in those countries with a lower HIV burden. Working in partnerships with alternative systems of service delivery is another possibility in countries with weak and neglected health care systems (such as through faith-based organizations in Papua New Guinea).

Integrating HIV with sexual and reproductive health and tuberculosis programmes and strengthening health systems are already being emphasized quite strongly, but this needs to go further. Both the Global Fund and the Secretariat of the Pacific Community (SPC) are promoting the integration of HIV with reproductive health and STI services. The Australian government has also committed increased funding to health systems in its Pacific HIV response. This includes focusing more on developing and strengthening primary care health services, home- and community-based care, training for healthcare workers, community participation in planning and delivery, laboratory strengthening and improvement of epidemiological surveillance capabilities¹²⁹.

The supply and distribution of condoms is of particular concern. In 2006, inadequate supplies and system slowness in the distribution of condoms to countries was reported for Kiribati, Solomon Islands, Marshall Islands, Vanuatu, Tuvalu and Nauru¹³⁰. Slowness in distribution within countries leaves some areas out of stock, even when condoms are available at the national level¹³¹. Lack of condom supplies at the country level provides little choice and weakens the creation of an enabling environment for behavioural change, highlighting an urgent need to study condom systems and distribution. **Procurement and distribution systems are likely to improve since the establishment in 2008 of a regional medical equipment and supplies service through the Fiji Pharmaceutical and Biomedical Services Centre.**

In Papua New Guinea, health services are particularly poor and declining. Universal infection control measures are poorly applied¹³². Care for HIV-positive patients is limited in hospital settings. Some faith-based organizations (FBOs) and other civil society organizations (CSOs) have established community care facilities but coordination between community and hospital-based care, and between district, provincial and national hospitals must be strengthened. In Papua New Guinea, ATprojects Inc has developed low-cost technologies to help families care for people living with HIV.

A public–private partnership between a number of private sector organizations, the ADB Rural Development Enclaves Project and the provincial government provides prevention and treatment for workers and surrounding communities.

129 AusAID, 2009. Intensifying the response: Halting the spread of HIV. Australia's international development strategy for HIV, Canberra.

130 Buchanan-Aruwafu, H., 2007b. An Integrated picture: HIV Risk and Vulnerability in the Pacific: Research Gaps, Priorities and Approaches.

131 Roberts, G., 2005. Condom Programming: Rapid Needs Assessment for the Pacific Region. Unpubl. report. UNFPA, Suva.

132 Papua New Guinea National AIDS Council Papua New Guinea, 2006. Papua New Guinea National Strategic Plan on HIV/AIDS 2006-2010, p 16.

This is developing as a model for delivering services to remote and inaccessible rural areas¹³³.

HIV-positive people, because of their unique experience and knowledge of HIV, should be welcomed in paid employment as counsellors, and to provide home-based care and community support. A number of CSOs have established such programmes¹³⁴.

4.5 Planning and coordination

Planning

With the exception of Papua New Guinea, most national programmes have been based on Pacific regional HIV strategies and workplans that have been funded by donors. Many of these resources have been directed towards workshops, conferences and training to analyse the situation, draft plans and prepare implementation strategies. Unfortunately, most HIV plans produced since the late 1990s have not proceeded past an initial draft; even fewer have been implemented to any extent; and fewer still have been evaluated as to their impact on the epidemic. These plans were often complicated and ambitious and usually unrelated to the number of known HIV infections in any country (Attachments 5 and 6). However, these processes have made a strong contribution by including wider groups of people in, and developing broad commitment to, the challenges of HIV in the region.

The Pacific Regional HIV and STI Strategy 2004–2008, developed by SPC and Pacific Islands Forum Secretariat after extensive consultation, was directed at supporting national HIV, AIDS and STI efforts while strengthening the capacity of regional organizations to coordinate their work, funding and partnerships with national programmes. The Strategy's Implementation Plan (PRISIP) aimed to oversee regional coordination of the activities of CSOs, governments, donors, multilateral agencies and communities, as well as to help build their capacity to implement programmes. **Despite the best efforts of regional and international organizations to respond to country needs, the PRISIP was not without critics. Better, thought some of them, to allow the plan to be driven much more by what the individual countries themselves felt were their needs, keeping donors' and multilateral agencies' implementation plans separate.** PRISIP did, however, provide a basis from which the region was able to succeed in accessing expanded donor funding for HIV¹³⁵.

A recent review of AusAID-funded HIV programmes in the Pacific concluded that the development of national HIV and STI strategic plans was one of the more challenging areas of providing support. **A new regional implementation plan, PRISP II for 2009-2013, aims to provide a regional framework with detailed implementation and**

133 Independent Review Group on HIV/AIDS, 2008b. Report from an Assessment Visit 27 August – 9 September; IMRG, 2008. Report No 4.

134 Leach, T, et al., 2006, The Involvement of People with HIV in Papua New Guinea's HIV Response: A review of the implementation of the Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA) Principle in Papua New Guinea.

135 IDSS, Burnet Institute and SPC, 2008. Pacific Regional HIV/AIDS Project Project Completion Report. p 33.

management plans residing at the country level. It is a complex arrangement involving 40 members and 20 implementing agencies and challenges remain in transferring the focus of activities from the regional to national and local levels, and particularly to targeted in-country HIV prevention programmes. **To date, limited funds have been directed specifically to prevention activities among groups such as seafarers, MSM and sex workers.** But there is optimism that PRISP-II will be more inclusive and country-focused than its predecessor.

National strategic plans will be more effective if countries themselves develop them, in order to match their specific situations and priorities. This affects the timing, process and content of the plans, which cannot be driven by the timelines of regional agencies or donor partners. The challenge is to harmonize and cost plans at national and regional levels—with regional plans providing an agreed Pacific framework for tailored in-country implementation in line with national priorities. The National Strategic Planning workshop in Tonga in 2008 is an example of a coordinated approach to support country-level implementation with assistance from regional and international agencies (PRHP, SPC, WHO, UNAIDS and UNICEF).

Coordination

Multisectoral responses are critical to the effective combating of HIV. This means strategic engagement at all levels of Pacific societies, with each sector responding to HIV in a way that reflects its comparative advantage. Each agency or key stakeholder group determines how it may be affecting the HIV epidemic; how HIV may be affecting its development outcomes; and how its activities can best respond to HIV. In the education sector, for example, sex education can be incorporated into curricula, with teachers instructing in an open and non-judgmental way.

To improve national coordination and harmonization of HIV programmes and avoid duplication of efforts, the UNAIDS “Three Ones” policy supports development of a country-specific HIV and AIDS action framework (either stand-alone or within national development or sector plans), a national coordinating mechanism and country-level monitoring and evaluation. In smaller Pacific countries, especially, frameworks and monitoring and evaluation arrangements can be integrated into national health plans or development strategies. For example, HIV coordination could be undertaken as a standing issue at Cabinet meetings, as already happens in Kiribati.

Most Pacific countries in the region have established national HIV coordination bodies to strengthen multisectoral responses. However, a recent AusAID programme review noted that: ‘The coordination role of NACs, while improved in **many countries, is still often performed inconsistently. The relationship between CSOs and government agencies also varies in strength across the region and has been a significant problem in some countries**’¹³⁶.

136 AusAID, 2008e. Project Regional HIV/AIDS Project, Independent Completion Report, p vii.

With the introduction of the Global Fund, Country Coordinating Mechanisms (CCMs) have also been established (as part of funding eligibility) in Cook Islands, Federated States of Micronesia, Fiji, Kiribati, Niue, Palau, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu, as well as one in Papua New Guinea, but **it is not clear how the CCMs engage with NACs.**

At a regional level, the Global Fund's Pacific Islands Regional Coordinating Committee (PIRCCM), which includes government and nongovernment representatives from 13 participating countries, supports coordination of the activities funded by the Global Fund. The recently-established Pacific Response Fund, principally supported by AusAID and NZAID, is another coordination mechanism that aims to help identify priorities and guide technical support. Both PIRCCM and the Pacific Response Fund are housed at SPC, a co-location that may further support improved regional coordination for stronger national impact. However, there is some apprehension that these structures overlap and reflect duplication and competition between donors.

National AIDS Council of Papua New Guinea

The Government of PNG established the National AIDS Council (NAC) and its Secretariat by an Act of Parliament in December 1997. Unfortunately, the NAC did not meet for two years and was re-established in October 2008 following an amendment to the NAC Act in 2007. The NAC Secretariat (NACS) has been affected by poor performance and poor leadership. A recent review by the Independent Review Group stated that: 'It appears that any current progress being made in responding to the epidemic is being made in spite of NACS rather than as a result of its efforts. NACS is currently seen as essentially non functional...The paralysis appears to be due largely to longstanding, poor and unaccountable management within NACS, coupled with resistance, amongst a significant number of NACS managers, to the authority now being exerted by the NAC'.¹³⁷

The scarcity of Government resource commitment to the epidemic in comparison to externally-driven efforts has undoubtedly contributed to the low morale and disintegration of the NACS. The recent appointment of high-profile local identities to the National AIDS Council and the Global Fund CCM in 2009 is beginning to show signs of revival and renewed commitment of the NACS.

Aligning regional mechanisms with national priorities

These planning and coordination challenges highlight the tension between regional approaches and national ownership and service delivery: a "one-size-fits-all" solution is simply not viable in the Pacific. Guided by the Pacific Plan, Pacific regional organizations are attempting to focus their programmes more sharply on providing resources to help countries achieve their development priorities¹³⁸. This recognizes that, given the unique challenges in the Pacific, the pooling of resources through regional or subregional mechanisms to achieve economies of scale can help enhance national development prospects. For example, for the smaller countries, surveillance, training for healthcare

137 Independent Review Group on HIV/AIDS, 2008b. Report from an Assessment Visit 23 April – 6 May 2009
p 18

138 Baaro, M, 2009. The Pacific Plan: The First Three Years.

workers and procurement may best be undertaken at a regional level based on national assessments of need and capacity. But donors and regional agencies must consult more meaningfully with governments on how regional mechanisms can best meet national requirements (e.g. training, technical advice). For an effective HIV response, national coordination must remain the responsibility of national governments in line with national planning processes and in partnership with community groups.

Regional collaboration on the procurement of HIV-related pharmaceuticals and health equipment has improved in recent years. Small countries can now purchase items they could not otherwise access at reasonable prices. Fiji Pharmaceutical Services, which manages the procurement and distribution of antiretroviral treatment, rapid diagnostic tests and STI drugs for the entire region, has established relationships with customs clearance and shipping agencies in Fiji for regional redistribution.

As an intergovernmental organization, the Secretariat of the Pacific Community (SPC) plays a major role in coordinating and managing the regional HIV response. It is the principal recipient of the Global Fund, manages PRSIP, houses the ADB regional programme, is secretariat of the PIRCCM, and manages the Pacific Response Fund. Although coordination has improved in recent years, the management of such a range and number of projects and funding mechanisms does pose significant challenges. Staff numbers of the STI and HIV section have grown from two to 26 in only a few years, overshadowing SPC's broader Public Health Programme. Coordination problems of different sections located in Noumea and Suva are now being addressed by co-location.

Respondents to the Commission's community perceptions survey noted that the SPC was appreciated for its regional leadership and the provision of technical and financial support. Respondents suggested that SPC could strengthen its response by greater dissemination of information, closer coordination with other stakeholders in the region, the inclusion of more Pacific nationals for capacity development, and greater sharing of information about which organizations they are working with. SPC's establishment of country strategies and in-country focal points will strengthen these processes.

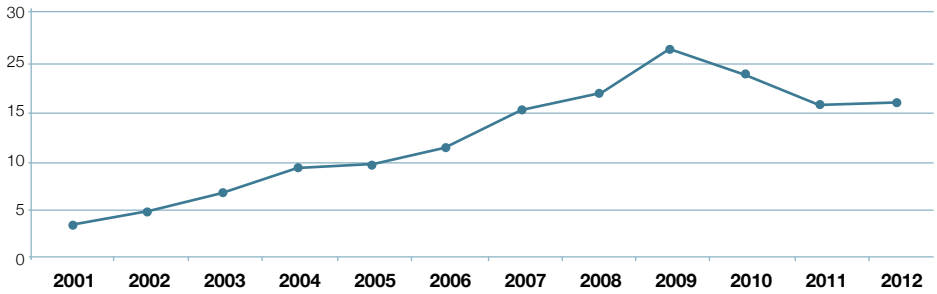
FUNDING LEVELS, NEEDS AND AID EFFECTIVENESS

4.6 Funding for HIV in the Pacific

Levels of aid

The Pacific has mobilized significant levels of external funding in the past five years to combat HIV—a significant achievement of which countries should be proud. Between 2001 and 2009 funding for HIV activities in the region increased more than fivefold (Figure 13). **More than US\$ 77 million was available for HIV activities in Papua New Guinea and the Pacific in 2008.** Approximately 88% was allocated to Papua New Guinea, which has two-thirds of the region's population and 96% of detected HIV infections. Another notable issue emerging from this data is the massive reliance on external funds, more than 95% in most years. While it is acknowledged that some data are missing (including Fiji's FJD 500,000 contribution in 2007) domestic spending on HIV activities is currently extremely low in the Pacific (Table 9).

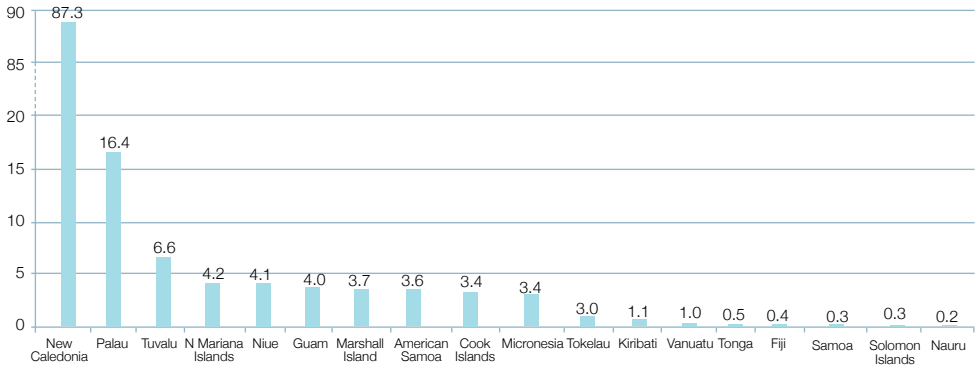
Figure 13: Pacific HIV allocation (including Papua New Guinea) from all official sources, 2001–2012 (US\$ millions)



Source: UNSW Global, 2009. *The Effectiveness of Financing and Aid Coordination in Responding to the HIV Epidemic in the Pacific Region*, p 25.

Note: These figures do not include household or private sector spending.

Figure 14: Annual HIV funding per capita, 2004–2007 (from PRHP, US Government, Global Fund and New Caledonia)



Source: UNSW Global, 2009. *The Effectiveness of Financing and Aid Coordination in Responding to the HIV Epidemic in the Pacific Region*, p 29.

Note: Like Australia, the US and France, New Caledonia contributes funds to SPC programmes additional to its membership contribution.

Table 9: Per capita ODA, Total external expenditure on health and HIV as percentage (US\$ – 2005)

Country	ODA received per capita 2005	External expenditure on health per capita 2005	External expenditure on HIV per capita – as % of external expenditure on health
Cook Islands	554.2	103.9	3.3
Fiji	76.8	9.6	4.2
Kiribati	302.2	29.8	3.7
Marshall Islands	996.1	143	2.6
Nauru	889.1	7.7	2.6
Palau	1164.1	146.4	11.2
Papua New Guinea	43.9	5.1	172.5
Samoa	238.4	14.1	2
Solomon Islands	419.5	22.7	1.3
Tonga	319	36.2	1.4
Tuvalu	856.2	37	17.8
Vanuatu	183.1	15.6	6.4
Guatemala	19.8	2.8	17.9
Indonesia	11	0.6	33.3
Namibia	60.2	48.3	41.0
Nepal	15.7	2.5	12.0
Tanzania	38.8	11.2	38.4

Source: UNSW Global, 2009. *The Effectiveness of Financing and Aid Coordination in Responding to the HIV Epidemic in the Pacific Region*, pp 51–52.

It is important to note the extremely high costs of working in the unique Pacific context. Geographic isolation and remoteness, unreliable and costly transportation options, poor economies of scale, and limited human resources combine to weaken the implementation of programmes across the region. The standard costs of establishing and sustaining an effective HIV response, regardless of population size, include health promotion and prevention activities, HIV testing, laboratory establishment and maintenance, capacity development of national staff, and treatment. As well, HIV funding levels need to be balanced against the need for the region to access sufficient funding to maintain current levels of low prevalence and reverse the trend of the epidemic in Papua New Guinea.

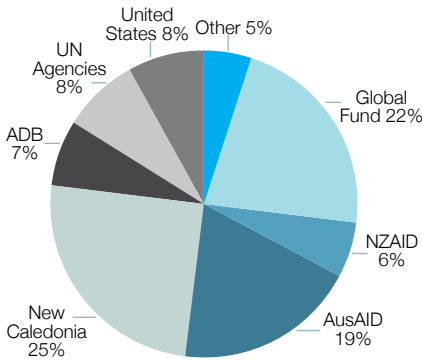
Funding sources

Pacific (excluding Papua New Guinea)

While some Pacific governments have made contributions to their HIV programmes, **international donors have provided more than 95% of the resources for HIV programmes across the region.** This situation carries some disadvantages as funding for HIV has fluctuated and can be vulnerable to changes in donor priorities. Some programmes (notably the Global Fund) operate on five-year funding cycles, but other development partners (such as AusAID, UNAIDS, WHO and UNFPA) cannot guarantee

financing beyond one or two years. This uncertainty undermines long-term planning and has a negative effect on activities that require consistent and predictable funding, particularly ARV treatment and prevention activities. Dependence on external funding can tend to undermine any national sense of ownership and local commitment. Lack of funding predictability is also at odds with multiyear donor commitments under the Paris and Pacific Aid Effectiveness Principles and the Accra Agenda for Action.

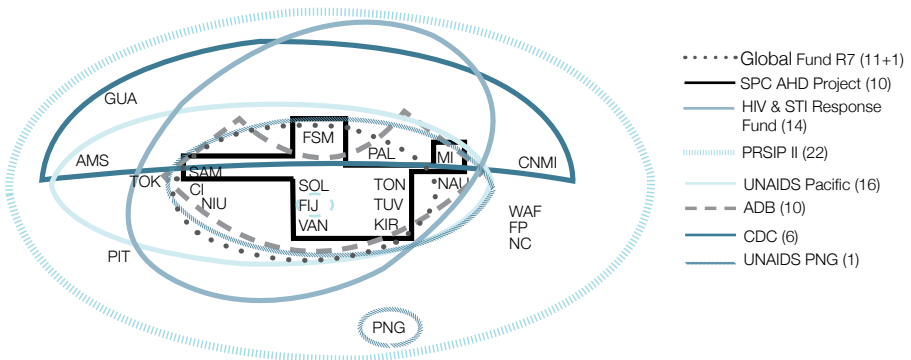
Figure 15. Source agencies to the Pacific (excluding Papua New Guinea) by percentage contribution



Source: UNSW Global 2009. *The Effectiveness of Financing and Aid Coordination in Responding to the HIV Epidemic in the Pacific Region*, p 28.

The main regional funding mechanisms in the region are the Global Fund, the Response Fund (funded by AusAID and NZAID) and the HIV/AIDS Prevention and Capacity Development Project (ADB)¹³⁹. The numbers of Pacific countries participating in these mechanisms vary (Figure 16).

Figure 16: Countries Covered by Regional Projects and Organisations



The US and French governments channel most of their assistance to their territories. US funds to American Samoa, Guam, Marshall Islands, Northern Mariana Islands, Federated

¹³⁹ As members of multilateral agencies and banks, Australia, the US and France are also key funding agents for the Global Fund and UN agency and ADB HIV programmes.

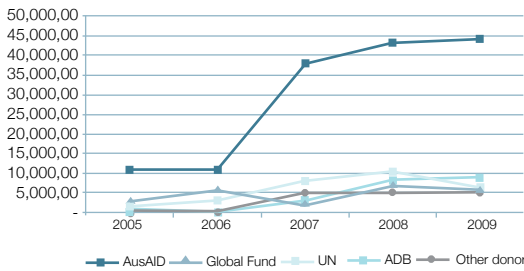
States of Micronesia and Palau dwarf those disbursed by Pacific regional programmes. French funding to New Caledonia, French Polynesia and Wallis and Futuna is also high¹⁴⁰. Over US\$ 5 million is spent annually on HIV activities in New Caledonia and, possibly, a similar amount in French Polynesia¹⁴¹.

The French government also contributes to regional programmes through SPC.

Papua New Guinea

Papua New Guinea receives its funding through separate mechanisms from the rest of the Pacific, most of it directly from AusAID, the Global Fund and ADB (Figure 17).

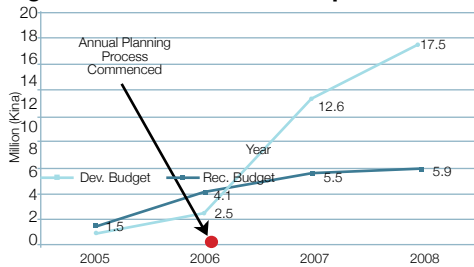
Figure 17. Donor financing of the HIV response in Papua New Guinea by source by year (A\$)¹⁴²



Source: UNSW Global, 2009. *The Effectiveness of Financing and Aid Coordination in Responding to the HIV Epidemic in the Pacific Region*, p 44.

The national recurrent government contribution to the HIV response has increased significantly by almost 400% from 2005 to 2008 (Figure 18). There was, however, a significant drop in 2009.

Figure 18: Government of Papua New Guinea Funding for HIV Response



Source: UNSW Global, 2009. *The Effectiveness of Financing and Aid Coordination in Responding to the HIV Epidemic in the Pacific Region*, p 44.

140 HIV financing information by country was available from only a few funding sources. These include: PRHP (which includes substantial amounts of Australian, New Zealand and French funding), Global Fund and US government data. Data available are from 2004 to 2007 and cover only the countries that receive funding from those sources. ADB and UN funding is not available by country as some of these funds are provided at regional level and no country-level participation data are available.

141 Precise figures are not available.

142 Government of Papua New Guinea data from NAC Secretariat. Donor data from UNAIDS Papua New Guinea and AusAID. 2009 data for GoPapua New Guinea are not available.

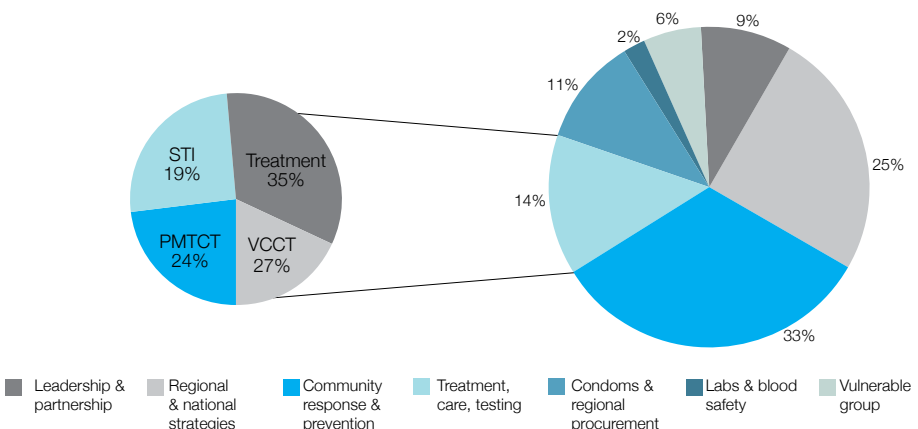
Funding flows

Pacific (excluding Papua New Guinea)

Most donors have preferred channelling of funds through regional agencies because capacity constraints in many Pacific countries can make it difficult to expend allocated funds fully. Some Pacific officials have been critical of this approach. Under the previous Global Fund Round 2 programme, almost two-thirds (61%) of funding was allocated to regional systems, predominantly through SPC. This occurred despite commitments that 53.2% of funds would be channelled to government agencies, 32.5% to NGOs, 7.7% to SPC, 5.4% to academic institutions, and 1.2% to PLHIV. Pacific governments noted a similar bias towards regional systems in the early stages of the PRHP. The Round 7 Global Fund grant now provides 85% of funding towards building national systems and appointing HIV coordinators in each country to improve the management and coordination of HIV programmes¹⁴³.

Even with these efforts to target HIV funding better there persists a gap in support for on-the-ground prevention activities among high-risk individuals and groups. Global experience shows that civil society organizations are best placed to implement HIV prevention and care programmes and should play a major role in supporting treatment. In the Pacific, CSOs have received support from some mechanisms, particularly PRHP and, to a lesser extent, the Global Fund. Otherwise, relatively little funding has gone directly to local organizations, particularly to faith-based organizations (FBOs). Some of the US funding channelled through local government bodies filters through to CSOs and community groups.

Figure 19: Spending on HIV Activities in the Pacific by Focus Area, 2005–2008 (US\$) cumulative) (PRSIP data only)



Source: UNSW Global, 2009. *The Effectiveness of Financing and Aid Coordination in Responding to the HIV Epidemic in the Pacific Region*, p 32.

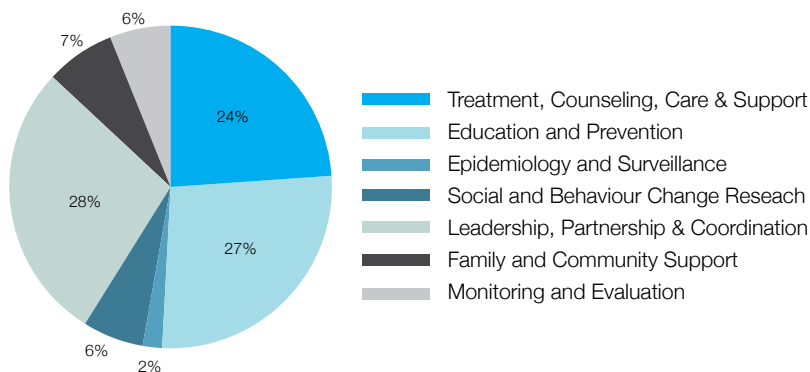
143 UNSW Global, 2009. *The Effectiveness of Financing and Aid Coordination in Responding to the HIV Epidemic in the Pacific Region*, p 12.

The competitive grant programme of PRHP provided 32 per cent (totalling A\$1,191,511) of its funds for targeted prevention, including MSM and transgender groups in Fiji and Samoa; sex workers in Fiji, the Marshall Islands, Vanuatu and the Solomon Islands; taxi drivers in Palau and Solomon Islands; and prisoners in Fiji and the Marshall Islands. **The ADB's HIV/AIDS Prevention and Capacity Development in the Pacific project focuses on vulnerable groups and, specifically, seafarers. US\$1.092 million is targeted to affected groups, including PLHIV.** Additional funds have been made available by NZAID, AusAID and the UN for targeted prevention activities. Global Fund Round 2 also provided funds for prevention among vulnerable groups but only approximately US\$60,000 went to peer education among vulnerable groups and prevention among seafarers from a total budget of around US\$3 million.

Papua New Guinea

In Papua New Guinea, an analysis of groups receiving funding as of December 2007 (from the Government, AusAID, NZAID, UN and GFATM) showed that 65% of funding went to government bodies, 16% to international NGOs, and 11 % to church groups.

Figure 20: Allocation of funding in Papua New Guinea



Source: UNSW Global, 2009. *The Effectiveness of Financing and Aid Coordination in Responding to the HIV Epidemic in the Pacific Region*, p 48.

It is difficult to undertake a systematic financial analysis of the HIV programme in PNG. The Independent Review Group has identified a number of concerns with the planning, budgeting and financial reporting processes for 2009:

- **The budget lacks any description of major activities to be implemented and achievements expected from 2009 resources.**
- **The budget is a compilation of budgets submitted by implementing agencies, from NGOs and provinces. It therefore fails to prioritize programmes or geographic areas. It appears that no consideration is given to whether the allocation of funds matches the priorities.**
- **The consolidated resource framework lacks details of funding to major government departments, e.g. NDoH and NDoE.**

- **There is no mechanism to track actual expenditure. As a result, Papua New Guinea failed to report on this UNGASS indicator in 2008, stating that “in the absence of a proper National AIDS Spending Assessment, it was extremely challenging to collect information regarding what was actually spent on the national response to HIV. Efforts made from October to December provided a very incomplete set of data that makes analysis and commenting impossible.”**

The Independent Review Group (IRG) notes “the need to move away from a budget development process which is driven by available finances and/or organizational needs to maintain specific programmes towards one which is based on ambitious targets to effectively combat the epidemic in Papua New Guinea”¹⁴⁴.

4.7 Absorptive capacity

The extent to which countries and regional agencies are constrained by their capacity (i.e. their limited “absorptive capacity”) makes it hard for them to utilize allocated funding fully. This has become more apparent with the relatively high levels of HIV funding in the region. Between 2003 and 2005, only 63% of Global Fund grants were disbursed and less actually used, leading to an eventual reduction in the grant. PRHP disbursements followed a similar course. By the end of 2007 (the fourth year of the five-year programme) only 60% of its grant funds and 50% of its competitive grants had been disbursed¹⁴⁵. This is often due to challenges associated with national management and technical capacity. Support to small, less experienced CSOs can slow implementation but donor investments in strengthening management capacity of CSOs is expected to strengthen community-based treatment and care in the longer-term¹⁴⁶.

In Papua New Guinea, with high levels of funding available for the HIV response, the challenge is to use resources effectively, especially in rural areas. Both government and donors have noted that too much attention has been given to national policies and not enough to service delivery. The Global Fund has cautioned that its grants to Papua New Guinea are at risk due to poor delivery and the inability to meet indicators and keep appropriate financial records. The IRG notes that many programmes are unable to spend their budgets:

- By July 2008, the National AIDS Council Secretariat had expended only 24% of its 2008 government development budget and still had more than K1 million unused from 2007.
- By the end of June 2008, the Health Sector Improvement Programme had spent or committed only 20% of its annual budget.

¹⁴⁴ Independent Review Group on HIV/AIDS, 2008b. Report from an Assessment Visit 23 April – 6 May 2009, p. 6.

¹⁴⁵ AusAID, 2008c, Pacific Regional HIV/AIDS Project, Independent Completion Report, p 15.

¹⁴⁶ PRHP, 2008. Pacific Regional HIV/AIDS Project – Project Completion Report.

- By the end of June 2008, the HIV Prevention and Control in Rural Development Enclaves Project had spent only 18% of its annual budget.
- Some NGOs supported by AusAID perform better but the picture is mixed.
- Reasons for these problems are multiple but include limited operational and financial capacity, excessive regulations and slow financial processes¹⁴⁷.

4.8 Aid coordination and effectiveness

Progress in Pacific HIV responses over the past decade could not have been achieved without the support of a range of development partners. But implementation challenges highlight the need for countries and donors to improve aid harmonization (between donors) and alignment (with national systems and priorities) to strengthen the effectiveness of aid, reduce duplication and significantly improve the use of available resources. In 2007, the Pacific Islands Forum Secretariat tailored the Paris Declaration on Aid Effectiveness to the specific needs of the region through the Pacific Aid Effectiveness Principles (Attachment 7). These Principles recognize that Pacific countries will continue to require external aid for capacity building and supplementation in an increasingly complex regional environment¹⁴⁸. Endorsed by Pacific governments and donors, they highlight the need to improve national ownership of service delivery, and call on donors to make greater use of government systems.

There has been some recent progress in aid alignment and harmonization. **Niue and the Cook Islands have harmonized Australian and New Zealand aid through a co-funded programme.** Samoa has developed a set of harmonization principles that requires donors to work within Samoa's national development systems rather than through parallel donor mechanisms. **Papua New Guinea's 2008 Kavieng Declaration has seen donors commit to better coordination of HIV activities.** Global Fund grants are now structured to strengthen national systems. **The Pacific Response Fund will also help improve aid coordination especially at the local level through CSOs.** US- and French-funded HIV programmes in their affiliated territories have operated separately from the rest of the region but both governments have shown interest in enhanced collaboration.

Some countries, notably Solomon Islands, Papua New Guinea and Samoa, are attempting to improve health sector coordination through sector-wide approaches (SWAPs) that fund a single sector policy and expenditure programme under government leadership. These relatively new mechanisms in the Pacific are providing early coordination hiccups. For example, the Papua New Guinea SWAP operates separately from the Global Fund grant. This draws attention to the problematic coordination between separate funding streams and mechanisms.

Nevertheless, the lack of national HIV programme targets, surveillance and monitoring makes it difficult to analyze the effectiveness of national responses and the extent to which donor-funded programmes have achieved their goals.

147 Independent Review Group on HIV/AIDS, 2008b. Report from an Assessment Visit 23 April – 6 May 2009 p 30.

148 Independent Review Group on HIV/AIDS, 2008b. Report from an Assessment Visit 23 April – 6 May 2009 p 30.

This highlights a critical need for countries, regional organizations and donors to monitor the progress of their initiatives and analyse whether the chosen funding modalities are the most effective means of delivering financial and technical support to HIV responses in the Pacific. The Global Fund now requires reporting against targets, although this does not capture qualitative information on performance.

Papua New Guinea, through the Independent Review Group (IRG), has begun to review its national HIV response regularly. The IRG has already noted progress in the scaling-up of HIV testing and provision of antiretroviral treatment; improved reporting from HIV testing sites; operationalization of the National Research Agenda; a growing number of grassroots and community groups providing family and community support; and improved coordination between NACS and the Department of Health.

However, the IRG also found that the “prevention response in Papua New Guinea continues to be inadequate in nature, intensity and scale, the consequence of which can only be continued growth of the epidemic—either within specific population groups or more generally”. It concluded that “Papua New Guinea urgently needs effective mechanisms for getting money and other resources to where they are needed for the response to AIDS”¹⁴⁹.

Other individual programme reviews that noted mixed results include: the Pacific Regional HIV/AIDS Project¹⁵⁰; the National HIV/AIDS Support Project in Papua New Guinea¹⁵¹; the Global Fund Round 2 Grant to the Pacific; and the Global Fund Round 4 Grant in Papua New Guinea¹⁵².

Within the UN system, agencies are operating in a more coordinated fashion under UN reform efforts and improving collaboration with SPC¹⁵³. WHO, UNFPA and UNICEF are jointly working on the integration of SRH, HIV and STI services across the region, and joint country programming missions and planning exercises occur regularly to clarify common priorities. **Under the regional UN Development Assistance Framework (UNDAF) 2008–2011, UN agencies have agreed to focus more on national HIV activities than on regional programmes.**

SPC plays a major role in coordinating and managing the regional HIV response, and has considerable influence over aid management and ensuring that donor funds are targeted effectively in Pacific countries. Global Fund Round 2 spending on SPC administrative personnel and coordination was approximately US\$ 1.1 million or around one-quarter of funds received. The goal should be to ensure that the bulk of funding is allocated to programmes supporting in-country service delivery.

Encouragingly, Pacific leaders are now addressing these aid coordination and effectiveness

149 Independent Review Group on HIV/AIDS, Report from an assessment visit 23 April – 6 May 2009, pp 19–20.

150 AusAID, 2009. Pacific Regional HIV/AIDS Project, Independent Completion Report, January 2009, p 10.

151 AusAID, 2005. Evaluation of the Papua New Guinea National HIV/AIDS Support Project December 2005; AusAID National HIV/AIDS Support Project Activity Completion Report Milestone 112, August 2006.

152 GFATM Papua New Guinea Grant Performance Report (Papua New Guinea-405-G02-H) Last Updated on:

153 Doupe, 2009. UNAIDS Second Independent Evaluation 2002–2008 Pacific Region Summary Report,

challenges. They agreed at the recent 2009 Pacific Islands Forum meeting that there is an urgent need to establish a new compact on strengthening development coordination in the Pacific (the Cairns Compact). This is intended to drive more effective coordination of available development resources from countries and all development partners.

4.9 Future funding needs

No Pacific country has, to date, estimated the costs of delivering optimal HIV services. As a possible proxy, the Government of Papua New Guinea has commenced a process to cost the provision of rural health services based on a minimum package of services. **It estimates that the cost of HIV services ranges from US\$6 to US\$24 per capita, depending on a number of variables, including the distance of the province from the capital, meaning that the delivery of services for the island provinces is the most costly¹⁵⁴.** These figures do not include the cost of antiretroviral treatments, which are provided by the national, and not provincial, government. The highest cost components are for administration and management of health facilities. However, final analysis is required.

Papua New Guinea has commenced a process to cost its national response to HIV. It has been calculated that Papua New Guinea should spend K38 per capita (a total of K268, 858,569) to fund a comprehensive HIV prevention, treatment and care programme with coverage sufficient to halt the spread of the epidemic.

To achieve modest targets in 2009 (with only 10% coverage of prevention programmes for sex workers and MSM, for example) Papua New Guinea will need to spend K161,231,807 or K25 per capita.

While it could be argued that the HIV programme should not include health system costs, the reality is that many prevention, voluntary counselling and testing targets cannot be reached without a functioning health system. **The greatest challenge in the Pacific to scaling up lies in improving the capacity of management and technical personnel to deliver and manage health care services.**

Papua New Guinea needs to implement a long-term development strategy for the health sector. The HIV response must focus on high impact interventions and alternative service delivery mechanisms to ensure that prevention and treatment services are available to those most at risk of HIV infection and those already affected by AIDS.

Our analysis indicates that Papua New Guinea will have a shortfall in funding in 2009 and certainly in the future years if the current funding levels remain static or even with some increases.

¹⁵⁴ Chandler, R., 2008, *Papua New Guinea Rural Health Services Costing: Exit Report*.

The government of Papua New Guinea and donors have pledged funds totalling K 99,720,340¹⁵⁵ against an estimated need of K 161,231,807 just to meet current targets. The strengthening of the kina against donor currencies, some decreases in donor funding and a major reduction in government allocations to the National AIDS Council

Secretariat and the Department of Health's HIV and STI programme have led to a reduction of 27.8% in funds pledged for the HIV response in 2009 when compared to 2008.

While allocations against these pledges are not available, it is likely that funding for treatment will be quarantined and the greatest shortfall will be in targeted prevention activities and monitoring and evaluation. It is essential for Papua New Guinea to do an urgent reassessment of its plans for 2009 and its planning process for 2010, to prioritize funding into high impact prevention programmes with a reduction in population-based awareness activities and training.

The best available data on costing in the Pacific are provided by the budget and grant requests submitted by countries, as well as SPC, for the Global Fund Round 7, which have been considered by governments and civil society organizations through NACs and CCMs. However, these budgets relate to the activities on which the proposals focus, and do not cover the range of required HIV responses. In addition, countries have not costed their activities on the basis of an analysis of best practice, but have relied on their usual budgets with estimates of what would be required.

Implications of the global economic crisis

The IMF estimates that world economic growth will shrink to 2.2% in 2009 compared to 5% in 2007. Growth is projected to be negative (-0.3%) among developed countries in 2009 and will slow appreciably in emerging and developing economies but should remain positive (5.1%)¹⁵⁶.

Even with current estimations for costing national HIV responses, adverse impacts of the 2008 global financial crisis on Pacific countries are expected. The economic problems experienced by many countries in the region, even before the crisis, helped to downgrade the quality of social services, thereby eroding the viability of some communities and entrenching the disadvantage of vulnerable groups.

According to the ADB, the crisis has already affected the Pacific by reducing the market value of offshore investments held by the region's superannuation and Trust Funds (primarily in the Federated States of Micronesia, Kiribati, Palau, Marshall Islands and Tuvalu). Commodity export income is expected to decline. In Papua New Guinea, the price boom that triggered a turn-around in economic growth in recent years is now over. Remittances and tourism activity are also likely to shrink as economic growth slows in key source economies, and investment may drop off as some major projects may find it

155 Unfortunately, it is has not been possible to calculate the total pledged funding accurately. Additional funding will be available through the National Department of Health (e.g. for provincial health staff) but it has proven difficult to disaggregate these budgets for HIV-related costs. Therefore, the funding gap will be less but not significantly so.

156 IMF, World Economic Outlook Update, November 2008.

harder to secure offshore funds at a reasonable cost. This increases the likelihood that economies will lose some ground. The key response should be to reinvigorate structural reform, which is crucial to achieving sustained economic growth. This includes action to improve basic social services¹⁵⁷.

UNAIDS and the World Bank have warned that for HIV response programmes, efforts aimed at prevention appear to be most under threat of cuts. If such funding reduction eventuates, prevention programmes for people who are at higher risk would probably be cut first, because that would be politically an easier option. The underlying argument is that the urgent need is to use existing funding better—to reallocate funds to high-impact prevention and treatment programmes. Countries that rely heavily on external resources should work with their donor partners to identify and address potential funding gaps¹⁵⁸. An analysis of the potential impact of the global economic crisis on HIV in Papua New Guinea noted that there may be two possibilities: direct effects on HIV programmes through a decline in resources; and indirect effects through changing behaviours of people. The former could result in the reduction of VCT and education programmes and/or decreases in the provision of antiretroviral treatment (ART). The latter could be related to higher levels of unemployment, changes in alcohol consumption and resulting violence, increases in transactional sex and changing migration patterns. Through mathematical modelling, the report concluded that there could be an increase in incidence and new diagnoses of 20% and 11% respectively, using intermediate assumptions, with a maximum increase of 46%, and 24% when more pessimistic assumptions are used. Reduced spending on treatment programmes would lead to an increase in the number of AIDS-related deaths¹⁵⁹. Any interruption to ART has an impact on the health of people living with HIV, as it could be expected to increase the chance of treatment failure¹⁶⁰.

It can be assumed that any effect of the global financial crisis on funding from donors will be negative. Although none has yet indicated a cut in HIV funding, some may have difficulty meeting their aid commitments for 2009 and 2010¹⁶¹. Countries such as Papua New Guinea, with both high HIV spending and high aid dependency, could be particularly vulnerable to changes in aid contributions. A national economic slow-down would make reallocation of domestic resources difficult. Other Pacific countries that have lower HIV spending but high aid dependency are also vulnerable to external funding decisions but have more scope to adjust the distribution of domestic resources. A regional conference in February 2010, as well as a forthcoming UN report, on the impact of the economic downturn in the Pacific will shed more light on these issues.

157 ADB, *Navigating the Global Storm*, Policy Brief of the Global Financial Crisis, 2008.

158 UNAIDS and World Bank, 2009. *The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact*.

159 Wilson, D. et al., 2009. *Evaluation of the potential impact of the global economic crisis on HIV epidemics in Southeast Asia*.

160 UNAIDS and World Bank, 2009. *The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact*, pp 2–3.

161 OECD, 2008: OECD estimates that donors need to increase commitments by 11% annually between 2009 and 2015 to reach commitments made at Gleneagles.

Chapter 5 Empowering partnerships

Key findings

- **With some exceptions, government engagement with civil society is, in general, poor, especially in decision-making processes (such as on national AIDS committees). If governments and donors increased core and activity funding for civil society organizations it would enable the CSOs to be more involved in national planning and the delivery and monitoring of services.**
- **Without the involvement of churches the response to HIV across the Pacific would not have been as strong as it is, especially in remote areas with limited government services. In Papua New Guinea the churches are making significant contributions in treatment and care. However, church responses have not always been inclusive of all community members or positive people in challenging HIV-related stigma and discrimination.**
- **Governments in the Pacific need to support the greater involvement of people living with HIV, with support from donors to improve policy-making and programme delivery.**
- **Workplaces can play a stronger role in establishing policies and protecting the rights of workers living with HIV and their families. Workplace programmes are particularly important for sectors with mobile populations, including seafarers, truck drivers, mining and agriculture workers and uniformed services.**
- **The media have for the most part limited themselves to coverage of events and reporting infection figures. They have the potential to play a more effective role in covering human rights issues and promoting HIV prevention and awareness, and in bringing about attitude change in the region.**
- **Sporting and cultural organizations are also becoming strategic partners and have a greater potential to reach young people across the Pacific.**

5.1 Introduction

This chapter focuses on the important role that civil society as a whole has played in the HIV response in the Pacific. Although its more visible face is often in the role played by the gamut of CSOs, civil society also includes the role of the private sector, Pacific workplaces, the community and the media as key partners in supporting multisectoral approaches to HIV and spreading awareness of HIV across the region.

5.2 Civil society contributions to the HIV response

The richness of the civil society organizational sector lies in the diversity of its work, across a range representing specific interest groups, delivering services, monitoring government action such as in human rights, connecting governments and communities. CSOs can be effective advocates in inclusive policy-making processes as their position is grounded in their day to day work with affected individuals, families and communities.

Civil society has been engaged in HIV prevention and education in the region from the outset of the epidemic. Different groups have formed over the years and many have faded away but, in many places, CSOs provide the only prevention programmes for sex workers, their clients, men who have sex with men and transgender people. Many CSOs involved in HIV activities have emerged in recent years in response to growing community concern about HIV as well as to the availability of donor funds for these activities.

CSOs' work on developing care and support networks and providing community support for ART has improved the lives of many people living with HIV in the region¹⁶². CSOs have been particularly active in advocacy and HIV has been a galvanizing issue in their growing involvement in governance and human rights. They have lobbied for marginalized groups to have better access to services including treatment, care and support; resources for networks of PLHIV and for the broader response to HIV; law reform (such as anti-discrimination); the inclusion of HIV in research agendas; and better HIV education activities. In some countries, they assist with school programmes for youth and encourage school authorities to integrate education about HIV and STI into curricula. They have also played a role in representing youth and creating opportunities for the development of young leaders.

CSOs often provide employment for many PLHIV, because of their knowledge and unique contributions to an effective HIV response, and to help counter the financial impacts of their HIV-positive status (see section 5.6). Civil society has played a major role in improving the understanding of HIV in the Pacific by supporting and conducting social research and monitoring and evaluating national programmes. Opportunities are opening for CSOs to become more active in conducting research alongside PLHIV and helping to ensure that research findings are used to benefit these groups¹⁶³. CSOs play a valuable role in efforts to move towards having universal access to HIV services.

162 Commission on AIDS in the Pacific, 2009. Regional Perceptions Survey. HIV-based NGOs were rated as most committed to the HIV response, followed by women's and youth groups.

163 PSDN, 2009. HIV/AIDS, Men Who Have Sex With Men + Transgender People in the Pacific: Recommendations for an Improved Response.

They are, increasingly, finding opportunities to collaborate and network among themselves, sharing their experiences, and jointly advocating the scaling-up of their programme. In Fiji, for example, a vibrant network of HIV, gender and human rights focused organizations is developing.

Despite these recognized benefits of their work, little emphasis has been given to building CSOs' capacity and skills, and provision of resources for programme implementation has been sporadic. "This has left [CSOs] fragile and isolated, and their HIV activity fragmented"¹⁶⁴. A report on strengthening civil society in the Pacific noted: **"For the most part, CSOs perform their work with minimal training and technical assistance and have difficulty attracting and retaining suitably qualified personnel to meet the increasingly complex demands placed on them by communities, governments and donors. A major concern for most CSOs is financial sustainability given the lack of core funding"**¹⁶⁵.

CSOs' dependence on donor funding, which is usually short-term and not guaranteed, constrains recruitment and retention of skilled staff. Smaller CSOs may not have the appropriate financial systems to support monitoring and accountability to their funders (although some donors are now providing core funding to help strengthen financial accountability)¹⁶⁶. Institutional and legal frameworks fail to be clear about the types of activities CSOs can carry out to improve their transparency¹⁶⁷. In combination, these factors limit CSOs' credibility and capacity to engage effectively with governments or other stakeholders.

With enhanced support—particularly through increased core and programme funding—many CSOs have the potential to improve their representational base and play a stronger role in policy development and keeping their governments accountable in protecting the rights of people most vulnerable to HIV. The role of women's organizations can be strengthened to help bring gender concerns into the mainstream, through national HIV strategies—including the increase in male to female transmission of HIV; the rising numbers of women with HIV; and the feminized burden of HIV care. Much of the burden of care in Pacific countries is undertaken by extended families, villages and clans (especially in Papua New Guinea), mostly by women and girls.

164 Keith-Reid, J., 2004. The role of non-state actors in the fight against HIV/AIDS, p 3.

165 Taylor, J., 2005. NGO Strengthening in the Pacific: End of Project Report, 2002–2005, p 4; PSDN, 2009. HIV/AIDS, Men Who Have Sex With Men + Transgender People in the Pacific: Recommendations for an Improved Response; personal communications during AIDS Commission visits to Papua New Guinea, Solomon Islands, Samoa and New Caledonia.

166 Commonwealth Foundation, 2003. Maximising Civil Society's Contribution to Democracy and Development, p 6; Development Resource Centre, 2007. Civil Society and Governance, p 29.

167 Klingelhofer S and Robinson D, 2004, Law and civil society in the South Pacific: Challenges and Opportunities: International Best Practices and Global Developments, p 23; Commonwealth Foundation 2003 Maximising Civil Society's Contribution to Democracy and Development p 5

Florence's story

Florence is HIV-positive and cares for her older husband Peter – also HIV-positive and very ill. Florence attended carers' training at the Anglicare Stop AIDS programme and learned about practical aids such as an easy-carry toilet bucket kit to use in his room, so she did not have to struggle with him out to the pit toilet. Even then, emptying his wastes and taking care of him throughout the night was exhausting. Peter was big and hard to lift. Peter's mother helped but Florence also needed to return to work, to bring some income into the household.

"Carers need support. As a carer myself, I have felt what it's like to care for someone very sick. I needed support from my family, NGOs, and health workers. Carers also need counseling and time off. My message is that if someone out there is caring for someone sick that person needs care too."

Source: Dobi Kidu, in Commonwealth Secretariat's forthcoming publication "The Economics of Dignity"

5.3 Engagement with national policy- and decision making

As discussed in Chapter 4, most Pacific countries have a National AIDS Committee (NAC) or equivalent to encourage broad multisector collaboration on HIV. NACs typically comprise representatives from government, churches, CSOs and academic institutions. Across the Pacific, the degree of CSO representation on these Committees varies. It ranges from full engagement to tokenistic involvement that can be limited to organizations sympathetic to the government, while ignoring those that may challenge official views, or who work with specific populations (such as sex workers, MSM and transgender people).

Given the cultural conservatism in many parts of the region many CSOs continue to defer—whether through discretion or conviction—to the voice of government and can remain silent when faced with difficult issues, especially those that relate to vulnerable groups¹⁶⁸.

Even where there is good will, civil society is often unable to engage fully in national mechanisms because they are uncertain about their roles when working with senior national figures¹⁶⁹. **Some members have reported feeling intimidated in CCM meetings by the formality of the process and the topics discussed¹⁷⁰.** Some civil society representatives do not have a clear mandate to represent particular groupings or are unclear about how to provide information to their constituencies¹⁷¹. Government representatives, too, may be unsure of what to expect of these groups or how to engage them in technical discussions.

168 Pacific Council of AIDS Service Organizations (PACASO), 2007. Pacific Civil Society Scaling Up Towards Universal Access Initiative Report, p 5.

169 Beracochea, E. et al., 2008. Technical Support to the Papua New Guinea/CCM, Leach et al., 2006, The Involvement of People with HIV in Papua New Guinea's HIV Response: A review of the implementation of the Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA) Principle in Papua New Guinea; PRHP, 2006. Review of National AIDS Coordination Mechanisms in Pacific Island Countries, p 22.

170 Beracochea, E. et al., 2008. Technical Support to the Papua New Guinea/CCM, p 2.

171 Beracochea, E. et al., 2008. Technical Support to the Papua New Guinea/CCM, p 5; PRHP, 2006. Review of National AIDS Coordination Mechanisms in Pacific Island Countries, p 22.

CSOs are more often consulted in planning processes than in policy-development and decision-making. But even then, consultations have been described as often rushed and superficial¹⁷².

For example, Fiji's Round 7 Global Fund application was originally rejected because there were too few CSOs involved in the CCM to meet eligibility requirements. Some countries are responding to calls for more civil society involvement. In Solomon Islands a recent review of the national HIV plan involved grassroots networks and created a wide sense of ownership for the plan¹⁷³. In Samoa, fa'afafine and MSM are routinely involved in policy consultations on HIV¹⁷⁴.

The PNG Country Coordinating Mechanism (CCM) and Civil Society

The PNG CCM has successfully won three Global Fund grants (Round 3 Malaria, Round 4 HIV and AIDS, and Round 6 TB). Although it still has some weaknesses in monitoring and oversight, it has been a catalyst for the formation of strong civil society alliances and promoting greater transparency and accountability in the health sector. Civil society is represented on the CCM through PNG's umbrella organization, the PNG Alliance of CSOs (PACSO). Two PLHIV are now represented but their participation is weak due to limited access to their constituents. The Churches Medical Council represents FBOs on the CCM and also manages government grants to the churches. Because they run 50 per cent of health facilities in PNG, these groups could be more active in the CCM. One academic from the University of Papua New Guinea participates in the CCM but, again, has difficulty representing broader academic views. A recent review recommended that the CCM needs stronger representation from the private sector, civil society, PLHIV, and less representation from donors. There is no representation from the provinces, where most Global Fund program activities take place, and most CCM members agree that some type of rotational provincial representation is necessary. Harmonization of various HIV programmes remains a challenge for the CCM, particularly in overseeing the Department of Health as the principal recipient of most donor funding.

Source: Beracochea et al. 2008 Technical Support to the Papua New Guinea CCM.

172 Leach et al., 2006, The Involvement of People with HIV in Papua New Guinea's HIV Response: A review of the implementation of the Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA) Principle in Papua New Guinea, p 21; PRHP, 2006. Review of National AIDS Coordination Mechanisms in Pacific Island Countries, p 15.

173 Elima, D. & Malefoasi, G. 2005. Taem fo lumi Waka Tugetha (Time to Work Together): Government and NGO collaboration in Solomon Islands, p 17.

174 PSDN, 2009. HIV/AIDS, Men Who Have Sex With Men + Transgender People in the Pacific: Recommendations for an Improved Response.

The Pacific Island Jurisdictions AIDS Action Group (PIJAAG)

PIJAAG was established in 2002 as a sub-regional response to address the needs of the six U.S. Pacific Island territories - American Samoa, Marshall Islands, Palau, Guam, FSM and CNMI - in the fight against HIV and AIDS. It represents health departments, CBOs and individuals to advance the state of HIV prevention, education, awareness and care. Assisted by the US Government and US-based advisors, PIJAAG advocates for positive national legislation that supports HIV and AIDS prevention and care services. This process has also been opened up to other international representatives.

Source: www.pijaag.org

5.4 Regional and international civil society organizations

The benefits of regional collaboration have been recognized across the Pacific (as highlighted in the Pacific Plan). Regional CSOs working to strengthen coordination of HIV responses include: the Pacific Islands AIDS Foundation (PIAF); the Pacific Council of AIDS Service Organizations (PACASO); the Pacific Sexual Diversity Network (PSDN); and the Pacific Alliance of CSOs.

The Pacific Islands Association of NGOs (PIANGO, the region's umbrella NGO organization), at their 2007 and 2008 annual forums, called on Pacific leaders to scale up HIV responses. But **efforts to develop national and regional civil society networks have met with difficulty**¹⁷⁵. Organizations in different countries often have different priorities and encounter high costs of travel and difficulties of communication. The Pacific Islands Forum Secretariat had developed a mechanism to help regional CSOs coordinate their policy positions but this process has stalled due to lack of commitment under the Secretariat's Pacific Plan coordination role¹⁷⁶. This was acknowledged at the 2008 Pacific Regional CSO Forum: **"Past experience has shown that the conveying of CSO outcomes statements and communiqués to Pacific Forum leaders between 2004 and 2007 has proven ineffective in influencing the highest political decision-making body"**.

Two broader regional networks, the Asia Pacific Network of PLHIV (APN+) and the Asia Pacific Council of AIDS Service Organizations (APCASO) have supported Pacific CSOs by funding travel of Secretariat members to attend meetings and conducting training workshops. However, having the offices based in Asia is making it difficult for them to cover the costs of travel to and from the Pacific. Concern has also been expressed that these networks do not properly reflect the needs of the Pacific during regional and global consultations because the scale of Asian problems and responses is overwhelmingly greater.

¹⁷⁵ Pascoe, F., 2004, Reaching the peak: contrasting experiences for NGOs in Solomon Islands and Papua New Guinea; Upton, M., 2006. Strengthening Civil Society in Solomon Islands: Organizational and Network Development in Development Services Exchange.

¹⁷⁶ Hewitt, P. and J. Constantine, 2008. 2008 Joint Triennial Review: Australian and New Zealand Approaches to Supporting Pacific Regional Organizations.

Aligning regional mechanisms with national priorities and service delivery provides as many challenges for CSOs as it does for governments, regional agencies and donors. The Commission's perceptions survey highlighted the value of regional CSOs' work when they directly supported local and community HIV responses with technical and financial assistance. There was less enthusiasm for participation in regional processes and structures than for delivering local services in socially and culturally-sensitive ways¹⁷⁷.

There is also some concern that the participation of regional and international CSOs in HIV responses can retard the growth and sustainability of national and local CSOs unless they are mandated to represent and partner with national organizations and mechanisms.

Pacific Islands AIDS Foundation (PIAF)

PIAF is the only regional non government organization for positive people in the Pacific region. Established in the Cook Islands in 2002, it aims to improve the quality of life of people living with HIV and support their public HIV prevention efforts. PIAF's vision is to create an AIDS-free Pacific where HIV-positive people have access to adequate treatment and medical care, where they are accepted by their communities, and where they are enabled to participate in preventing the further spread of the virus.

PIAF has advocated for universal access to anti-retroviral treatments (ART) in the Pacific; improving the visibility of the needs of PLHIV; supported at least 15 public HIV-positive advocates, speakers and leaders; and established support groups within countries. PIAF's current programmes target HIV-positive people in the area of public speaking, counseling, hardship relief, support and care, legal literacy and aid, and research. It is also a member of various regional committees that have mandates to oversee the planning, monitoring and funding of the HIV response. It is focal point of the Commonwealth Foundation in the Pacific region and provides secretariat support to the Pacific Alliance of Civil Society Organizations and PLHIV (the Alliance). It has produced a number of videos, audio and print materials that are accessible on its website: www.pacificaids.org; It also offers a website specifically for Pacific HIV positive people accessible through its main website.

Source: PIAF

5.5 Churches and faith-based organizations (FBOs)

Without the involvement of churches the response to HIV across the Pacific would not have been as strong as it is. In 2005, Pacific churches held the first regional meeting on HIV, with a subsequent declaration and action plan. Within the theological bounds of their various faiths, the churches and FBOs have been and continue to be prominent in driving HIV responses.

Pacific churches, fundamental as they are to Pacific societies, are powerful social institutions. **Christianity is interwoven into almost all aspects of Pacific societies and daily life, and elements of Pacific traditions and culture are blended into all**

177 Australian Research Centre in Sex, Health and Society, 2009

aspects of church structures and services. Fiji is the only country with a large non-Christian population, which includes Hinduism and Islam, both of which have likewise taken on a Pacific flavour¹⁷⁸. In many Pacific countries, faith-based organizations (FBOs) provide a large proportion of education and health service delivery. They have gained trust and legitimacy in providing HIV services, with networks even in remote areas where there are few government services¹⁷⁹.

Churches in Papua New Guinea were among the first to provide care and support for PLHIV. They responded to the stigma and discrimination that surround HIV and now provide voluntary counselling, testing, treatment and care. **Some have relaxed particulars of formerly tenaciously held dogma and provide explicit information on condom use and other sensitive matters**¹⁸⁰. The Salvation Army has been active in six provinces, raising HIV and AIDS awareness, especially in urban settlements¹⁸¹. The crucial role of churches and FBOs in Papua New Guinea's HIV response is acknowledged by their representation on the National AIDS Council; AusAID's Papua New Guinea Church Partnership Programme; and the Ministers Fraternal Organization, which is active in the NCD and several provinces.

A Model for Community Based Care for Children

The Catholic Diocese of Kundiawa in Simbu Province of PNG provides support to children affected by HIV and AIDS and other vulnerable children. The programme is not an orphanage: it leaves children where they are and provides the support they need. It engages and builds the capacity of the community to address issues that arise. The programme delivers integrated protection, care and support through an adaptable, community-based approach with strong participatory focus.

The children receive quarterly monitoring visits by child protection volunteers. The estimated cost is US\$7,000 per annum for 50 children. The care centres are built by the community using bush materials – the only programme cost is for maintenance support, costing US\$500 per annum per centre. The church pays for school fee assistance to about 50% of children. The key to success has been the sense of ownership by the community and the cultural attitude that children belong to the extended family and the clan – not to individual parents.

The programme strength is that it is one of a package of services offered by the Catholic Diocese, including health, HIV and education and thus it integrates into an established FBO structure.

(Extract from a presentation at ICAAP IX by Carol Kidu)

178 UNDP, 2009. Pacific Human Development Report 2009: Improving services and living conditions through better governance.

179 Hauck et al., 2005. Ringing the Church Bell: the role of churches in governance and public performances in Papua New Guinea; Rhodes, D., 2007. Analysis of the 'Community Sector' in Solomon Islands,

180 Luker, 2003. Civil Society, Social Capital and the Churches: HIV/AIDS in Papua New Guinea p10; Hammar, L. 2009b. There wouldn't even be a response without them

181 Hammar, L. 2009b. There wouldn't even be a response without them, p 8.

A common pattern throughout the region, however, is a contradiction between some church responses on HIV and sexual matters on the one hand, and FBOs' increasingly progressive interventions on the other¹⁸². The mainline and more established churches on the one hand, and the newer evangelical churches on the other, respond to HIV in markedly different ways. The churches and FBOs also generally respond at quite different levels, the former being more conservative in their approaches. **Some churches have perpetuated sex-negativity, homophobia and anti-condom attitudes that, paradoxically, seem to facilitate HIV transmission**¹⁸³.

In Papua New Guinea, for example, pastors from the Christian Revival Church have instructed their HIV-infected congregation members to cease taking ART¹⁸⁴. **The Evangelical and Pentecostal churches have tried to “cleanse” the alleged sins of the HIV-positive**¹⁸⁵ and some church officers encourage fear of people with “dreaded” diseases, or instruct people to fear God in order to avoid infection¹⁸⁶. The National HIV-AIDS Support Project (NHASP) has sponsored national FBO conferences to give church leaders and FBOs better information on HIV matters. From this process **emerged the concept of Red Ribbon Churches, which models best practices and serves as centres of education, information, support and healing, including hospice care**. A recent review concluded that this work has contributed to a dramatic shift in the thinking of bishops, priests and pastors in the multiple denominations of Papua New Guinea, although there is still a long way to go¹⁸⁷. Greater openness in discussing sex and sexuality and greater involvement of religious leaders are still needed. Churches and FBOs should be guided by government policy when accepting government or donor funding (most Pacific countries have a condom-use policy in relation to HIV).

The media have given attention to negative statements of some church representatives, glossing over the fact that the churches and FBOs were the first institutions to help PLHIV and assist communities deal with the HIV epidemic. For example, **the first person in Papua New Guinea to disclose HIV status and work in community education did so with church encouragement and support**¹⁸⁸.

While there remains much to be done to overcome stigma and discrimination, some church leaders have begun to write and talk more about sensitive subjects such as human sexuality, homosexuality and rape. A special edition in 2007 of the South Pacific Association of Theological Schools (SPATS) *Pacific Journal of Theology* on HIV and AIDS¹⁸⁹ discussed lessons learnt from working with Pacific churches. It included information on the HIV-related programmes of the World Council of Churches (WCC) Pacific Office, the

182 Hammar, L. 2009b. There wouldn't even be a response without them, p 6.

183 Hammar, L. 2009b. There wouldn't even be a response without them,

184 Hammar, L. 2008. 'Fear and Loathing in Papua New Guinea: sexual behaviour and sexual health in a nation under siege'.

185 Eves, R. 2003. 'AIDS and Apocalypticism: interpretations of the epidemic from Papua New Guinea; Tevi, K. 2005. 'Churches and HIV/AIDS: The care and love is there but for the wrong reasons.

186 Miva, 2006: 9 cited in Hammar, L. 2009b. There wouldn't even be a response without them, p 25.

187 NHASP, 2006a. Papua New Guinea – Review of Church Engagement and Future Directions

188 Luker, 2004. Civil Society, Social Capital and the Churches: HIV/AIDS in Papua New Guinea, p 11.

189 SPATS, 2006. The Pacific Journal of Theology, Series II, No 36.

Pacific Conference of Churches (PCC) and SPATS. Notably, in 2008 the Pacific Office for WCC provided the first official apology to PLHIV for the discrimination and neglect they had experienced from their churches.

5.6 Greater involvement of people living with HIV and AIDS (GIPA)

Countries across the region have come a long way from initial denial to accepting people living with HIV (PLHIV). There is now recognition that greater involvement of people living with HIV is critical for strengthening HIV responses across the region, especially as story-telling is important in Pacific cultures. **HIV-positive people are the faces and voices of the epidemic and can convincingly bring alive the psychological and social traumas of an HIV diagnosis and the restrictions imposed by having to live with HIV.**

The numbers of HIV-positive people working in advocacy are growing. They are now better represented at regional and international fora (such as the 2009 International Congress on AIDS in the Asia Pacific) and in decision-making processes through involvement with, for example, National AIDS Committees, regional and national Country Coordinating Mechanisms for the Global Fund and overseeing bodies of the Pacific Regional Strategy Implementation Plan and the Pacific Response Fund. Some HIV-positive people have found work with CSOs and as public advocates to promote better public understanding about HIV.

However, there remain significant impediments to having people living with HIV even more involved in HIV responses. Negative public statements by health, political or religious authorities continue to isolate HIV-positive people and promote stigma and discrimination. **There is a sense of “tokenism”, an implication that involving HIV-positive people is in itself all that needs to be done to satisfy GIPA principles.** In fact there can be quite a gap between the roles and expectations of PLHIV and the actual contributions they can make. With low HIV prevalence across most of the region, absolute numbers of HIV-positive people with the appropriate educational background or skills and willingness to be involved in decision-making processes and public advocacy are limited. As a result, the involvement of PLHIV tends to be confined to engagement in HIV programmes and activities at the lower levels and to activities where what is asked of them is to share their stories with the public to support prevention programmes.

PLHIV need opportunities to contribute at various levels in a range of HIV responses according to their skills, experiences and interests. A progressive approach would combine this involvement with support and training for their new roles and responsibilities. Whenever possible, the opportunity of paid employment, including in peer support, peer education, counselling and home-based care, should accompany this greater involvement.

CSOs and support groups for HIV-positive people require adequate funding to ensure that the capacity building needs of PLHIV are consistently addressed. There are many examples of empowerment and greater involvement of positive people who began working as “interns”, became “public story tellers”, then “educators” and finally engaged in more complex responsibilities such as planning, managing, mobilizing resources and decision-making.

The implementation of GIPA principles requires ongoing support from donors and technical agencies for those regional and national organizations assisting HIV positive people. Support provided to national networks such as *I Gat Hope* in Papua New Guinea and the Fiji network for PLHIV (FJN+) has increased the visibility of HIV positive people and their needs and demonstrates how they can contribute to and enrich the HIV response across the region. These networks have also helped people to find jobs or undertake self-employment ventures.

At a regional level, the Pacific Islands AIDS Foundation (PIAF) has been a catalyst for the empowerment of HIV-positive people and their greater involvement in the HIV response in the Pacific. PIAF's work in expanding visibility, capacity and opportunities for HIV-positive people has seen the development of HIV support groups in Fiji, Samoa and Vanuatu. It has demonstrated that the collaboration of HIV-positive people and their meaningful involvement in strategies and activities benefits the overall response to HIV. As a regional organization PIAF has been able to address controversial and sensitive national issues as well as raise the profile of the needs of PLHIV for more active country engagement.

5.7 Engaging employers and workers

The private and public sectors are essential partners in connecting HIV responses to people in Pacific workplaces and establishing policies and working conditions that can constrain the spread of HIV. This is particularly the case for those sectors employing mobile workers, including seafarers, truck drivers, mining and agriculture workers and uniformed services. These populations may be more vulnerable to HIV as they are separated from their families and communities for lengths of time, and may not be able to access HIV prevention services. In most countries, private sector participation, especially any involving participation in national policy-making bodies such as NACs, has been limited. Low HIV prevalence rates across most of the region make it all the more urgent for the private sector to become more active in HIV responses.

More recently, a partnership between PIAF and the IFC aims to prioritize discussions of HIV in public sectors across the region. In Papua New Guinea, particularly, development of private–public partnerships is seeing growing commitment by major industry groups to provide HIV care and treatment. **The Papua New Guinea Business Coalition Against AIDS (BAHA) has assisted 100 organizations to develop workplace HIV policies, covering almost 40,000 workers. The HIV SMART workplace model promotes condom use and programmes to engage men in campaigns against domestic violence.** BAHA also provides a free telephone service and website for information and referral, distributes condoms and produces newsletters¹⁹⁰. In 2003, the Papua New Guinea Chamber of Mines and Petroleum began to develop a strategy and code of practice for the industry. But current standards of care and treatment are not known and facilities need to be scaled up and coordinated by the Department of Health. More generally, resources are needed to implement workplace programmes.

A 2004 study of trade unions' response to HIV found that in those Pacific countries where they exist, few unions had been active in the struggle against HIV despite scope to link technical assistance and funding with the resources of the international union movement¹⁹¹. **The extent of HIV in the workforce and of assistance by unions is not well known, perhaps due to the small number of cases in most countries. Even in countries with more PLHIV, fear of the disease and stigma are powerful disincentives to disclosure of HIV status by union members.** The French territories provide protection for the rights of HIV-positive workers and disallow involuntary HIV testing. Elsewhere in the Pacific, the rights of workers are not yet protected in law once their status becomes known. **PLHIV in Papua New Guinea have related stories of dismissal from their employment, in both the private and public sector**¹⁹². Union leaders and members need accurate information and greater awareness on HIV generally and in the workplace to broaden workplace education and address discrimination. The ILO Code of Practice should be widely disseminated and legal provisions, where they exist, need to be enacted.

Collaboration for Health in PNG

The Collaboration for Health in Papua New Guinea (CHPNG) is a philanthropic organization comprising pharmaceutical companies, Boehringer-Ingelheim, Gilead, GlaxoSmithKline, Merck Sharp and Dohme Australia, and Pfizer Australia. It has developed and implemented home-based HIV and care training programs with the Australasian Society for HIV Medicine (ASHM) at the request of the Department of Health and the National AIDS Council Secretariat (NACS). These adult-learning programs include on-site visits and extensive mentoring. Work has involved the Catholic Health Services, the National Catholic AIDS Office of PNG and Catholic Family Life. Training and workshops have been held for Health Secretaries; allied health-care workers in Port Moresby and Mingende (Simbu Province); Catholic Health Service staff in the island provinces and Momase regions; diocesan HIV secretaries; the Australia-based Uniting Church; the United Church of PNG; the Salvation Army; and the Churches Partnership Programme.

Source: Hammar, L. 2009b. There wouldn't even be a response without them

5.8 Media

The media, potentially powerful strategic partners, can be more actively and sensitively engaged in raising awareness of all aspects of the HIV response in the Pacific. **However, their role in covering human rights issues and creating demand for good governance of HIV responses has not been strong in the Pacific—although it is a region of relatively sound press freedom.** Public and private media coverage of HIV has, overall, been limited because of the influence of the conservatism of Pacific cultures, mirrored in the conservatism and caution of media proprietors; and a lack of knowledge—more especially of awareness and understanding—of the links between human rights, gender and governance. The disproportionate emphasis on reporting infection rates, international funding and regional workshops has been at the expense of in-depth analysis

191 APHEDA, 2004. Waiting for Something to happen: Trade Union responses to HIV/AIDS in the South Pacific.

192 As related to Pacific AIDS Commission members during a visit to Papua New Guinea in 2008.

of the disease or educational content. In addition, while the language (predominantly in English) and tone of HIV stories show more sensitivity to PLHIV than in the past, the need is still urgent to widen coverage and report on the political, social, economic, cultural, religious and relationship aspects of HIV, to lessen fear and stigma¹⁹³.

In Papua New Guinea, for example, a study of the two daily English language newspapers¹⁹⁴ found that although there had been a substantial increase in the level of reporting on HIV since 2005, the print media could do still more to spread information intended to influence the policy environment and community attitudes towards HIV. **Often, stories use combative language (such as “war”, “battle”, “fight”) and stereotype groups of people as the causes of HIV infection (such as sex workers) or victims (such as women and carers).** Sensationalist coverage of issues limits a balanced discussion of the social determinants of the spread of HIV, including gender inequalities and the impact of sexual violence¹⁹⁵.

A number of regional and national workshops on media coverage of HIV in recent years have helped to educate journalists and media proprietors in the improved reporting of issues. **HIV-related issues are now incorporated into the University of the South Pacific (USP) and the Fiji Institute of Technology (FIT) journalism courses.** This training of journalists should be complemented with better systematic engagement of the media by all HIV stakeholders (such as through special media events).

The use of entertainment to spread HIV messages can also be expanded. Vanuatu’s *Wan Smolbag* Theatre has been working with communities and schools on health issues since 1989. Much of its work has been in the area of HIV and STIs and its approach has been replicated by CSOs, with varying degrees of success, across the region. The USP Oceania Centre for Arts, Culture and Pacific Studies has demonstrated effectively that the creative arts can convey appropriate HIV messages to the wider community with considerable emotional force, and stimulate awareness and discussion on “taboo” and sensitive topics.

The flagship programme of SPC’s Regional Media Centre, The *Pacific Way*, is a one-hour magazine show broadcast by 20 television stations throughout 19 Pacific countries. It has gained widespread popularity and is one of the best-known regional television programmes. Its primary focus on topical Pacific issues provides Pacific communities with an important forum for discussion and can be accessed by HIV programmes to spread awareness. Similarly, better use could be made of the websites of organizations working in HIV, such as SPC.

193 Cullen T 2003 Press coverage of HIV/AIDS in the Pacific: Short term view of long term problem.

194 Clarke, A, 2008 The Press Coverage of HIV in Papua New Guinea 2005 – 2007: Strengthening HIV journalism in a developing country, BAHA,

195 In *The National* and *Post Courier* HIV or AIDS was mentioned in 1,808 news articles (90%) and editorials and letters (10%) between Nov 2005 and Dec 2007. Half of articles related to awareness, prevention or new projects or efforts; 16 per cent were about the impact of HIV or AIDS; 11 per cent provided statistical data; and less than a quarter provided an analysis of the issues surrounding HIV.

The Samoa AIDS Foundation

The Samoa AIDS Foundation's (SAF) 'HIV/AIDS Corner' has been a weekly one-page feature in the Sunday issue of the *Samoa Observer* newspaper since January 2006. It aims to highlight the work of the Foundation; advocate for HIV and AIDS issues in the national agenda; improve access to information to help dispel popular myths that fuel stigma and discrimination; highlight the needs and experiences of people living with HIV; and attract potential donors on the success of media in HIV prevention. The weekly 'HIV/AIDS Corner' has been supported by the Pacific Regional HIV/AIDS Project, Canada Fund and the European Union. The marketing team of the *Samoa Observer* provides special advertising rates and has sponsored some SAF community activities.

Issues featured range from personal experiences of PLHIV and their families, to regional and global developments in prevention, community response and attitude shifts, especially among members of the church and legislators in the region. 'HIV/AIDS Corner' also highlights the challenges facing traditional communities, especially in areas of violence against women and children; traditional taboos on open discussions of sexuality and sexually transmitted infections; and the weaknesses in health systems and economies that constrain access to counseling and treatment for HIV people. It features training, workshops, conferences and community initiatives that help build the profile of SAF as a dynamic organization of young people dedicated to working with the community and stakeholders in responding to STIs and HIV in Samoa. 'HIV/AIDS Corner' also promotes an after-hours phone information service and includes activities such as HIV Trivia Quizzes. The popularity of *Samoa Observer Online* has promoted SAF internationally. This has broadened the Foundation's message to places that it would otherwise not have been able to reach and expanded its audience, especially for potential donor funding.

Source: Samoa AIDS Foundation

5.9 Other organizations

A number of other potential partners, including cultural and sporting bodies, could be more constructively engaged in the Pacific HIV response. It is encouraging to note that all of the major sporting events now promote the concept of safe sex and an increasing number of cultural events across the region are highlighting issues related to HIV.

Chapter 6 Navigating the future - an OPEN strategy

Introduction

The Pacific region is diverse, not only in its sociopolitical and cultural characteristics but also in the spread of HIV and the responses to it. The Pacific is also uniquely vulnerable, given the smallness and isolation of its many countries, which face significant capacity and service delivery challenges. On this basis there is no single “correct” response to the threat of HIV to individuals, families, communities, cultures and economies. Different and highly-focused strategic policy and programme approaches are required in Papua New Guinea (the largest population and the overwhelming locus of the Pacific epidemic); those countries with a significant number of HIV cases (Fiji, French Polynesia, Guam and New Caledonia); and those with lower-level epidemics (including the smaller island states).

Despite these differences, HIV continues to require an exceptional response because HIV vulnerability and risk are influenced by and have a significant impact on all aspects of Pacific societies, cultures and economies. There is a range of innovative and effective approaches from around the region that could be better supported and shared. The essential ingredients for moving forward involve strengthening health systems; overcoming stigma and discrimination, to create a safe environment for PLHIV; and better alignment of regional and international support with national priorities and national service delivery.

Pacific countries will be best served by using the challenges and opportunities provided by HIV to provide an expanded, multisectoral and integrated approach to primary health care using an OPEN strategy¹⁹⁶. This means:

- **OWNERSHIP** of the epidemic at all levels of society;
- **PARTNERSHIPS** to develop integrated responses;
- **EMPOWERING** and **ENABLING** environments; and
- **NETWORKING** to share experiences and outcomes.

HIV cannot be managed in isolation and a whole-of-government and whole-of-society response is crucial. The interrelationships between HIV and other social, cultural, political and economic indicators make the Pacific Plan and the Millennium Development Goals important vehicles for responding to HIV in the region.

Recommendations

The Commission recommends that decisive steps should be taken to implement the following actions to protect Pacific societies, cultures and economies from HIV.

Leadership

- 1. Political leadership** and commitment remain critical determinants driving HIV responses. Political leaders must continue to be effectively engaged and commitments made at regional level must not be allowed to be mere lip service. They must flow on into normal and continuing national action through wholehearted across-the-board government initiatives and follow-up.

¹⁹⁶ The OPEN strategy response was designed by participants in a community workshop in Papua New Guinea.

2. **Traditional, church and community leaders** must stay actively engaged in the HIV response.

Legislation and the enabling environment

3. Countries must provide **legislative protection and enforcement mechanisms** for people living with HIV and their families; their protection from human rights abuses is a matter of priority.
4. Countries must undertake progressive **legislative reform** to repeal legislation that criminalizes high-risk behaviour and promotes HIV-related discrimination. Changing the laws need not imply approval of the behaviour but would signal a greater concern for people.

Civil society

5. Governments and donors must be more proactive in engaging with and supporting civil society and civil society organizations (CSOs) in **decision-making mechanisms**. Countries can achieve this outcome by ensuring that:
 - donor grants, including from the Global Fund, are not restricted to service delivery but are available for core and operational support;
 - national AIDS coordinating authorities (NACs) or their equivalent strongly represent civil society and the private sector (including representatives from human rights organizations) to ensure accountability;
 - Global Fund Country Coordinating Mechanisms (CCMs) have strong representation of civil society, democratically elected from their constituencies; and
 - professional development is provided to CSO representatives to support their effective involvement in national decision-making processes.
6. Community-based programmes are best delivered by communities themselves. Support for civil society organizations must include **core and capacity-development funding**.

Strategic planning and implementation

7. Countries, regional organizations and donor partners must continue to work together to ensure that **realistic targets and time frames** are set and adequate resources are available to implement the HIV response. It is time to progress to **implementation and action**, away from the focus on strategy development and designing new mechanisms and financing structures.
8. Coordinating **multisector national responses** must follow the principles of the “Three Ones” (one framework, one coordinating mechanism and one monitoring and evaluation framework). This does not require the establishment of stand-alone entities in all countries. In smaller island states, especially, these processes can be integrated within national health or development plans with appropriate monitoring and reporting.
9. In the spirit of the “Three Ones” principles, Global Fund Country Coordinating Mechanisms (CCMs) must be harmonized with National AIDS Coordinating

Authorities (NACs), in those countries where they are established, with common membership for stronger and more effective **coordination** and management

10. As potential strategic partners, the **media** must be more actively and sensitively engaged to play a more effective role in covering human rights issues and promoting HIV prevention and awareness in the region.
11. **Workplaces** must play a stronger role in establishing policies and programmes to reduce the spread of HIV, and protect the rights of workers living with HIV and their families.
12. **National HIV plans** (or HIV components of health/development plans) must be:
 - costed and prioritized for maximum effectiveness and the full utilization of available resources;
 - based on an analysis of whether regional and/or subregional mechanisms are appropriate;
 - supported by implementation plans and monitoring and evaluation (M&E) frameworks; and
 - informed by the findings of surveillance and social research.
13. Strengthening **health care systems** is an essential component of an effective HIV response. Available funding for HIV must strengthen health care services to achieve economies of scale. Increased investment must be directed towards:
 - scaling-up of laboratory capacity;
 - treatment of opportunistic infections and STIs;
 - maintenance of HIV-qualified staff; and
 - the care and monitoring of AIDS patients.
14. Treatment for HIV, opportunistic infections and STIs and **prevention of mother-to-child transmission** (PMTCT) programmes must be integrated within a strengthened health care system.
15. **National priorities must drive regional mechanisms** and approaches. Regional action should focus on advocating regional political commitment and providing appropriate in-country technical capacity and resource mobilization. Countries must focus on implementation of programmes and be accountable for their performance.
16. Greater funding must be provided for **prevention activities** that address high-risk behaviours and produce maximum impact. These include:
 - focusing on HIV risk behaviours, not population groups, to avoid stigma and discrimination,
 - using, in prevention programmes, the language of the people most affected, and
 - reviewing the experience from other regions in implementing innovative prevention programmes that integrate HIV with other behaviour-change programs (such as drug and alcohol use, sexual and reproductive health and gender-based violence).

17. Mandatory testing in all forms, including provider-initiated testing and counselling, must be avoided since they give rise to concerns about confidentiality, gender-based violence and the lack of cost-effectiveness in low prevalence countries. Countries must endorse good-quality testing standards and protocols that focus on **voluntary counselling and confidential testing (VCCT)** offered in conjunction with other testing services, to improve access and avoid stigma.
18. **Gender inequality and gender-based violence** are major social drivers of the epidemics in the Pacific. Countries must assess their HIV policies and programmes so that they empower women and reduce their vulnerability to HIV.
19. **Young people** comprise 40% of the Pacific population and must be supported to engage actively in the design, implementation and monitoring of responses to address their needs. Countries must scale up their efforts to:
 - include culturally-sensitive and age-appropriate sex education in the curriculum at appropriate levels of the school system, including teacher training and improving the understanding of heads of institutions and community leaders;
 - revive and strengthen youth peer education programmes;
 - establish and expand youth-friendly facilities, to improve access to HIV prevention services and commodities and appropriate sexual and reproductive health services;
 - use opportunities where young people gather to promote safe sexual behaviour; and;
 - make use of innovative approaches, including peer-reviewed messages through Internet and mobile phones, to target young people, particularly out-of-school youth, in line with objectives of the Pacific Regional Digital Strategy.
20. Countries, CSOs and donors must be more actively engaged in supporting the involvement of **HIV-positive people** in decision-making and HIV responses, including as members of national AIDS coordinating authorities (NACs) and country coordinating mechanisms (CCMs). This will require capacity building and innovative approaches, including :
 - internships for HIV-positive people with UN and regional agencies;
 - twinning of PLHIV groups and individuals of different countries and;
 - initiatives such as the Pan-Pacific Gathering for HIV Positive People and the International Congress on AIDS in the Asia and the Pacific (ICAAP).

Strategic information, surveillance and monitoring

21. National plans in the Pacific must be informed by a **strong evidence base**. The urgent strengthening of evidence-informed systems should include:
 - establishing country surveillance plans—including first and second generation surveillance—supported by regional and international agencies as required; and
 - ensuring that national surveillance data are made open and transparent and put into the public domain.
22. Countries' efforts to improve their monitoring and surveillance must be supported by:

- instituting second generation surveillance including: repeated cross-sectional biological and behavioural studies among population groups with high-risk behaviours; seroprevalence studies in consistent sites among pregnant women, and a population-based survey with measurement of HIV prevalence in Papua New Guinea;
- developing **capacity-building** programmes to support improved surveillance, planning, implementation and monitoring of HIV responses. Simple and standardized surveillance training packages can be adapted at national level;
- supporting the interagency **technical working group** of regional and international organizations (SPC, WHO, UNAIDS) to help countries improve HIV and STI surveillance, research and population-based surveys;
- and integrating HIV and STI **surveillance** as part of national communicable disease surveillance.
- modify second generation surveillance protocols, by the Secretariat of the Pacific Community (SPC) and World Health Organisation (WHO), to the scale and characteristics of Pacific countries. This may require the development of novel sampling approaches or standard methods combined with community education to combat stigma and discrimination. Behavioural surveillance surveys (BSS) should be complemented by ethnographic data.

23. Pacific countries must initiate culturally-appropriate **research**, including:

- integrating HIV with other **behaviour-change programmes**, such as drug and alcohol use, gender-based violence and aspects of sexual and reproductive health;
- engaging **men who have sex with men and those individuals of other culturally-constructed genders** in more high-quality and participatory operational research that can be translated into effective prevention programmes;
- investigating **injecting drug use** in French Polynesia, New Caledonia and US territories, and in other countries in the region as the need becomes apparent;
- evaluating the **effectiveness** of treatment and care;
- understanding the **economic impacts** of HIV; and
- reviewing **new global approaches** to HIV prevention (including addressing concurrent sexual partnerships) for appropriateness for the Pacific region.

Resourcing and aid effectiveness

24. Given the global economic crisis and the uncertainty of sustained external funding, countries must ensure more efficient use of resources and improved aid effectiveness. Countries must progressively increase their commitment of domestic resources to HIV programmes in order to reduce dependence on external assistance.

25. Countries and donors must ensure that disaggregated data on funding levels, allocations and expenditure on HIV programmes are put in the public domain and made accessible.

26. Donors must strengthen aid **coordination and harmonization** through broader involvement with existing funding mechanisms and closer **alignment** with national HIV strategies and/or health sector plans.

Attachment 1 HIV Testing Sites in Pacific countries and territories 2009

	VCCT	ANC	ART	STI clinics or syndromic management
American Samoa	1	4	1	4
Cook Islands	2	11	0	10
Fiji	9	14	3	106
French Polynesia	8	6	5	2
FSM	4	25	4	8
Guam	7	2	0	15
Kiribati	8	95	1	111
Marshall Islands	4	62	2	3
Nauru	2	1	0	2
New Caledonia	n.a.*	n.a.	n.a.	n.a.
Niue	1	0	0	1
CNMI	9	5	5	9
Palau	2	1	0	2
Papua New Guinea	153	90	49	793
Samoa	3	27	4	28
Solomon Islands	18	12	3	17
Tokelau	0	3	0	4
Tonga	n.a.	n.a.	n.a.	n.a.
Tuvalu	2	1	0	2
Vanuatu	10	4	0	12
Wallis and Futuna	n.a.	n.a.	n.a.	n.a.
	243	363	77	1129

* n.a. - not available

Source: Rachel James, UNAIDS Pacific Office, from national HIV programme manager reports

Attachment 2: Surveillance and behavioural surveys in Pacific countries and territories

Country	General Population	Youth	Antenatal Women	Female Sex Workers	MSM	Seafarers	Military /Police	STI Clinic Attendees	Other
American Samoa	n.a.	1993 1997 1999 2007	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	2006 Cannery workers
Cook Islands	n.a.	1999 2005	n.a.	n.a.	2009	n.a.	n.a.	n.a.	n.a.
FSM	2001 (Chuuk)	2001 2003 2005 2006	n.a.	2007	n.a.	n.a.	2007 -Polin P & Y	n.a.	2006-Adults
Fiji Islands	1994- 1995	1996 2008	2004- 2005	n.a.	n.a.	2008	2004- 2005	2004- 2005	n.a.
French Polynesia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Guam	n.a.	1995 1997 2001 2007	n.a.	n.a.	2007	n.a.	n.a.	n.a.	2007-Migrants
Kiribati	n.a.	n.a.	2002-2003 2004-2005	n.a.	n.a.	2002-2003 2004-2005	n.a.	n.a.	n.a.
RMI	n.a.	2003 2007 2008	1999 2000 2001	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Nauru	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
New Caledonia	n.a.	2005-2006	2005-2006	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Niue	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
CNMI	n.a.	2003 2005	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Palau	1991	1999 2001 2003	2005-2006	n.a.	n.a.	n.a.	2005-2006 (Pol)	n.a.	n.a.

Attachment 2: Surveillance and behavioural surveys in Pacific countries and territories (continued)

Country	General Population	Youth	Antenatal Women	Female Sex Workers	MSM	Seafarers	Military /Police	STI Clinic Attendees	Other
Papua New Guinea	n.a.	1996	n.a.	2002	1995-1998 (TG)	n.a.	1994 (Pol)	2006	n.a.
		2004		2005			1998 (Pol)	(truckers, port, ramu sugar workers)	
		2006		2006			1998 (Pol-F)		
		2006					2006 (Mil)		
Samoa	n.a.	2004-2005	1999-2000	n.a.	n.a.	n.a.	n.a.	2004-2005	n.a.
		2008	2004-2005						
Solomon Islands	2007	2004-2005	2004-2005	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
		2007							
		2008							
Tokelau	n.a.	2008	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Tonga	n.a.	2003	2004-2005	n.a.	2008	n.a.	n.a.	n.a.	n.a.
		2005							
		2008							
Tuvalu	n.a.	2005-2006	2005-2006	n.a.	n.a.	2005-2006	n.a.	n.a.	n.a.
Vanuatu	n.a.	2004-2005	2000		n.a.	n.a.	n.a.	2004-2005	n.a.
		2005	2004-2005	2007					
		2005-2006	2005-2006	n.a.					
Wallis & Futuna	n.a.	2005-2006	2005-2006	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

* n.a. - not available

Source: Rachel James, UNAIDS Pacific Office, from national reports

Attachment 3: STI prevalence studies among women attending antenatal clinics

Country	Year	Number of women	Results
Fiji	2004-2005	303	Chlamydia = 29% Gonorrhea = 1.7% Syphilis = 2.6%
Solomon Islands	2004-2005	241	Chlamydia = 6.4% Gonorrhea = 0.4% Syphilis = 10%
Vanuatu	2004-2005	288	Chlamydia = 13.2% Gonorrhea = 2.4% Syphilis = 0.8%
Marshall Islands	2001	144	Chlamydia = 9.2% Gonorrhea = 6% Syphilis = 7.1%
Palau	2005-2006		Chlamydia = 16.8% Gonorrhea = 2.9%
Samoa	2004-2005	299	Chlamydia = 26.8% Gonorrhea = 2.3%
Tonga	2004-2005	348	Chlamydia = 14.5% Gonorrhea = 2.5% Syphilis = 3.2%
Tuvalu	2005-2006	114	Chlamydia = 17.5% Gonorrhea = 0.9% Syphilis = 1.7%
Papua New Guinea	2006	3407	Chlamydia = 18.2% Gonorrhea = 11% Syphilis = 13.6% Trichomoniasis = 18.3% HIV = 2.2% At least 1 STI = 39.6

Source: Burnet Institute, 2009 HIV in the Pacific, 1984 - 2007

Attachment 4: Pacific Island Country and Territory Public Health Laws

Country	Enacted Public Health and AIDS-Specific Laws	Description of Relevant Legal Content
American Samoa	Reportable Diseases and Conditions	Diseases to report, including AIDS and HIV (within 1 working day)
Cook Islands	Public Health Act 2004: AIDS and HIV are transmissible notifiable conditions and dangerous conditions.	Act provides for mandatory reporting by medical practitioner, or mandatory testing of person suspected by Director of Health to be infected; mandatory reporting by all infected people entering Cook Islands
Fiji	Addition to Public Health Act Jan 2006: HIV and AIDS included as infectious diseases. Public Health Act under review (2008) to address inappropriate provisions for management of HIV and AIDS.	Act includes regulation of movement of people; medical examination; mandatory testing; restraint and isolation if required to prevent spread; notification procedures for deaths; and the offence of not taking precautions against transmission, or carrier permitting it.
French Polynesia	Deliberation No. 97-67 AT of 14 June 1990 declaring that infection with HIV (seropositivity and the disease of AIDS) is a condition of major seriousness having priority for French Polynesia.	It declares that infection with HIV is considered a serious condition and to be given priority by the government. It also provides that testing is to be anonymous and that the government is to pay for the testing of anyone who asks to be tested.
Guam	NGCA Crimes and Corrections. Chapter 28. Public Indecency, Article 1. Prostitution	Prostitution is illegal in Guam on a one off act basis (i.e. no requirement to prove course of conduct)
Kiribati	New law is planned. Public Health Ordinance (Chapter 80).	Persons with infectious diseases, including STI, may be isolated, and contacts may have movement restricted.
Marshall Islands	Communicable Diseases Prevention and Control Act 1988: Includes HIV	Provides for reporting, identification, prevention and control of communicable diseases; including STI and HIV, and mandatory testing for some groups of people.
FSM	Laws bound by constitution, which follows US Bill of Rights. No specific mention of HIV or AIDS.	Director of Health Services has powers to control communicable disease, including through isolation, quarantine, and mandatory reporting.

Attachment 4: Pacific Island Country and Territory Public Health Laws - Continued

Country	Enacted Public Health and AIDS-Specific Laws	Description of Relevant Legal Content
FSM	Pohnpei AIDS Prevention and Control Act (2006). State provision regarding education, discrimination, and treatment	<p>Section 2 of the Act promotes the right to information and education regarding HIV; states that compulsory testing is illegal; protects PLHIV from discrimination; and obligates the state to address social conditions that may affect the spread of HIV.</p> <p>Section 7 of the Act provides for HIV and AIDS education to be provided to Pohnpeians going abroad, and thus addresses the vulnerabilities of migrant workers.</p> <p>Section 34 of the Act specifically outlaws discrimination in schools based on an individual's real or perceived HIV status.</p>
Nauru	Notification of Infectious and Contagious Diseases Ordinance 1923	No system for voluntary HIV testing, but testing conducted on donated blood and antenatal women.
Niue	Public Health Ordinance (1965) HIV not included in existing public health legislation. Sex work and male-male sex are criminalized.	Venereal diseases included as a notifiable infection. Provisions include requirements to notify, detention orders, mandatory testing, restrictions on work and occupation, restrictions on change of abode etc.
CNMI	CNMI Public Law 12-75 Mandatory prenatal HIV education Routine HIV prenatal testing Waived fees for prenatal HIV testing Provision for consents given by minors for medical care and service involving STI/HIV services	<p>To require the Commonwealth Health Centre to provide free counselling and screening of pregnant woman in order to prevent the prenatal transmission of Human Immunodeficiency Virus (HIV) and to provide for clear authority for medical care providers to provide medical care related to the testing and counselling of sexually transmitted diseases, who request such care without parental consent; and for other purposes.</p> <p>Website citation: http://www.cnmilaw.org/pdf/public_laws/12/ph12-75.pdf</p>

Attachment 4: Pacific Island Country and Territory Public Health Laws - Continued

Country	Enacted Public Health and AIDS-Specific Laws	Description of Relevant Legal Content
CNMI	<p>CNMI Public Law 10-24</p> <p>The Department of Public Health shall develop a plan for a comprehensive program to impede the spread of the HIV infection within the Commonwealth.</p>	<p>To require the Department of Public Health to submit to the Governor and the Presiding Officers of the Legislature a plan for a comprehensive program which itemizes specific action to be taken to impede the spread of the HIV infection within the Commonwealth; and for other purposes.</p> <p>Website citation: http://www.cnmilaw.org/pdf/public_laws/10/pl10-24.pdf</p>
	<p>CNMI Public Law 9-9</p> <p>The Department of Public Health and Environmental Services shall provide to the victim of sexual offence counselling on HIV, testing, and the availability of health care and support services.</p>	<p>To require HIV testing of certain convicted sex offenders; and for other purposes.</p> <p>Website citation: http://www.cnmilaw.org/pdf/public_laws/09/pl09-09.pdf</p>
	<p>CNMI Public Law 10-81</p> <p>The Attorney General or the head of another department or agency that conducts an investigation of a sexual assault shall pay for the cost of a physical examination of the victim up to 2 anonymous and confidential tests of the victim for STI, including HIV, during the 12 months following sexual assaults, and a counselling session.</p>	<p>To establish an Office of Victims' Rights within the Criminal Justice Planning Agency; to require informing victims of crime of their rights; to require victims' impact statements be incorporated in every felony pre-sentence report; and for other purposes.</p> <p>Website citation: http://www.cnmilaw.org/pdf/public_laws/10/pl10-81.pdf</p>
	<p>CNMI Public Law 12-48</p> <p>Environmental health and sanitation law that deals with communicable disease reporting, outbreak and control deals with communicable disease reporting, outbreak and control</p>	<p>To repeal and re-enact 3 CMC Div.2, Chapter 1, Article 2; and for other purposes.</p> <p>This Act may be cited as the Commonwealth Environmental Health and Sanitation Act of 2000 to revise statutes relating to environmental health and sanitation.</p> <p>Website citation: http://www.cnmilaw.org/pdf/public_laws/12/pl12-48.pdf</p>

Attachment 4: Pacific Island Country and Territory Public Health Laws - Continued

Country	Enacted Public Health and AIDS-Specific Laws	Description of Relevant Legal Content
<p>CNMI</p>	<p>CNMI Public Law 6-21 Blood Testing Act of 1998 for blood borne pathogens</p>	<p>To amend 1 CMC, Div. 2, Chapter 12, Section 2605 for the purpose of requiring the testing of blood for AIDS, Syphilis and Hepatitis "BN or any other communicable disease detectable by blood test before accepting such blood for transfusion; and for other purposes. Website citation: http://www.cnmilaw.org/pdf/public_laws/06/pl06-21.pdf</p>
	<p>CNMI Public Law 15-38 The "Commonwealth Employment Act of 2007.</p>	<p>To repeal and re-enact Chapters 4 through 8 of Division 4 of Title 3 of the Commonwealth Code; and for other purposes. Foreign national worker and members of the immediate family shall have in his or her possession a certificate of freedom from communicable disease. Website citation: http://www.cnmilaw.org/pdf/public_laws/15/pl15-108.pdf</p>
<p>Palau</p>	<p>3 NMIAC (NMI Administrative Code) 140-10.3-001, et seq</p>	<p>General provisions and rules and regulation of Department of Public Health including HIV and STIs as reportable diseases to DPH.</p>
<p>Palau</p>	<p>Quarantine and Communicable Diseases 1994 Public Health Laws; Palau National Code 34 (PNC)</p>	<p>AIDS/HIV described as a routine reportable disease, and cases must be entered on a weekly reporting form.</p>
<p>Papua New Guinea</p>	<p>HAMP Act 2004: quarantine and public health provisions displaced by HAMP Act</p>	<p>The HAMP Act, Section 11, makes it unlawful to deny a citizen protection from HIV infection of himself or another; Part II forbids discrimination against an individual infected by or affected by HV.</p>
<p>Samoa</p>	<p>1987-88, HIV and AIDS added to list of infectious or communicable diseases by gazetted notice; Western Samoa Health of the People Bill, 1996</p>	<p>Sex work and male-male sex are criminalized. Village Fono (traditional leaders) have powers to banish people from villages in the interests of public order and public health.</p>

Attachment 4: Pacific Island Country and Territory Public Health Laws - Continued

Country	Enacted Public Health and AIDS-Specific Laws	Description of Relevant Legal Content
Solomon Islands	Environmental Health (Public Health Act) Regulations do not include HIV and AIDS as notifiable diseases, but this can be amended by Minister of Health by notice.	Sex work and male-male sex are criminalized. Public Health Act provides for isolation of infectious diseases. A policy of voluntary informed consent testing has been established.
Tokelau	Human Rights Rules 2003; gives full legal effect to the right to health and other aspects of the Universal Declaration of Human Rights.	Legislation largely governed by New Zealand. Sex work and male-male sex remain criminal offences in Tokelau as law there has not yet been updated in line with current New Zealand law.
Tonga	Tonga Public Health Act 1992 includes HIV and AIDS as notifiable diseases.	Sex work and male-male sex are criminalized. Public Health Act provides for isolation. No non-discrimination legislation or other HIV legal protection.
Tuvalu	Public Health Act includes venereal diseases as infectious diseases.	Mandatory testing of visa applicants, seafarers, and entrants to local marine training centre.
Vanuatu	Vanuatu Public Health Act 22 of 1994 list HIV and AIDS as a notifiable disease but relevant sections of the Act have not yet been commenced. A draft Public Health Bill was prepared in 2000 by not passed.	Sex work and male-male sex are criminalized. Director of Health has wide powers over infectious diseases, to the extent that contravene human rights principles and the Constitution, but these provisions not enforced.
New Caledonia	Deliberation n° 68 of 23 September 1986 related to the designation of laboratories authorized to proceed to the detection of the anti-HIV. Deliberation n° 154/CP of 16 April 2004 related to the implementation of free and anonymous testing for HIV.	HIV is recognized as a public health problem and it is a priority of the government. First, laboratories are allowed to proceed to the detection of anti-HIV and the second deliberation introduces the free and anonymous testing for HIV by implementing an agreement process for doctors and midwives.
Wallis & Futuna		

Source: Summary table developed by UNAIDS Country Office Fiji, using data provided by work done by Christine Stypula on behalf of UNAIDS, UNDP Pacific Centre and FARRI.

Attachment 5: Focus of early National Strategic Plans

UNAIDS Focus Areas for STD/HIV/AIDS Response	Priorities	Cook Is.	Fiji	Kiribati	Nauru	Samoa	Solomon Is.	Tonga	Tuvalu
Reducing the vulnerability of specific groups and promoting safer sexual behavior	Reducing the vulnerability to HIV/STI/AIDS of specific groups	*	*	*	*	*	*		*
	Boarding women			*					*
	Children	*	*				*		*
	Community								
	Street kids		*				*		
	Health workers			*					
	Men/married men	*					*		
	Military & police		*						
	Mobile populations/ travelers								*
	MSM		*	*					
	People with multiple sex partners			*					
	Poor		*						
	Prisoners		*						
	Seafarers		*	*				*	*
	Sex workers		*	*				*	
	Provision of safe blood supplies	Traditional birth attendants						*	
Women/married women		*	*	*		*	*		*
Youth		*	*	*			*		*
Alcohol harm reduction									*
Infection control					*				
HIV testing & counselling		*			*				
Safer sex & condom promotion		*	*	*	*		*		*
Promoting safer drug injection behaviour	Provision of safe blood supplies	*	*	*	*		*		*
	Promoting safer drug injection behaviour								
Preventing and controlling STIs	Preventing and controlling STIs	*	*	*					*

* Primary priority secondary priority

Attachment 5: Focus of early National Strategic Plans (continued)

UNAIDS Focus Areas for STD/HIV/AIDS Response	Priorities	Cook Is.	Fiji	Kiribati	Nauru	Samoa	Solomon Is.	Tonga	Tuvalu
Support and caring for PLHIV	Care & support for PLHIV, their families and carers Health care workers Pregnant women with HIV	*	*	*	*		*		*
Human rights & HIV/AIDS		*	*						
Coordinating a multi-sectoral response to STD/HIV/AIDS	Coordinating the multisectoral response to HIV/STI/AIDS Monitoring, surveillance, evaluation & research	*		*	*		*		*
			*						

* Primary priority * secondary priority

Source: Wiseman, G , S. Vete, J. Rudland 2000. AusAID Pacific Regional HIV/AIDS Initiative: Report of Prefeasibility and Project identification Study.

Attachment 6: An overview of the current status of National Strategic Plans

Country	HIV Plans	Finalized	No plan	M&E Plan
American Samoa			X	
Cook Islands	2000 2008-2013	√		
FSM	4 State Plans, 1 Nat Plan			
Fiji	2007-2011	√		√
French Polynesia	Health Plan 2001-2005	√	X	
Guam			X	
Kiribati	2001-2004 2005-2008	In draft		
Marshall Islands	2006-2009	√		
Nauru	2000 Health Plan 2008-2009	√	X	
New Caledonia	2001-5(4th), 2008-13 (5th)	√		
Niue	2003-	√		
CNMI			X	
Palau	2009-2013	√		
Papua New Guinea	2004-2008 2006-2010	√		
Pitcairn Islands			X	
Samoa			X	
Solomon Islands	2000-2005 2005-2010	In draft		
Tokelau			X	
Tonga	2001-2005 2009-2013	√		
Tuvalu	2009-2013	√		
Vanuatu	2008-2012	In draft		
Wallis and Futuna			X	

Source: Rachel James, UNAIDS Pacific Office

Attachment 7: Application of the Pacific Aid Effectiveness Principles

Pacific Aid Effectiveness Principle	Pacific HIV Response Adherence to Principle
<p>Principle 1: Country leadership and ownership of development through an accountable and transparent national development planning and financial management system/mechanism which is adequately resourced from the national budget - including longer term operation and maintenance of donor sponsored development</p>	<p>While this principle emphasises national ownership and leadership, much of the Pacific HIV response is channelled through parallel regional systems including Global Fund, ADB, PRHP and the new Response Fund. The Response Fund is committed to providing resources to national governments which is a positive step and the fact that most of the funding sources are committed for five years facilitate longer-term operation and reliability.</p> <p>The Papua New Guinea HIV response is largely provided to the national government (ADB, Global Fund, AusAID) which facilitates national ownership. AusAID's movement from project funding to programmatic support is a positive step.</p>
<p>Principle 2: Multi-year commitments by development partners and countries aligned nationally identified priorities as articulated in national sustainable development strategies, or the like, with agreement on performance indicators and monitoring and evaluation mechanisms</p>	<p>Multi-year commitments are made by donor partners in the Pacific HIV response. There is some concern however that the regional strategy is not sufficiently aligned with nationally identified priorities and is also not aligned with national development plans. Greater integration between regional and national is needed. Some governments have lamented the development of parallel HIV specific mechanisms that are not integrated with national systems and policy.</p>
<p>Principle 3: Greater Pacific ownership of regional development, Development Partners' Pacific Regional Strategies designed and formulated with the Pacific Plan and other Regional Policies as their corner stone</p>	<p>The Pacific HIV response adheres to this principle. Pacific ownership of the regional HIV/AIDS strategy is strong and Pacific engagement with PRSIP II seems good. There is a regional strategy that donors adhere to, and national workplans that PRSIP II will work through.</p>
<p>Principle 4: Pacific Development Partners and Countries pursue a coordinated approach in the delivery of assistance. Encouraging harmonization will be a priority for both.</p>	<p>Harmonisation of the HIV response in the Pacific is likely to be much improved through PRSIP II and the Response Fund.</p>

Attachment 7: Application of the Pacific Aid Effectiveness Principles (continued)

Pacific Aid Effectiveness Principle	Pacific HIV Response Adherence to Principle
<p>Principle 5: Strengthened institutional mechanisms and capacity in countries to enable increased use of local systems by development partners.</p>	<p>PRHP emphasised local capacity building through its CDO grants as well as the NAC and Competitive grants. Despite this, capacity to implement HIV activities in the Pacific remains limited according to most interviewees. Structures for the HIV response remain at the regional level through SPC rather than at the national or local level. The hiring of HIV coordinators for each Global Fund recipient country will be a significant step forward in building local capacity to use funds appropriately. AusAID has also moved from project funding to programmatic support and is increasingly untying aid which supports this principle.</p>
<p>Principle 6: (i) Provision of technical assistance (TA), including in aid coordination/management, in such a way that ensures that capacity is built with tangible benefits to the country to support national ownership. Provision of an appropriate level of counterpart resources through established procedures and mechanisms.</p> <p>(ii) Short term TA, that addresses local skills gaps to conduct studies, and are culturally sensitive.</p>	<p>The hiring of HIV coordinators in each country through the Global Fund will ensure greater capacity development and technical support in country rather than at SPC or through regional mechanisms. The fact that a large percentage of the Global Fund Round Two funds supported regional and not national activities suggests that this is an area where the regional HIV response can still improve.</p>
<p>Principle 7: Use of an agreed monitoring and evaluation framework that will ensure joint assessments of the implementation of agreed commitments on aid effectiveness.</p>	<p>PRSIP II has an agreed M&E framework that includes implementation of agreed commitments on aid effectiveness. In particular, outcomes 5.2, 6.1, 6.3 and 6.4.2 directly track implementation of harmonisation and Three Ones.</p>

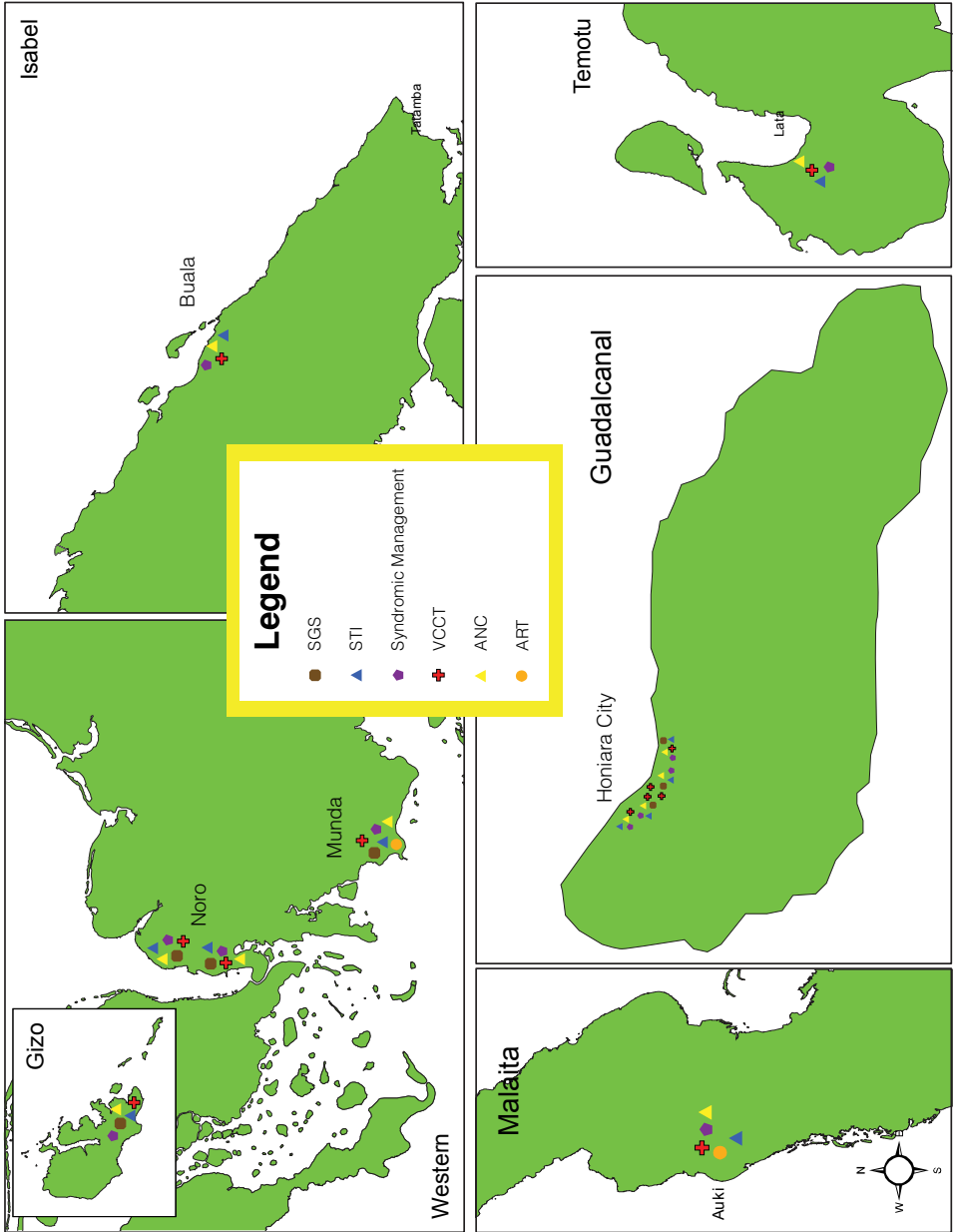
Source: UNSW Global 2009 *The Effectiveness of Financing and Aid Coordination in Responding to the HIV Epidemic in the Pacific Region*, p 59-60

Attachment 8: Allocation of HIV funds by country and sources of funding

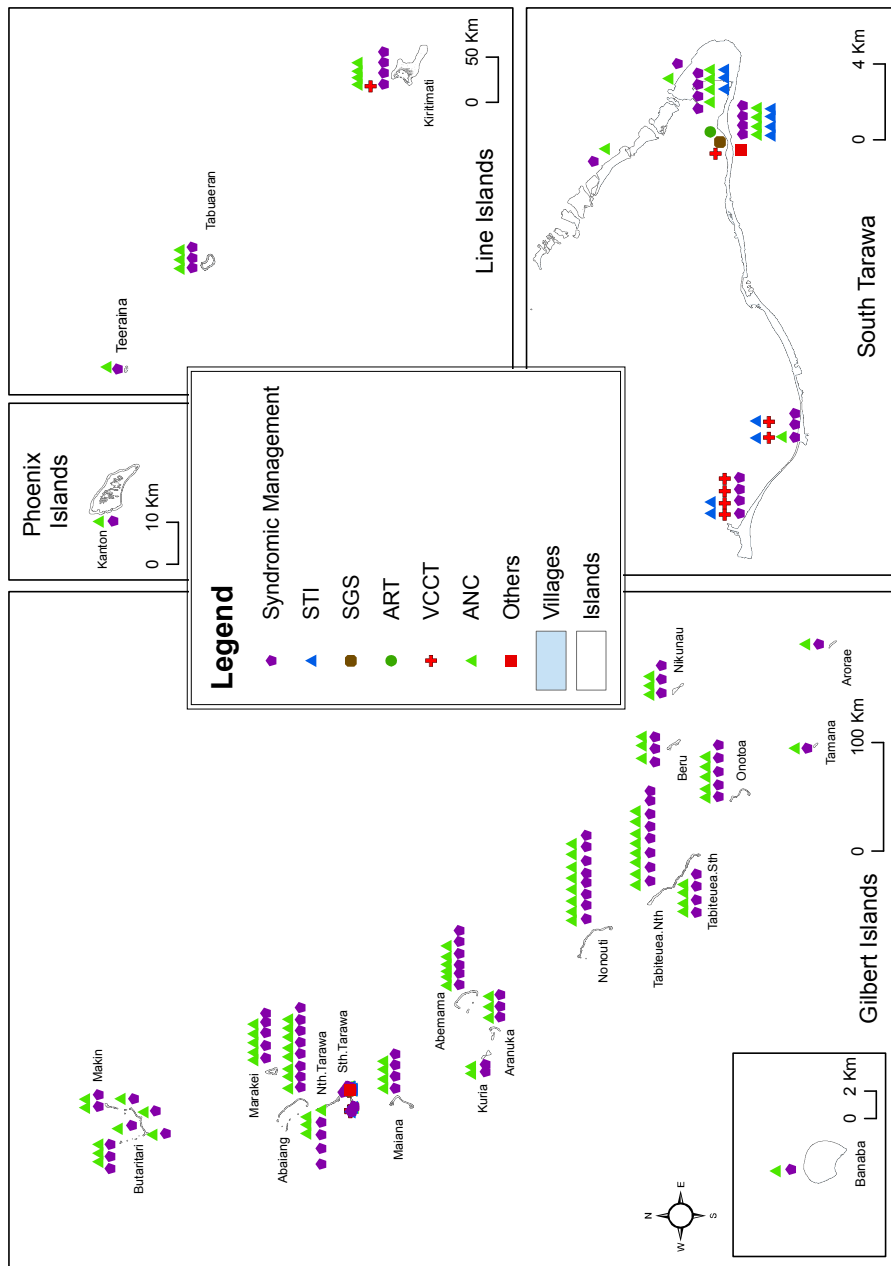
Country	ADB Prevention & Capacity Dev Project	GF Round 2	GF Round 7	PRHP CDO Grants	PRHP NAC Grants	US Govt Support	French Govt Support
American Samoa						X	
Cook Islands	X	X	X	X	X		
Fiji		X		X	X		
French Polynesia							X
FSM	X	X	X		X	X	
Guam						X	
Kiribati	X	X	X	X	X		
Marshall Islands	X		X		X	X	
Nauru	X		X		X		
New Caledonia							X
Niue		X	X		X		
Northern Mariana Isles						X	
Palau		X	X			X	
Samoa	X	X	X	X	X		
Solomon Islands	X	X		X	X		
Tokelau					X		
Tonga	X	X	X	X	X		
Tuvalu	X	X	X	X	X		
Vanuatu	X	X	X	X	X		
Wallis and Futuna							X

Source: UNSW 2009 Note: Papua New Guinea is excluded from this table as its HIV aid comes directly from bilateral and multilateral donors. Higher prevalence countries are bolded.

Attachment 9: Map of Solomon Islands HIV Service Delivery Sites



Attachment 10: Map of Kiribati HIV Service Delivery Sites



Attachment 11: Terms of Reference for the Commission on AIDS in the Pacific

The Pacific region covers an immense geographical area, comprising countries with small, widely dispersed and highly mobile populations. Within the Pacific region are some of the least developed countries in the world. Progress, over the past 30 years has been generally slow and uneven across the region; particularly with regards to economic growth and poverty reduction.

The reasons are many and complex. The geographic isolation of many countries, limited and expensive transport and communications infrastructure and small populations preclude them benefiting from economies of scale in commerce and in the provision of public services. Most countries have a narrow economic base and therefore limited means to employment generation and improving living standards. This results in escalating poverty, high unemployment particularly for youth, and consequent erosion of human capital. Other challenges include, unequal access to social services, high rates of population growth, high dependency on migration remittances, escalating environmental costs and negotiating spaces within dual political systems.

As Pacific countries struggle with these challenges, AIDS is posing an additional threat. The AIDS pandemic is having enormous health, social and economic consequences throughout the world. In the Pacific, failure to effectively prevent its future spread will pose a direct and significant threat to the sustainability of the health, economic, social development goals and potential threat to national security of Pacific communities. Some of these impacts are already being seen in Papua New Guinea.

HIV was first reported in the Pacific in 1984 and in the decades since, the virus has been officially reported in all but three Pacific countries and territories: Niue, Pitcairn Island and Tokelau. An estimated 81,000 people were living with HIV at the end of 2006 (UNAIDS, 2006), with Papua New Guinea accounting for more than 90% of all HIV infections. In 2006, the region's adult prevalence rate was 0.4%, mainly due to the epidemic in Papua New Guinea (national prevalence rate of 1.8%), with an estimated 4,000 deaths and 7,100 new infections. In addition, due to inadequate and weak surveillance systems and capacity, there are almost certainly many unreported cases throughout the region. The epidemic is growing vigorously in the Pacific region and there are no signs that it is abating.

The rapid explosion of HIV in the Pacific region is caused by many factors. These include: low use of and access to condoms; accelerating STI rates; increasing alcohol and drug abuse; lack of sex education and a highly mobile population.

Factors impinging on an effective response to HIV include low level of awareness and understanding of its long term impact among policy makers and administrators to weak health care delivery systems, inadequate budgets, weak governance and poor community involvement. Part of the reason for the low level support and commitment among policy makers and opinion leaders is the preoccupation with the many and competing development problems facing the region and the lack of appreciation by decision makers, of the devastation that an uncontrolled epidemic can cause to the fragile communities of Pacific Island countries.

The HIV pandemic has also raised some basic questions on societal norms that form the basic fabric of societies. While there are signs of change in the attitudes of some leaders towards sex and sexuality including the introduction of sex and family life education, much remains to be done to avert the disastrous consequences of a burgeoning epidemic. As the epidemic is mainly driven by unprotected sex, Governments are often at a loss to define priorities for implementation of control programmes including access to care and treatment for infected populations. As a result, the infected populations remain highly stigmatized and deprived of even the limited health care services available in the countries.

Without the possibility of a cure or a preventive vaccine emerging on the international scene in the near future, the problem of HIV will continue to challenge Governments and civil societies for the next decade and beyond. It would be necessary for countries in the Pacific region to be sensitive to the short and medium term implications of the presence of a large HIV infected population and members of their families who are affected. The problem needs to be understood not just at the macro economic level but at the individual, family and community level as well where the maximum impact will be felt in the Pacific countries. Governments need to adopt policies which will minimize the impact of HIV at all levels while attempting to halt and reverse the spread of the epidemic.

UNAIDS, the Joint UN Programme for HIV/AIDS considers that it is vital that objective and independent analysis be conducted to assess the status and impacts of the epidemic in order to provide policy options to member countries in the Pacific region. This will enable a more informed basis on which to respond to the pandemic in individual countries and across the region. UNAIDS therefore proposes to constitute an independent Commission on AIDS in the Pacific with a view to obtaining appropriate policy recommendations in the areas of prevention, care and support and impact mitigation. The list of members and their profiles are attached.

The duration of the Commission will be for 12 months and financial support for the functions of the Commission will be provided by the UNAIDS Secretariat. Given the short time frame, maximum use will be made of available data and information and operational research will be undertaken only for filling critical gaps. For commissioning such studies, putting together the evidence in the form of a Report and providing secretarial assistance to the Commission in its day to day work, a leading Research/Academic Institution will be engaged from the Region.

The Commission on AIDS in the Pacific will carry out the following:

- Collate and analyse existing information on the incidence and prevalence of HIV and AIDS.
- Assess the socio economic composition of the infected and affected populations and the impact of the epidemic on them at household, community, workplace and societal levels;
- Analyse the medium and long term implications of the presence of a large HIV infected population in Pacific communities and its impact on the socio economic environment in the affected countries. Special focus will be given to the impact on human resources, including migrant labour, labour productivity, poverty reduction, social stability and household savings;

- Review the impact of the epidemic on Governments, NGOs and regional bodies with regard to allocation of limited resources to health budgets, assessing strain on existing health systems, diversion of resources from priority areas of social and economic development, and related issues of national security; and
- Provide specific recommendations on the nature of institutional reforms and policies that need to be adopted to reverse the epidemic and minimize the adverse impact of HIV and AIDS on households, communities, societies and the economies.

The findings of the Commission will be summarized in a Report that will be widely disseminated to the UNAIDS Cosponsors and the Secretariat, National Governments of the Region, bilateral and multilateral donors communities infected and affected by HIV and prominent leaders of civil society.

Attachment 12: List of Commission on AIDS in the Pacific Members

Chairperson (posthumous)



Dr Langi Kavaliku, Former Deputy Prime Minister and Minister for Education, Civil Aviation and Works, Tonga and former member of the Board of Governors of The Commonwealth of Learning. Having retired from public service at the end of 2000, he was most recently the Chancellor of the University of the South Pacific. Dr Kavaliku was a member of the Eminent Persons Group which reviewed the South Pacific Forum in 2003.

Dr. Senipisi Langi Kavaliku died on Wednesday 3 December in a tragic motor accident in Nukualofa, Tonga. Dr. Kavaliku was a gentle and wise leader who encouraged us all to work in a way which “enhanced the capabilities of Pacific peoples to lead free and worthwhile lives” – words that he used many times during his chairpersonship of the AIDS Commission

Chairperson



Honourable Misa Telefoni Retzlaff M.P Deputy Prime Minister and Minister of Trade Commerce, Samoa Hon Misa Telefoni is the Deputy Prime Minister of Samoa. He has been an HIV/AIDS champion since holding the health portfolio (1996 - 2001) and has spoken at many international fora on the subject.

He has published a novel “Love and Money” and a book of his writings “To Thine Own Self Be True”. He has served as President of the African Carribean Pacific Region - ACP (2007 - 8) in Brussels and delivered speeches in Universities including Georgetown (Washington DC) and Auckland University (NZ). He considers the chairpersonship of the Pacific AIDS Commission one of his greatest and most rewarding challenges.”

Misa Telefoni Retzlaff is the Patron of the Samoa AIDS Foundation (SAF).

Members



Ms Maire Bopp Dupont, Journalist and Chief Executive Officer of Pacific Islands AIDS Foundation (PIAF)

Maire Bopp Dupont, a journalist from French Polynesia, has been actively working to raise awareness of HIV/AIDS among Pacific island communities. Her crusade started in December 1998 when, still a university journalism student in Fiji, she broke a taboo in her community by revealing that she was HIV-positive during a Pacific Islands News Association (PINA) conference in Tahiti.

Following her graduation, Maire joined Tahiti's Radio Tefana as a journalist in May 1999. Five months later, she won PINA's Pacific Freedom of Information Award for her outstanding efforts in the promotion and defense of freedom of information and expression in the region. She has since been touring the islands to speak to communities, schools and non-governmental organizations (NGOs) about the epidemic. Maire Bopp Dupont is currently president of a Tahitian NGO that promotes HIV/AIDS awareness in French Polynesia.



Professor Satish Chand, School of Business, University of New South Wales, Australia. Prior to joining UNSW, Satish Chand was with the Crawford School of Economics and Government at the Australian National University. Satish's research interests are on economic development, particularly the developmental challenges faced by small island states. Much of his recent writings and research have been on the Pacific Islands. Satish Chand was born, educated and worked for several years in Fiji. He has a PhD in Economics from the ANU and has published extensively on trade, economic growth, labour markets and development.



Dr Rob Moodie, Professor of Global Health at the Nossal Institute for Global Health at the University of Melbourne. Between 1998 and 2007 he was the CEO of VicHealth. He is the chair of the Australian Preventative Health Task Force.

After graduating in medicine from Melbourne University in 1976, Dr Moodie spent 8 years working with refugees in the Sudan and with Australian indigenous people in Alice Springs.

From the late 80's he spent many years in various roles developing and leading HIV/AIDS prevention and management programs in Australia and overseas, initially with WHO's Global Program on AIDS. He was the inaugural Director of Country Programs at UNAIDS from 1995-8.

Rob chairs the Technical Panel to the Bill and Melinda Gates Foundation's HIV prevention program in India. He also chairs the Melbourne Storm Rugby League Club.

He writes regularly in the media and is co-editor/author of four books, including Community Action on HIV; Hands on Health Promotion; and Promoting Mental Health. His most recent book is Recipes for a Great Life.



Ms Hitelai Polume Kiele, Acting Secretary for Justice and Attorney-General, Papua New Guinea Ms Hitelai Polume-Kiele is the new Acting Secretary and Attorney General in PNG.

Ms Polume- Kiele from Loniu Village in Manus Province joined the organisation 16 years ago.

Hitelai Polume-Kiele graduated with her Masters Degree in Law from the University of Melbourne in March 2006. She graduated from the University of PNG in 1981 with a first degree in Law and was admitted to practice law in 1986. She began work with the National Public Service in the Department of Justice & Attorney General, WAIGANI, Papua New Guinea in May 1992 and was attached to the Office of the Solicitor General until on 17th January 2007 when she was appointed as the Acting Secretary.



Mr Warren Lindberg M.N.Z.M., Group Manager, Public Health Operations, New Zealand Ministry of Health. Prior to his current position, Warren was Commissioner with a special interest in health and disability issues with the NZ Human Rights Commission.

Warren has worked in the New Zealand health sector for over twenty years, initially as Executive Director of the New Zealand AIDS Foundation from 1986 to 1998. During that time he was involved in the establishment of the International Council of AIDS Organisations (ICASO) and the Asia- Pacific Council of AIDS Organisations (APCASO). Following this, he managed the Ministry of Health's Project to Counter Stigma and Discrimination Associated with Mental Illness.

Before entering the health sector, Warren Lindberg was a teacher and community worker in Otara, Manukau City. He holds Master of Philosophy and Bachelor of Arts degrees, a Diploma in Teaching and a Certificate in Community Studies, and was made a Member of the New Zealand Order of Merit in 1999 for services to welfare.



Honourable Dame Carol Kidu, CBE, MP, Minister of Community Development, Papua New Guinea The Hon. Dame Carol Kidu is the sole woman member of the 109-member Papua New Guinea parliament and cabinet. Dame Kidu was first elected into the PNG Parliament in 1997 and in 2002, and appointed Minister of Welfare and Social Development. She has facilitated the preparation of major legislative reforms to the criminal code on rape and sexual assault, as well as new legislation on child sexual abuse and sexual exploitation of children. She has spearheaded a major shift in public policy to refocus social development to an integrated community development approach. Dame Kidu is a member of the United Nations Development Programme Advisory Panel on Poverty and Social Development for the Pacific Sub Regional Centre based in Fiji, and a member of the Board of the Commonwealth of Learning for a four-year tenure from 2008.

Dame Kidu is the 2008 Regional Rights Resource Team Pacific Human Rights Award winner for her outstanding contribution to promoting the rights of Pacific Islanders; she is also recognized as the "mover behind the scenes" for the reservation of four seats for women in Parliament for this year, 2009.



JVR Prasada Rao, is the Regional Director of the UNAIDS Regional Support Team, Asia and the Pacific. From 1997 to 2002, he was the Director of Indian National AIDS Control Organisation (NACO). Among other initiatives, he devised and put into operation a national level sentinel surveillance system for tracking the epidemic which was the first of its kind in Asia and the Pacific. As Secretary for Health and Family Welfare Departments, he was instrumental in drafting the National AIDS Prevention and Control Policy and the National Blood Transfusion Policy of India. Prasada Rao participated as member of important Global Initiatives like the Transitional Working Group (TWG) which decided the operation mechanism for Global for AIDS, Tuberculosis and Malaria (GFATM) and the High Level Forum (HLF) which was set up jointly by World Bank, World Health Organization and bilateral donors for monitoring achievement of health-related Millennium Development Goals (MDG). He also served as a member of the Programme Coordinating Board (PCB) of UNAIDS while he was Director NACO. As Regional Director of UNAIDS in Asia and the Pacific, Prasada Rao also served as the Member Secretary of the Commission on AIDS in Asia which released its report in March 2008.

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The Pacific is home to some of the world's smallest, least developed, and most isolated communities. Development progress over the past 30 years, particularly in economic growth and poverty reduction, has been slow, uneven, and in some countries, even negative. Pacific island countries have also experienced pockets of instability with social and political unrest, civil conflicts and natural disasters all contributing to the region's development burden. The region's vulnerability is compounded by the impacts of climate change and globalization.

As the region struggles with these and other challenges, HIV is posing an additional threat. The HIV epidemic has had enormous health, social and economic consequences throughout the world. In the Pacific, the failure to effectively slow the epidemic will undoubtedly have a direct and significant impact on national and regional social, health, and economic development gains.

It was within this context that UNAIDS established an independent Commission on AIDS in the Pacific in October 2007 with a mandate to study and consider the real and potential impacts of HIV on the Pacific region, and to recommend strategies for accelerated and strengthened responses to HIV.

In this Report, the Commission draws on existing and new research to make recommendations for policy makers, programme implementers, development partners, communities, people living with HIV and all those concerned about the impact of and responses to HIV and AIDS in the Pacific.

The Commission concludes that the Pacific region has, despite limited capacity, a poor evidence base, high levels of risk taking behaviours and vulnerabilities, made fairly good progress in responding to HIV. However, increased political and civil society engagement and commitment will be needed to sustain the region's response.