

Introduction

HIV IN THE PACIFIC

By the mid-1980s, a few of the 22 Pacific Island countries and territories (PICT) from the three subregions of Melanesia, Micronesia, and Polynesia began reporting HIV infections through passive surveillance. The first HIV infections were reported in the Republic of the Marshall Islands in 1984, followed by French Polynesia and Guam in 1985, New Caledonia in 1986, and Papua New Guinea (PNG) and Tonga in 1987. By close of the decade, Fiji Islands and the Federated States of Micronesia had joined the list. During the 1990s, HIV continued to spread to other countries in the Pacific, including Western Samoa (1990); Kiribati (1991); and Palau, the Solomon Islands, Tuvalu, and Wallis and Futuna (by 1995). In the new millennium, the Northern Marianas, Nauru, and Cook Islands (2000); Vanuatu (2002); and American Samoa (2004) for the first time reported people living with HIV. Thus, by the end of 2004, surveillance data confirmed HIV infections in all PICT, except for Niue, Tokelau, and Pitcairn (Sladden, 2005).

The HIV epidemiological situation varies greatly within and between PICT, with epidemics increasing in different places at different speeds and with different intensities (NACS, 2005b; Sladden, 2006; UNAIDS, 2005). By the end of 2004, many countries were identified as low prevalence epidemics reporting less than 10 HIV infections (e.g., American Samoa, Cook Islands, Nauru, Solomon Islands, Tuvalu, Vanuatu, and Wallis and Futuna). While statistics of PLWH might appear small in many countries, these can reflect high rates of infection because of their tiny populations—and the potential impact can be great. As Jenkins (2005) explains, “the distribution of recorded infections might be viewed in different ways. The ‘cumulative incidence per 100,000’ is a good indicator of the potential impact of HIV on the local population. Even small numbers of cases in small populations (e.g., Tuvalu), particularly if found among young working men, can have a devastating impact at the local level.” Only nine people in Tuvalu have been diagnosed with HIV. However, with a population of only 9,600, the rate of infection

in Tuvalu is close to that of French Polynesia and Guam, which have some of the highest numbers of HIV infections in the Pacific outside of PNG.

As of the end of 2004, some countries were reporting rising numbers of PLWH and accelerating trends (Fiji Islands, French Polynesia, Guam, New Caledonia, and PNG), with sharp increases seen in some countries (Fiji Islands). PNG is in the midst of a serious generalized epidemic, with the number of infections increasing about 30% per year since 1997 (UNAIDS, 2005). More than 90% of reported HIV infections in PICTs were in PNG at the end of 2004 (UNAIDS, 2005; NACS, 2005a). Outside of PNG, Fiji Islands, French Polynesia, Guam, and New Caledonia accounted for 84% of HIV infections among PICT.

While the number of reported infections continues to grow, the epidemiological situation in the Pacific remains uncertain, and reliable estimates are unavailable. Limited passive surveillance data on people diagnosed with HIV in PNG leave important questions unanswered about how HIV is being transmitted, whether AIDS-defining illnesses are present at diagnosis, and what are the ages and gender of those testing positive for HIV. Much of the essential data for PNG was missing as of the end of September 2005: 68% of HIV surveillance data did not identify whether an AIDS-defining illness was found; the mode of HIV transmission was not known in 75% of the cases; and age was missing in 38%, while the gender was unknown in 6% (NACS, 2005b). Country HIV passive surveillance data reported to the Secretariat of the Pacific Community by the end of 2004 had much less missing information. In the data on HIV infections from PICT outside of PNG, the mode of transmission was missing for only 3%, the age was unknown for 3%, and the sex of the person diagnosed with HIV was missing for only 1%. What is becoming clearer is that HIV in the Pacific is most prevalent among young people and young adults 15–34 years old. This group in its reproductive and productive years—whether defined as youth or adults because of biological or social markers—represents 61% of reported HIV infections in PICT outside of PNG.

However, it is highly probable that HIV in the Pacific region is underreported and underestimated. Widespread voluntary and confidential counseling and testing is not accessible, and the availability of blood screening, particularly in rural areas, varies. A perceived lack of confidentiality in health systems, limited knowledge and fear about HIV and

AIDS, and stigma and discrimination towards PLWH can create avoidance. These factors do not create enabling environments for testing, or encourage PLWH to be open about their situation. Underdeveloped HIV surveillance and the lack of probability sampling do not clarify the changing HIV epidemics in the Pacific, which “leaves the observer wondering what is missing” (Jenkins, 2005). Considering the limitations of surveillance and other data, the complex contexts of vulnerability and risk in the Pacific must be understood and addressed to slow the spread of HIV.

What has created the environments for HIV to spread more rapidly in some countries, such as PNG, than in others? Is it possible that HIV is spreading quietly undetected in some Pacific island countries? What is known—from HIV prevalence studies with sex workers and rural women; HIV sentinel surveillance with antenatal mothers and sexually transmitted infection (STI) patients in PNG; data about STIs and teenage pregnancy in Pacific island countries; and limited behavioral surveillance and other research—indicates that behaviors and sexual practices create considerable risk for HIV transmission (Buchanan-Aruwafu, 2002; Mgone et al, 1999 and 2002; NACS, 2005b; NSRRT and Jenkins, 1994; UNAIDS, 2005; UNFPA, 2005; WHO, 2006). However, to prevent the further spread of HIV in the Pacific, a better understanding is needed of the cultures, traditions, ideologies, practices, and contexts in which people live, as these influence HIV epidemics.

CULTURE, CONTEXTS, PRACTICE, AND HIV

The Joint United Nations Programme on HIV/AIDS (UNAIDS) has long acknowledged the need to look at the factors that create vulnerability to HIV, including socioeconomic situations, legal and political contexts, instability and armed conflict, migration, sociocultural ideologies and practices, and social change (UNAIDS, 1998). However, few in-depth studies are available on the interrelationships between culture, contexts, ideologies, norms and values, sexualities, attitudes, and behaviors in the Pacific. This publication seeks to fill that knowledge gap, providing insight into the great diversity of cultures and traditions in the Pacific; the changes that these cultures have undergone and their impact; and the similarities

and contrasts in contexts, ideologies, attitudes, and practices that might be facilitating the spread of HIV epidemics in PNG and in other PICT.

Available data suggest that sexual transmission accounts for the majority of HIV infections reported worldwide; this also appears to be the case in the Pacific. Thus, it is essential to understand the integrated nature of people's lives, how culture and other factors relate to sexuality, and how these can contribute to HIV epidemics. In the first part of this publication, Carol Jenkins identifies and discusses in detail the cultural traditions, values, and scenarios that impact sex and sexuality in PNG—and the concepts and patterns of sexual behaviors most likely to put people at risk of HIV. Drawing on 15 years of research and experience in PNG, Jenkins aptly illustrates how historical and cultural changes over the years are relevant to HIV programs and policies in PNG today. In the second part, Holly Buchanan-Aruwafu focuses on the majority of the population of the Pacific—the young people. Through a review of available literature, she discusses from global and Pacific perspectives what is known about the epidemiology of HIV and other STIs in this group, young people's knowledge of HIV, their sexual practices and involvement in highly vulnerable groups, the similarities and contrasts in the contexts of young people's lives, and the structural factors that constrain them. Drawing on ethnographic research in Malaita, Solomon Islands, she illustrates how culture, sociocultural change, taboos regarding discussions about sex, age and gender inequalities, and conflict affect young people's vulnerability and risk of HIV infection.

Both authors discuss contextual and structural factors, including culture, which can impede HIV prevention efforts in the Pacific. Both also conclude that the power and strength of the diverse cultural traditions of the Pacific must be tapped to reduce HIV prevalence. By creating opportunities for sharing and discussing information, and engaging a wide range of cultural groups, local communities and leaders, and young people, locally adapted solutions and change can be created from within.