

## ***Charting the Course of the AIDS Epidemic in the South Pacific***

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### **Abstract**

*There is a growing consensus that HIV/AIDS is a 'time bomb' ticking in the South Pacific. This may in fact be the case. However, there are at least two major problems with this approach. First, research on the vectors of the epidemic is only as good as the data that it relies on. There are major testing and surveillance gaps in the South Pacific that mean that projections are often based on patchy and incomplete data. This can skew priorities. Second, analysis of the implications of the epidemic are based on links between the epidemic and social, economic and political outcomes. Many of these apparent links have not been established (because the data is not available for the South Pacific). So, much of the method for discussing the ramifications of the epidemic are borrowed from elsewhere, notably Africa. Reflecting on these problems is important because of the clear ramifications for the development of good public policy in, and toward, the South Pacific.*

### **Introduction**

There is concern amongst academics, policymakers and practitioners over instability in the Pacific. At first glance this concern seems warranted because recent tensions in Fiji, Papua New Guinea (PNG), the Solomon Islands and, Vanuatu have highlighted what appears to many to be endemic instability. Furthermore, this concern extends to whether issues such as AIDS<sup>1</sup> are contributing to instability.

The need for good public policy responses within and outside the region makes it a priority to make sense of these events in the Pacific. How we frame the AIDS epidemic has a direct bearing on competing policy priorities in resource poor settings; does the AIDS epidemic warrant more attention than TB or malaria? But doing so must be based on sound foundations. Therefore this paper takes one issue of concern to many policymakers and researchers (the AIDS epidemic) to provide a foundation for analysis of its connections to instability in the South Pacific. The aims of this paper are twofold: (1) to provide a succinct summary of available information; and (2) to highlight some of the problems associated with providing a solid foundation of data on which to base public policy. In so doing it sounds a warning about the influence of African<sup>2</sup> analogies for understanding and countering AIDS in the region.

This paper begins with a brief summary of the literature establishing a link between the AIDS epidemic, governance and development (drawn primarily from African scholarship). This is followed by an overview of

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<sup>1</sup> "AIDS" is used throughout as shorthand for the HIV/AIDS epidemic.

<sup>2</sup> This paper uses "Africa" to denote Sub-Saharan Africa.

available data on the epidemic in the South Pacific. This leads to a discussion of the relevance of surveillance methods in interpreting and contextualising the available data. The aim is to illuminate orthodoxies between AIDS and governance that implicitly and explicitly inform foreign policymaking toward the Pacific. The uncritical transfer of these orthodoxies is not the foundation for good public policy and can be as Donald Denoon warns - "a lazy substitute for careful observation."<sup>3</sup>

## **AIDS, governance and development orthodoxies**

At the outset an important contextual point is required. It is beyond the scope of this paper to comprehensively appraise arguments about AIDS and development in Africa. What is important to the argument here is that the orthodoxy is that AIDS has had a major impact on governance and development in Africa.

There is a voluminous literature connecting state fragility in Africa to the AIDS epidemic. For instance, Poku argues that there is a vicious circle where state fragility is implicated in the spread of the epidemic and AIDS is implicated in the development of fragility.<sup>4</sup> The Joint United Nations Programme on HIV/AIDS (UNAIDS) provides a representative example of the perspective of intergovernmental organizations (IGOs) and state based aid agencies:

In regions where HIV prevalence rates are high, the epidemic destroys the very fabric of what constitutes a state: individuals, families, communities and political institutions. AIDS affects and eventually breaks down community structures. Public administration, governance and social services become unsustainable in the process, and both coping capacity and policing capacity are reduced. As a result, communal conflict is likely to increase, which is particularly true for areas with a history of violence and armed conflict.<sup>5</sup>

From this perspective, which has become orthodoxy, the implications of AIDS for governance and development are serious and ongoing. They are: first, it has significantly lowered quality of life by increasing morbidity and mortality, reducing life expectancy and increasing poverty. Second, it has undermined economic growth and national wealth by reducing productivity, savings and human capital and by increasing national debt. Third, it has reduced state

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<sup>3</sup> Donald Denoon, 'Black Mischief: The Trouble with African Analogies', *Journal of Pacific History*, 34 3 (1999), 289.

<sup>4</sup> Nana Poku, *AIDS in Africa: How the Poor are Dying* (Cambridge: Polity, 2005), 9; Alex De Waal, 'AIDS-Related Famine in Africa: Questioning Assumptions and Developing Frameworks', in *The Political Economy of AIDS in Africa*, ed. Nana Poku and Alan Whiteside (Aldershot: Ashgate, 2004); and International Crisis Group (ICG), *HIV/AIDS as a Security Threat*, (Brussels: ICG, 2001), 1.

<sup>5</sup> UNAIDS. 'Security and Humanitarian Response to AIDS', UNAIDS, <http://www.unaids.org/en/PolicyAndPractice/SecurityHumanitarianResponse/default.asp> (accessed January 17, 2008).

capacity leading to a decline in standards of governance and the provision of public goods. Furthermore, much research paints a very bleak picture of this downward spiral<sup>6</sup> with the implication that there is no escape in sight from weak governance, corruption and the epidemic that afflicts these states.

Clearly this type of scenario would be of great concern and interest if repeated in the South Pacific. It may in fact be the case that this relationship between state failure and AIDS exists in Africa, but it has not been demonstrated in the Pacific, and even the case from Africa appears to be unravelling.<sup>7</sup> Furthermore, discussion of the security implications of AIDS has led to claims that “Africa provides the prelude to the disease” elsewhere and the implications are considered dire.<sup>8</sup> As such this developing orthodoxy is very important because many analysts, politicians and policymakers have uncritically accepted that the course of the AIDS epidemic in Africa, and its implications, is being or will be repeated in the Asia-Pacific.<sup>9</sup> An orthodoxy based on plausible speculation demands further analysis.

Is the orthodox view reflected in Australian foreign policy? It was certainly the case for the Howard government. For instance, Foreign Minister Downer noted that “the growing incidence of AIDS will have a dire economic impact on households, firms and the Government” in PNG.<sup>10</sup> And the previous Foreign Affairs White Paper included some emphasis on combating AIDS and noted that “HIV/AIDS is emerging as a major health and development challenge for PNG, affecting about one in every 350 Papua New Guineans.”<sup>11</sup>

There is not enough evidence to conclusively argue that the Rudd government will continue the DFAT/AusAID focus on countering AIDS in the South Pacific.<sup>12</sup> However, the anecdotal evidence, such as the faithful repetition of AusAID statements by the Prime Minister, the pledge to increase funding on the occasion of Rudd’s visit to PNG in March, and the continuity in DFAT policy statements suggest that it will be business as usual.<sup>13</sup> In addition, during the election campaign Rudd’s speeches included statements such as:

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<sup>6</sup> Andrew Price-Smith and John Daly, *Downward Spiral: HIV/AIDS, State Capacity and Political Conflict in Zimbabwe*, (Washington, DC: US Institute of Peace, 2004).

<sup>7</sup> See, for instance, Tim Allen, ‘AIDS and Evidence: Interrogating Some Ugandan Myths’, *Journal of Biosocial Science* 38 (2006).

<sup>8</sup> PW Singer, ‘AIDS and International Security’, *Survival* 44 (2002): 147. See also Asian Development Bank (ADB), *Socioeconomic Implications of HIV/AIDS in the Pacific* (Manila: ADB, 2005); and ADB, *Poverty Implications of HIV/AIDS in the Pacific* (Manila: ADB, 2005).

<sup>9</sup> See, for instance, S., Ratuva, *Pacific Islands States Security Issues*, Briefing Paper for Forum Security Committee, Auckland, 15 June 2005: 9 & 25.

<sup>10</sup> See for instance, Alexander Downer, *Papua New Guinea: The Road Ahead*, Parliament House, Canberra, 1 December 2004, A Speech at the launch of the DFAT Economic Analytical Unit report,

<[http://www.foreignminister.gov.au/speeches/2004/041201\\_eau\\_report.html](http://www.foreignminister.gov.au/speeches/2004/041201_eau_report.html)>, (accessed May 12, 2008).

<sup>11</sup> DFAT, *Advancing the National Interest*, Canberra, 2003.

<sup>12</sup> An excellent analysis of the first steps of the new government is provided by Charles Hawksley, “Rudd’s Way” – *The ALP in Government and its Policies Toward the South Pacific*, A refereed Paper for the Third Oceanic Conference on International Studies, University of Queensland, St Lucia, 2-4 July 2008.

<sup>13</sup> Steven Marshall. ‘Rudd pledges \$13m for PNG AIDS fight’, Australian Broadcasting Corporation, <<http://www.abc.net.au/news/stories/2008/03/07/2182913.htm>> (accessed May 12, 2008).

“the explosion of the *HIV – AIDS* pandemic in PNG presents a growing risk to the public health of Australian communities”.<sup>14</sup>

So, the orthodox view of the implications of the epidemic developed from African experience has been internationalised in Australia’s foreign policy toward PNG and is implied when the South Pacific is discussed. For some politicians, policymakers and analysts it would be possible to rest the argument at this point, however, this brief survey begs the question: is there an epidemic of African proportions developing in the South Pacific?

### **An overview of AIDS in the South Pacific**

AIDS was first recorded in the Pacific in 1984, but it was a number of years before it spread across the South Pacific; PNG’s first case was reported in 1987 and Fiji’s first case was reported in 1989. Since the late 1990s the spread of AIDS has been accelerating. According to the latest available comparative figures from the Secretariat of the Pacific Community (SPC) as of 2004 the cumulative number of HIV cases was below 10,000. However, if the latest figures from PNG were included the cumulative number of HIV cases would rise to approximately 20,000.

Due to the incomplete nature of the figures from any single source the prevalence (total cases) and incidence (new cases) rates of infection discussed here are compiled from several sources over various years, but figures produced by South Pacific states themselves are privileged. Table 1 integrates the latest SPC figures and is augmented from other sources, such as the Fiji Ministry of Health, Pacific Islands AIDS Foundation, UNAIDS and the World Health Organization (WHO).<sup>15</sup> Despite being a few years old the SPC figures are significant as they represent the only data that focuses on *known* cases and also includes all regional states. Case data such as this generally underestimates the true prevalence of the epidemic, but it is used here in contrast to surveillance data and HIV prevalence estimates that generally overestimate the epidemic. A focus on known case data was chosen due to the large variance in estimates from various sources (more of this later).

**Table 1: HIV/AIDS Case Data from the Pacific**

		HIV incl. AIDS (Dec. 2004)	Cumulative AIDS cases (Dec. 2004)	Cumulative AIDS deaths (Dec. 2004)	As of:
American Samoa	SPC	2	1	0	Dec 2003
Cook Is	SPC	1	0	0	Dec 2003
Fiji	SPC	142	25	15	Dec 2003
	UNAIDS	(182)	(25)	(17)	
	FMOH <sup>16</sup>	249		24	

<sup>14</sup> Kevin Rudd. ‘Fresh Ideas for Future Challenges: A New Approach to Australia’s Arc of Instability’, (speech, Lowy Institute, Sydney, July 5, 2007).

<<http://www.alp.org.au/media/0707/speloo050.php>> (accessed May 12, 2008).

<sup>15</sup> Pacific Islands AIDS Foundation. ‘HIV/AIDS Statistics for Pacific Islands Countries and Territories’, Pacific Islands AIDS Foundation, <[www.pacificaids.org/grafix/PICTHIVcases03-05-04.doc](http://www.pacificaids.org/grafix/PICTHIVcases03-05-04.doc)> (accessed January 17, 2007).

<sup>16</sup> Information provided to the author by the Fiji Ministry of Health, Suva, August 2007.

FSM	SPC	14	7	3	Dec 2003
French Polynesia	SPC	229	77a	56a	Nov 2003
Guam	SPC	176	86	45	Dec 2003
Kiribati	SPC	42 (46)	19 (28)	19(23)	Dec 2003
Marshall Is	SPC	9	2a	2a	Jun 2002
Nauru	SPC	1	0	0	Dec 2003
New Caledonia	SPC	263	99	58	Dec 2003
Niue	SPC	0	0	0	Dec 2003
Northern Mariana Is	SPC	25	11	7	Oct 2002
Palau	SPC	4	2	2	Dec 2003
PNG	SPC	7,320	1,336a	n/a	Aug 2002
	WHO	2889	13765		
	2005/2000 PNG 2007 <sup>17</sup>	18484			
Pitcairn	SPC	0	0	0	Dec 2003
Samoa	SPC	12 (12)	8 (8)	8 (8)	Dec 2003
Solomon Is	SPC	2 (5)	1 (2)	1 (2)	Feb 2004
Tokelau	SPC	0	0	0	Dec 2003
Tonga	SPC	13 (13)	11 (9)	11 (8)	Dec 2003
Tuvalu	SPC	9	2	2	Dec 2003
Vanuatu	SPC	2 (2)	2 (2)	0 (0)	Dec 2003
Wallis and Futuna	SPC	2	1	n/a	Oct 2000
<i>TOTAL reported</i>	SPC	8,268 (11212)	1,672 (2237)	n/a (610)	Dec 2003
	Inc. PNG 2007	19,432			
<i>TOTAL (without PNG)</i>		948 (1028)	336 (394)	226 (257)	Dec 2003
Source: Secretariat of the Pacific Community <sup>18</sup>		Notes: (a) as of 21 December 2001; n/a = not available, (b) As of Dec 2003.			

One of the more striking trends revealed by this data is that more than 95 per cent of cases are in five states; the epidemic is concentrated in French

<sup>17</sup> Ministry of Health/National AIDS Council, *The 2007 Estimation Report on the HIV Epidemic in PNG*, (Port Moresby: Ministry of Health/National AIDS Council, 2007), VII.

<sup>18</sup> SPC, *The Pacific Regional Strategy on HIV/AIDS 2004-2008* (Noumea: 2005) 18. World Health Organization (WHO), *Second Generation Surveillance Surveys of HIV, Other STIs and Risk Behaviours in 6 Pacific Countries (2004-2005)* (Geneva: WHO, 2006).

Polynesia, Guam, New Caledonia, Fiji and PNG. Furthermore, if PNG's figures were removed then the South Pacific would have less than 1,000 cases (that is according to reported figures and estimates between 70 to 97 per cent of cases are in PNG). There are more than 150 cases of HIV reported per month in PNG, more than the rest of the Pacific combined.<sup>19</sup> In addition, AIDS has been the top cause of death at the Port Moresby General Hospital since 2001, and evidence points to a similar epidemic developing across the border in West Papua.

WHO and UNGASS have classified the epidemic in the Pacific as limited, concentrated or low prevalence, but PNG is excluded from this judgement. While the estimated prevalence rate in Oceania is 0.3 per cent, in PNG there is an estimated 1.8 per cent prevalence amongst adults (15-49).<sup>20</sup> This means that the known (and for that matter estimated) prevalence in many South Pacific states is very low, as low as many developed states. Two states, Niue and Tokelau, have not reported any cases. In addition, incidence rates in much of the Pacific are not extremely high.

It is clear from the available information that there are a number of epidemics in the region; there is no 'South Pacific' epidemic. Dramatic differences in the trajectory of the epidemic can be explained by different political and social contexts, which effect mode of transmission (and in part by the patchiness of surveillance and data, which is discussed later).

In contrast to catastrophic comparisons to Africa, it seems very surprising that 25 years into the global pandemic a few South Pacific states have no known cases. This highlights the caution required when viewing the inevitability of the spread of the pandemic (and associated connections to issues such as state fragility or failure).

As it stands the argument that the is significantly negatively impacting on the whole South Pacific region is not founded on sound evidence and faithfully replicates a key weakness in African analogies of the course of the epidemic, namely treating a region as a coherent whole. So from the standpoint of AIDS, and any African style implications of the epidemic, there is PNG (and West Papua) on the one hand and the rest of the South Pacific on the other.

### ***PNG as the Africa of the Pacific?***

"PNG is the Africa of the Pacific: big numbers of infections, very little resources, a lot of poverty, hardly any communication facilities across the country, different languages and a very poor literacy rate." Maire Bopp Allport, Pacific Islands AIDS Foundation founder.<sup>21</sup>

The statistics highlight the fact that by any measure PNG has the most serious epidemic in the region. Furthermore, in PNG the epidemic is growing fast. PNG is the only state in the South Pacific to report a generalised epidemic and

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<sup>19</sup> UNAIDS. 'Papua New Guinea', UNAIDS, www.UNAIDS.org (accessed July 27, 2005).

<sup>20</sup> UNAIDS, *AIDS Epidemic Update 2006* (Geneva: UNAIDS, 2006) Annex 2, 512. By contrast the rate estimated by the PNG National AIDS Council is 1.28. Ministry of Health/National AIDS Council, *The 2007 Estimation Report on the HIV Epidemic in PNG*, IV.

<sup>21</sup> Maire Bopp Allport, *Australian*, June 30, 2006.

furthermore it is one that has not been contained.<sup>22</sup> According to the best available surveillance and modelling by the PNG National AIDS Council the prevalence rate is estimated to be 1.28 per cent and therefore 46,275 people are estimated to be living with HIV.<sup>23</sup> So having become generalised means that PNG's epidemic involves a much higher prevalence rate than the rest of the Pacific, and due to the relatively large population base, much larger numbers of people are involved (both as people living with AIDS [PLWA] and people living with PLWA).

For these reasons, when it comes to the epidemic, and its implications, PNG should be separated from the rest of the South Pacific. The question is: is what's unfolding in PNG a mirror of the epidemics in Africa?

**Table 2: New and Cumulative HIV infections detected in Papua New Guinea, 1987 - 2006<sup>24</sup>**

<b>Year of Diagnosis</b>	<b>Male</b>	<b>Female</b>	<b>Unknown</b>	<b>Total HIV Infections by year</b>	<b>Cumulative HIV Infections</b>
1987	2	4	0	6	6
1988	8	5	0	13	19
1989	11	7	0	18	37
1990	24	12	0	36	73
1991	17	16	2	35	108
1992	12	18	0	30	138
1993	19	21	0	40	178
1994	42	31	1	74	252
1995	68	57	1	126	378
1996	94	96	2	192	570
1997	173	174	1	348	918
1998	331	307	23	661	1579
1999	418	335	37	790	2369
2000	598	448	27	1073	3442
2001	642	615	56	1313	4755
2002	840	796	78	1714	6469
2003	1058	1137	121	2316	8785
2004	1152	1193	284	2629	11414
2005	1310	1587	156	3053	14467
2006	1711	1965	341	4017	18484
<b>Total</b>	<b>8530</b>	<b>8824</b>	<b>1130</b>	<b>18484</b>	

While the comparatively low prevalence rates and numbers of deaths in PNG hardly compare to the tens of millions of people infected in Africa or the growing epidemic in Asia, there are plentiful risk factors and anecdotal evidence supporting the need for vigilance. For instance, PNG is characterised by many conditions present in Africa and elsewhere that are linked to a heightened risk of epidemic diseases becoming threats to human security and

<sup>22</sup> See David Plummer, Margaret Lokoloko, Alison Heywood and Albert Bunat, *Evaluation of the PNG National HIV/AIDS Support Project* (Canberra: AusAID, 2005) Appendix 1, 8.

<sup>23</sup> Ministry of Health/National AIDS Council, *The 2007 Estimation Report on the HIV Epidemic in PNG*, IV.

<sup>24</sup> Ministry of Health/National AIDS Council, *The 2007 Estimation Report on the HIV Epidemic in PNG*, 7.

state stability.<sup>25</sup> Taken alone none of the following are necessary and sufficient conditions, but together they become so. Conditions include: subsistence economics, limited transport of surplus goods, high dependence on the environment (and vulnerability to natural disasters), poverty, high fertility, rapidly increasing population, a disproportionately young population, lack of commensurate employment opportunities (high levels of unemployment), 85 per cent of the population lives in rural areas, urban migration, squatter communities, low literacy, limited travel (and lack of access to health services), high child mortality and maternal mortality, growing incidence of STIs, and a relatively high incidence of TB, a focus on village or clan units for social organization (whose governance structures are under challenge), gender inequality, gender violence, sex work, sex for trade, polygamy, alcohol and drug abuse, crime, weak law enforcement, high levels of religiosity, ignorance about HIV/AIDS (for instance 50 per cent of respondents in one survey knew of the protection afforded by condoms and 50 per cent wanted to ban condoms in an attempt to stop promiscuity), and stigma (cultural taboos that do not necessarily encourage risk-minimising behaviours).<sup>26</sup>

In addition, moving from the known data presented earlier, credible projected prevalence rates do compare with some African states. So despite caveats that will be introduced later about surveillance and modelling, it is clear that PNG faces a serious epidemic. For example, a recent report commissioned by AusAID predicted that by 2025 HIV prevalence will be above 10 per cent of the adult population, 500,000 people would be living with HIV, 300,000 people would have died, 117,000 children will have lost their mothers, gross domestic product (GDP) would have dropped by 1.3 per cent and the workforce by 12.5 per cent, and the health system would be overburdened with over 70 per cent of beds occupied by PLWA.<sup>27</sup> And it is from these types of projections that predictions of social, cultural, political, economic and environmental challenges akin to those facing many African states arise.<sup>28</sup>

Despite the clear case of a serious epidemic developing in PNG, the observations about the implications of AIDS for governance must take account of the local political, social and cultural context. All too often conclusions about the impact in Africa have influenced modelling for the Pacific, with little or no reflection on the former factors. For instance, the SPC points to the impact of HIV on the most productive members of society, its impact on families that support the sick and on health care systems with

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<sup>25</sup> For the link between AIDS and Human Security see for instance Centre for Conflict Resolution, *HIV/AIDS and Human Security: An Agenda for Africa*, Policy Advisory Group Meeting, Addis Ababa, September 2005.

<sup>26</sup> National Aids Council Papua New Guinea, *National Strategic Plan on HIV/AIDS 2004-2008* (Port Moresby: National Aids Council, 2004); National Aids Council Papua New Guinea, *National Strategic Plan on HIV/AIDS, 2006-2010* (Port Moresby: National Aids Council, 2006); National HIV/AIDS Support Project (NHASP), *Social Mapping of 19 Provinces in Papua New Guinea: Summary Report* (Port Moresby: 2005), 3-5; and SPC, *The Pacific Regional Strategy on HIV/AIDS 2004-2008*.

<sup>27</sup> AusAID, *Impacts of HIV/AIDS 2005-2025 in Papua New Guinea, Indonesia and East Timor: Synopsis Report* (Canberra: AusAID, 2006) 1. This was the baseline scenario based on the best available data and the situation could be markedly better if greater intervention occurs.

<sup>28</sup> ADB, *Socioeconomic Implications of HIV/AIDS in the Pacific*; and ADB, *Poverty Implications of HIV/AIDS in the Pacific*.

already limited resources.<sup>29</sup> AusAID, by far the largest donor supporting PNG's HIV program, notes that "HIV is a long term threat to the people of Papua New Guinea".<sup>30</sup> And according to an AusAID funded report into the future of the epidemic "at the levels of prevalence and consequent death rates projected under the baseline scenario, HIV infection has the potential to undermine governance and increase poverty."<sup>31</sup>

Clearly the orthodox view of AIDS and governance that originates from the African experience of the epidemic has permeated the policies of major donors, but does this mean that 'Africanisation' is occurring,<sup>32</sup> and that it is inevitable? Work is being done on the local impact of AIDS. A particularly good example of these implications in the context of PNG is Heather Worth and Klara Henderson's work on society.<sup>33</sup> And from the perspective of state stability and human security the author has conducted research on whether the epidemic can in fact be framed as a threat to governance, economics and society.<sup>34</sup> More work needs to be done, and as it will necessarily be based on epidemiological data, the first priority must be the provision of accurate, consistent information.

### **Surveillance and estimates of the epidemic**

An important caveat to generalisations about the epidemic developed in Africa and elsewhere is that prevalence rates do not tell a great deal about the implications of the epidemic. An extended discussion of surveillance is beyond the scope of this paper, but it is worth noting that estimates are often used to create prevalence rates for South Pacific states and there are problems with methods and modelling. These problems can be illustrated by reviewing figures from a few sources taken at about the same time (or allowing for lag). As of 2004 AusAID put the number of HIV cases in PNG alone at between 25,000 and 69,000. These figures represented a HIV rate of between 0.9 per cent and 2.5 percent of 15 to 49 year olds.<sup>35</sup> By contrast, Human Rights Watch (HRW) noted "that at least eighty thousand people – around 3 to 4 percent of the population in the capital" and one per cent elsewhere have HIV.<sup>36</sup> Furthermore, HRW cites predictions that the rate will reach 13 per cent by 2010.<sup>37</sup> By contrast, the Asian Development Bank has cited much lower

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<sup>29</sup> SPC, *The Pacific Regional Strategy on HIV/AIDS 2004-2008*, 19.

<sup>30</sup> See Plummer, et. al., *Evaluation of the PNG National HIV/AIDS Support Project*, 52.

<sup>31</sup> AusAID, *Impacts of HIV/AIDS 2005-2025 in Papua New Guinea, Indonesia and East Timor: Synopsis Report*, 10.

<sup>32</sup> Ben Reilly, 'The Africanisation of the South Pacific', *Australian Journal of International Affairs*, (2002).

<sup>33</sup> Heather Worth and Klara Henderson, 'AIDS is a Tear in the Social Fabric of Papua New Guinea: HIV and its Impact, 2005-2025', *Health Sociology Review* 15 (2006).

<sup>34</sup> Michael O'Keefe, 'HIV/AIDS and Security in PNG', in *Law, Order and HIV/AIDS in Papua New Guinea*, ed. Vicki Luker, Sinclair Dinnen and Allan Patience (Canberra: ANU Press, forthcoming).

<sup>35</sup> David Plummer, et. al., *Evaluation of the PNG National HIV/AIDS Support Project*, Appendices, 10.

<sup>36</sup> Human Rights Watch (HRW), *World Report 2006*, (NY: HRW, 2006), 305.

<sup>37</sup> Human Rights Watch, *"Making Their Own Rules": Police Beatings, Rape, and Torture of Children in Papua New Guinea* (NY: HRW, 2005) citing results of a National AIDS Council and UNAIDS workshop in November 2004.

figures,<sup>38</sup> highlighting again the incomplete picture that we possess of the epidemic in PNG.

Estimates vary so widely as to be almost indecipherable. For instance, for WHO the standard practice has been to multiply the reported cases of HIV and AIDS by between 5 and 25 depending on perceptions of the state of the epidemic in a given area.<sup>39</sup> Furthermore, the national prevalence rates for PNG that have informed public policy in the past have been based on sentinel surveillance data from anti-natal clinics and blood donors in a few provinces (a very small sample) and extrapolated to other areas. Clearly these methods can lead to problems with estimates as evidenced by the drop in the incidence rate in the early 2000s that was attributed to a decline in testing rather than to prevention.<sup>40</sup> In the circumstances this approach is the best option but one that provides uncertainty about the state of the epidemic in much of PNG.

A lack of resources and practical difficulties means that many statistics, on high-risk groups and health sector responses to the epidemic for instance, simply have not been collected in the region. Furthermore, due to the paucity of information even breaking down national figures into important categories for public policymaking, such as mode of transmission, has not been possible. For instance, in PNG gender is the only variable for which information is nearly complete.<sup>41</sup> And even as surveillance improves dramatically in a few South Pacific states any form of historical comparison (which is generally a necessity for the trajectory and implications of the epidemic to be assessed) relies on the use of some fairly imprecise and incomplete data. For instance, as of 2006 almost no South Pacific states provided any meaningful Country Progress Indicators as part of the UNGASS Declaration of Commitment on HIV/AIDS.<sup>42</sup>

A clear sign of the problems with gathering accurate data was evidenced in the re-evaluation and downward estimation of UNAIDS and WHO AIDS statistics in late 2007.<sup>43</sup> Both UNAIDS and WHO found that global prevalence was stable or had started to decline.<sup>44</sup> The global figure was put at 33.2 million, down from the earlier figure of 40 million. This is striking news that could be evidence of the success of prevention and treatment programs but also reflects adjustments to the methodologies for estimating HIV prevalence. The estimates of PLWA in Oceania dropped from 78,000 to 75,000 and the number of deaths from AIDS related diseases from 3,400 to 1,200/1400.<sup>45</sup> These are not insignificant numbers, and the downgrade in estimates by the peak global body concerned with the epidemic is telling.

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<sup>38</sup> ADB, *Country Strategy and Program Update 2005-2006, Papua New Guinea*, (Manila: ADB, 2005), 12.

<sup>39</sup> See Pacific Parliamentary Assembly for Population and Development (PPAPD), 'Suva Declaration on the Fight Against HIV/AIDS', 13 October 2004, 1; and SPC, *Pacific Islands Regional Millennium Development Goals Report 2004*, (Noumea: SPC, 2004), 81.

<sup>40</sup> National HIV/AIDS Support Project (NHASP), *2004 National HIV/AIDS Consensus Workshop: Key Findings Summary and Analysis*, Milestone 82, (National AIDS Council PNG, Port Moresby, April 2005), 4 - 5.

<sup>41</sup> NHASP, *2004 National HIV/AIDS Consensus Workshop*, 5.

<sup>42</sup> UNAIDS, *2006 Report on the Global AIDS Epidemic*.

<sup>43</sup> WHO, *Global HIV Prevalence has Levelled Off*, (Geneva: WHO, 2007).

<sup>44</sup> WHO, *Global HIV Prevalence has Levelled Off*.

<sup>45</sup> There is an inconsistency in UNAIDS figures. See UNAIDS, *AIDS Epidemic Update 2007* (Geneva, UNAIDS and WHO, 2007) 41; and UNAIDS, *Key Facts by Region – 2007 AIDS Epidemic Update*, (Geneva: UNAIDS, 2007) 3.

In the circumstances modelling based on limited data is the only, and therefore best option, but one that provides uncertainty about the state of the epidemic in much of the Pacific, especially given that population-based HIV surveys from Africa often highlight a bias toward high estimates.<sup>46</sup> That is, when undertaken comprehensive surveillance has shown previous assumptions and estimates to be inaccurate, sometimes widely so. For various reasons, most notably a lack of resources, it is unlikely that population-based surveys will be undertaken in the South Pacific any time soon.

A concern about surveillance is nothing new to the epidemiologists whose reports form the basis of much public policy on AIDS in the region. Studies of HIV prevalence in the South Pacific agree that the surveillance is the largest obstacle to providing clear policy guidance. For instance, the 2004 PNG Consensus Workshop found that:

the lack of a comprehensive, systematic approach to behavioural surveillance is a major barrier to implementing...second-generation surveillance ...that allow decision makers to better understand and explain observed trends in the HIV epidemic, in addition to better assessing the impact of national HIV/AIDS control programs.<sup>47</sup>

This means that estimates are “the most appropriate given the inadequate extent of data from many provinces.”<sup>48</sup>

If one seeks to delve a little deeper into the statistics the problems are magnified. Prevalence rates are the most basic measure of the trajectory of the epidemic, but tracking its impact requires much more data. For instance, the relation to state fragility requires in-depth analysis of a wide range of social and economic indicators and cross comparison with HIV statistics that are gathered *over time*. And statistics certainly have not been collected in time series that allows trends to be analysed. And, if they have been collected it is often unclear whether a consistent method has been used which would allow analysis of the sort undertaken in Africa. Therefore, whether any useful comparison can be made between epidemics in Africa and PNG, or the South Pacific for that matter, is questionable.

### **Patchy surveillance and estimates and public policy**

Due to the inherent problems with methods such as these it is clear that in most South Pacific states prevalence rates may not reflect reality and may not even approximate it. And while they may be the best we have, methods such as these have additional problems such as including a bias toward over-estimation and upward estimates. Further, as noted earlier, these methods are required for areas lacking good surveillance and as such are more likely to be used in the South Pacific. For instance, the 2006 UNAIDS report on the epidemic estimates that there are 60,000 people living with HIV in PNG, but

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<sup>46</sup> See, for instance, UNAIDS, *AIDS Epidemic Update 2007*, Table 2, 11.

<sup>47</sup> NHASP, *2004 National HIV/AIDS Consensus Workshop*, 6; and WHO, *Second Generation Surveillance Surveys of HIV, Other STIs and Risk Behaviours in 6 Pacific Countries (2004-2005)* (Geneva: WHO, 2006) 9.

<sup>48</sup> NHASP, *2004 National HIV/AIDS Consensus Workshop*, 6.

the range is from 32,000 to 140,000.<sup>49</sup> This equates to prevalence rates ranging from 0.9 to 4.4 percent, and the upward estimate for PNG is almost double UNAIDS' 2007 downward estimate *for the whole region*.

The reason for the overestimation bias may appear straightforward. Resources are often allocated based on perceptions of the seriousness of the epidemic, so higher prevalence rates, and discussion of the epidemic as a ticking time bomb, may attract greater funds from INGOs and state donors. However, from a practical standpoint overestimation is a legitimate approach. If the lowest estimate is used then the prevention and control strategy may not contain the epidemic, so using worst-case scenarios can ensure that public health programs are able to deal with them. So, while prevalence rates are generally low, sexually transmitted infections (STIs) are generally rising and it is argued that a "failure to act" could have catastrophic effects.<sup>50</sup> And there is evidence to support this perspective. For instance, "a high ratio of reported AIDS cases relative to HIV infections (1:3.5) is apparent and is suggestive of a larger reservoir of infections."<sup>51</sup>

Despite having a sound basis an overestimation bias is particularly significant in resource poor settings or where there is strong competition for scarce resources because worst-case scenario planning can skew public policy priorities, say toward HIV and away from malaria, TB or diabetes. And these conditions of scarcity are most apparent in developing states, such as the South Pacific, where issues such as diabetes may actually pose a greater immediate risk to public health than HIV. Clearly the large difference between the high and low estimates has a major impact on the design of prevention and treatment programs and analysts must be mindful of the use of estimates and overestimation bias throughout the South Pacific. And, it is clear that major efforts need to be put into improving surveillance in the region. Significantly for some time major efforts have been underway to improve this deficiency, especially where it is most needed; in Fiji and PNG.<sup>52</sup> For instance, innovative initiatives such as the 2005 Social Mapping exercise have provided much needed insight into the cultural context within which prevention programs need to be run.<sup>53</sup> However, from present data it is not possible to make the type of comparisons with Africa necessary to inform good public policy making.

Another factor influencing the usefulness of data from the South Pacific is its relative unimportance to the global epidemic. That is, due to its geographic isolation, political and economic marginalisation, and apparent low prevalence rates (in small populations) it is far from a priority for most IGOs and non-government organizations (NGOs). For instance, according to the latest UNAIDS figures there were an estimated 14,000 new infections in Oceania in 2006 (range 11,000 to 26,000) versus 1.7 million in Africa (range

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<sup>49</sup> UNAIDS, *AIDS Epidemic Update 2006*, Annex 2, 511.

<sup>50</sup> See, for instance, David Fowler, Bill O'Loughlin and Sister Vika Tikinatabua, *Mid-Term Review of the Pacific Regional Strategy on HIV (2004-2008) and its Implementation* (Noumea: SPC, 2007) 7.

<sup>51</sup> WHO, *Second Generation Surveillance Surveys of HIV, Other STIs and Risk Behaviours in 6 Pacific Countries (2004-2005)*.

<sup>52</sup> See for instance, WHO, *Second Generation Surveillance Surveys of HIV, Other STIs and Risk Behaviours in 6 Pacific Countries (2004-2005)*.

<sup>53</sup> NHASP, *Social Mapping of 19 Provinces in Papua New Guinea: Summary Report*.

1.4 to 2.4 million).<sup>54</sup> Relative unimportance is reflected in resource allocation. So at the country level UNAIDS *Epidemiological Fact Sheets* are only available for Fiji and PNG and the absence of data under many headings is notable. In addition, the severity of the epidemic in Africa has prompted population-based HIV surveys, which have often yielded surprising results (when compared to previous estimates) but resources have not been allocated to using this method in the South Pacific.

The low priority given to the region is also reflected in how regional programs are organised. For the purposes of making neat generalisations the Pacific is most often treated as part of another area. UNAIDS focuses on regions and in “Oceania” it only lists Australia, Fiji, New Zealand and PNG (presumably because these are the only states that have significant epidemics but also because of the lack of accurate data from elsewhere). WHO’s Western Pacific Region is even broader linking the South Pacific with Asia, so similar problems are observed (again only Fiji and PNG are mentioned). Clearly Australia and New Zealand or China and Cambodia for that matter have very different epidemics than those of the South Pacific so any regional aggregation for statistical purposes will be skewed by them. South Pacific states are very small when compared with China, a comparison that inevitably happens when regional generalisations are made. Therefore, the arbitrary nature of regional aggregation does little to focus attention on the problems of prevention in the South Pacific. So, the time for ‘like’ states in the South Pacific to be grouped together is long overdue. This would be a step in the right direction, which could be followed by focussing attention on where the epidemic in the region is at its worse: PNG.

The SPC HIV/AIDS advisor has noted that “HIV/AIDS is a generalized epidemic in Papua New Guinea. We could be just seeing the tip of the iceberg in the rest of the Pacific region.”<sup>55</sup> But the problem is that without accurate and comprehensive surveillance there is no way of knowing. Prevalence rates are only as accurate as the surveillance and reporting in a particular area and therefore they do not say anything about the demography and numbers of those with HIV who are *not* tested. This makes comparison based on estimates tentative at best.

## **Conclusion**

Superficially it would be easy to accept the orthodox view that the experience of AIDS in Africa will be repeated in the South Pacific. The AIDS epidemic in PNG has much in common with Africa, but assertion is not evidence and a convincing link is not evident. In contrast to the similarities there are sound reasons for de-linking epidemics in Africa and the Pacific, or at least to be more critical of the relevance of African analogies to the South Pacific.

AIDS is not ‘spreading like wildfire’ in the Pacific. The epidemic has become generalised in PNG and has the potential to grow quickly, but this

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<sup>54</sup> UNAIDS, *AIDS Epidemic Update 2007*, 15 and 36.

<sup>55</sup> Dennie Iniakwala, *Situational and Response Analyses for HIV/AIDS and STI prevention, control and support services in the Pacific Region in relation to the components of the 1997-2000 regional AIDS/STD Strategic Plan* (Noumea: SPC, 2004).

does not mean that the rest of the South Pacific will be the 'next battleground' in the global AIDS epidemic. Like any facts, prevalence rates are embedded in particular political and social contexts and both need to be analysed in order to ascertain the implications of the epidemic for a particular state and society.

The paucity of available data means that this work certainly cannot be the definitive account of AIDS and instability in the Pacific, but it provides the basis for future research in this area and highlights areas where much more attention is required in order for definitive analysis to be undertaken. Clearly surveillance is the largest obstacle to providing clear policy guidance and major efforts, of the sort being undertaken in PNG, are required to remedy this situation.<sup>56</sup> So a key conclusion of this paper is that even greater resources need to be applied to surveillance to ensure that policy is based on accurate data.

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<sup>56</sup> National HIV/AIDS Support Project (NHASP), *2004 National HIV/AIDS Consensus Workshop: Key Findings Summary and Analysis*, Milestone 82, National AIDS Council PNG, April 2005, p. 6. & WHO, *Second Generation Surveillance*, p. 9.