# Virus et Cetera: Examining Local Reception and Response to Global HIV/AIDS Discourses in Papua New Guinea

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***Abstract***

In this paper, I explore the multitude of meaning-making processes and ideologies that are at play in the contested field of HIV prevention and care in Papua New Guinea. First, I will explain how the biomedical frameworks of HIV/AIDS knowledge-making discursively enter the locale and contest the local etiology of health and sickness. I will consider a variety of ethnographies and theoretical works that contemplate the intersectionality and contestation between the biomedical framework and local peoples' context and perception. Through comparative case studies of local practices, I contemplate how current biomedical models of HIV prevention and care succeed and fail in effectively addressing the epidemic in Papua New Guinea. In the end, I validate the biological framework's great potential in HIV/AIDS prevention after modulation in a way that is suitable to the local context.

## Introduction

The global HIV/AIDS pandemic attracted great attention in biomedical research, policy making and critical writings. However, efforts in trying to contain the pandemic tended to be dominated by biomedical and epidemiological frameworks (Lepani 2012, 157), and Western negative representations of cultural practices that are contrary to knowledge of Western biomedicine (Eves 2003, 249). There is a general lack of incorporation of local sense-making and practices, which could be informative in making more effective programmes and initiatives.

In this paper, I assess how local societies in Papua New Guinea receive and respond to national HIV/AIDS prevention and care campaigns, examine the roles different institutions play in the reception and delivery of these campaigns, and disentangle the many entwined rationals in sense-making processes in HIV prevention and care amongst local societies.

I start with an overview of the past and present Papua New Guinean healthcare system, and the severity of HIV/AIDS in the nation. Then, I examine how local societies receive biomedicine-informed national campaigns, and contemplate their agency in receiving and incorporating global HIV/AIDS practices into local cultural contexts. Further, I examine how local people respond to the pandemic with Christian-informed knowledge and practices, and discuss the deficiency of current interventional campaigns in addressing the socio-cultural aspect of the illness in local cultural landscapes. I then finish with a contemplation on how a study in Christianity could potentially shed light on the integration of (instead of the intervention of) explanatory frameworks that could contribute to developing more effective prevention and care programmes.

## Background: Healthcare In Papua New Guinea

Biomedicine, which refers to the predominant medical theory in Euro-American societies that focuses on human biology and pathophysiology processes (Hahn and Kleinman 1983, 306), has a long history in Papua New Guinea, coming ashore in the 19th century with European colonists. Colonial institutions (namely the German and British authorities) initially set up healthcare facilities for the safeguard of European administrators who were prone to tropical infections such as malaria. Primary care and surveillance systems in rural areas were served by colonial patrols. Later on, missionaries incorporated healthcare facilities, which were exclusive to European colonizers, into Christian charity services and moral education institutions for locals. The significant position of the Churches in healthcare during colonial times established "an indelible link in many places between biomedical and Christian knowledge, technologies and practices" (Street 2019, 301).

Whilst biomedicine has often been the first option of treatment in case of illnesses and injuries for a long time, it exists as one of the many options in Papua New Guinea's multi-layered system of care. For example, Alice Street (2019, 305) and John Barker (2003) describe that when biomedicine failed to cure certain ailments, local people, in turn, perceived the failure as a confirmation of village sickness, which are ailments believed to be rooted in social conflict, failure of reciprocity, or sorcery. Consequently, local people turned to other options such as Christian healing or repairing social relationships. Barker (1990, 139) also notes that European doctors at town hospitals would send those with village sickness back to local healers for further care. Therefore, instead of taking biomedicine as an ultimate framework of illness, superior to any other forms of explanation, local people consider it as a new source of power to which the privileged class have access. Biomedicine is associated with colonial apparatuses, and it exists in parallel with a multitude of other explanatory frameworks.

## HIV/AIDS in Papua New Guinea: an Epidemic Brewing

The HIV/AIDS pandemic in Papua New Guinea has become a concerning one: the National AIDS Council (NAC) estimates in 2017 that approximately 47,177 people in PNG were living with HIV, an increase of 13,077 (38%) from the estimate in 2009. The number translates to a prevalence rate of 0.84% nationally. The Highlands and Southern regions have higher prevalence rates than that of the Momase and the Islands regions, which were reported at 1.10%, 0.74%, 0.74% and 0.42%, respectively. (National AIDS Council PNG 2011;2018)

Amidst the absence of a comprehensive national healthcare network, the HIV/AIDS pandemic arrived in Papua New Guinea and attracted local, national, and global attention. In early 2000, international efforts assisted in the establishment of the National AIDS Council (NAC) in response to the growing pandemic. Along with its establishment, several policies and interventions were also drafted in line with the global biomedical HIV discourse. In 2011, the NAC published the National HIV and AIDS Strategy (NHS) 2011-2015 and identified three priority areas of focus in their publication: Prevention; Counselling, Testing, Treatment, Care and Support; and System Strengthening. Specifically, the NAC identified the top ten strategic

interventions designed to address these three areas of focus. These interventions included discouraging multiple sexual partnerships, increased focus on more-at-risk populations, condom promotion, addressing gender violence, preventing parent-to-child transmission, increased availability of testing, greater access to antiretroviral treatment (ART), strengthening the pandemic surveillance system, increased technical assistance to sub-national organizations, and strengthening the overall functionality of the NAC (National AIDS Council PNG 2011).

However, with the inflow and implementation of a plethora of antiretroviral treatments, counseling practices, workshops, and expert support from both national and international organizations, problems started emerging when national efforts reached the sub-national level. The epistemological differences in conceptualizations of causes and cures of illness between the national and the local resulted in significant resistance amongst the local peoples. In addition to socio-structural determinants that are largely ignored by national campaigns, and pre-existing infrastructural deficiencies that would render HIV-specific interventions from higher-up less effective, the discrepancy between global/national HIV/AIDS knowledge and that of the locals' produced an array of entirely unexpected outcomes.

## Reception of National Campaign

Whilst national efforts strive to promote HIV prevention and care campaigns at the local level, the outcome of these efforts has had varying degrees of success. The 'ABC' (Abstinence-Be Faithful-Condom) prevention model, which is prominent in global biomedical discourses and promoted as a national strategy, has encountered considerable resistance with local communities.

Richard Eves (2012, 68) identified two main categories of arguments amongst locals that opposed condom use. First, they believed the reliability of condoms is low, and thus it cannot protect one from infection effectively. Charles Wilde (2007, 64) reports that amongst 114 Gogodala people whom he surveyed, 59 of them reported that they have never used a condom, of which 5 reported having never seen one. Whilst many Gogodala people acknowledge that condoms "help stop the transmission of HIV" and over 30% of men surveyed "thought condoms would totally prevent the transmission of HIV/AIDS if used correctly", there is still widespread belief that condoms are not 100% effective (as put into the local language, '*o paepa awapa ela mologa'*, which translates as fifty-fifty) because of fears for breakage and spillage (Wilde 2007, 64).

Second, many societies link condoms to promiscuity, infidelity, and irresponsibility. Therefore, condoms are often considered not as modes of prevention, but as facilitators of HIV transmission. Ethnographic works of Alison Dundon (2007), Richard Eves (2012), Katherine Lepani (2007), and Charles Wilde (2007, 64) all account for the fact that in many regions, the promotion and distribution of condoms is presented as problematic instead of as a solution. Whilst the ABC model of HIV prevention campaign has argued for condoms as the most effective behavioural (as opposed to sociocultural/structural) prevention strategy, it has intrinsically positioned condoms on the bottom of the moral hierarchy of behaviour, in alignment

with discourses of promiscuity and risk (Lepani 2007, 15). For example, in Dundon's (2007, 41) work with the Gogodala people, one of her informants said,

> *"some men, when they get hold of these condoms, they are just looking for women all round the place [and] not their own wives".*

Even in societies such as the Trobriand Islands where sexuality is more liberal and condoms are more embraced, structural obstacles such as condom accessibility and availability also impede the effectiveness of condom campaigns. Lepani (2012) in her work explains that while in theory, free condoms ought to be available throughout PNG, structural obstacles have to a great extent made condoms inaccessible in actuality. For example, there is a common belief held by HIV programme implementers that only condoms distributed through formal channels such as outreach and activities would be properly used. Condoms that are distributed through informal channels, on the other hand, will result in negative outcomes such as promoting promiscuity or be used in other ways such as fish baits. Therefore, whilst condoms are readily available on the local level, they tend not to be distributed and remain unopened because of the unwillingness of the officials or a lack of logistical structures for doing so (Lepani 2012, 171).

Furthermore, the discrepancy in knowledge about contraceptives undermines condom promotions. For example, The Gogodala people adhere to *ela gi* (a responsible, "good" lifestyle on which evangelical Christian principles and practices have an important influence) to prevent illnesses. HIV/AIDS, as a result, is part of the manifestation of the breakdown of *ela gi.* Whilst *ela gi* put great emphasis on sexual responsibilities and marital fidelity, *ela gi* itself, to a great extent, surrounds topics such as family planning and social responsibilities (such as preventing premarital pregnancy) instead of solely on individual sexual behaviours. Gogodala people believe that conception occurs as a result of an accumulation of semen in the mother's womb which requires several occasions of intercourse. Carefully limiting the number of acts with each sexual partner, rather than using a condom, would both effectively prevent transmission as well as pregnancy. This belief, in turn, is translated into the belief that HIV transmission could only happen after more than one act of intercourse (Wilde 2007, 63).

In addition, the reluctance of the Church to engage with condom promotions in Papua New Guinea, where more than 95% of its residents are Christian, is also influential and arguably inimical to condom promotion. The NHASP (National HIV/AIDS Support Project) highlights the resistance to condoms of the Church:

> *"Churches in the districts were strongly opposed to the distribution of condoms to young people, and many respondents, especially in Koroba/Kopiago, were totally against it on the grounds that it goes against church rules and the word of God."* (NHASP 2005a, 51)

As a result, health care workers in both religious (e.g., the Catholic Diocesan Health Services) and more secular health care settings face delicate consideration and moral conflicts in regards to condom distribution. For example, one of Hammar's interviewees reports that he is not allowed to touch condoms nor to suggest condom use; if he were to discuss condoms with "a member of a Catholic congregation or women's group", he might risk the loss of his career (2007, 77).

The ‘B’ component in the ABC model — ‘Be faithful’ — has also had inconsistent outcomes amongst local societies upon reception. It calls for limiting the number of sexual partners and discourages extramarital sex. However, the inflow of ‘authoritative, global discourses’ about HIV, which links sexuality with ‘promiscuity’ and ‘risk’, undermines both positive aspects of sexual relationships as well as pre-existing local knowledge about sexuality.

In some Papua New Guinean communities, sex has social functions  pivotal to people’s sociality. For example, in the Trobriand Islands, sexuality is an important means of reciprocity upon which inter-clan relationships rely. Lepani suggests in her work that Trobriand cosmology “values sexuality as a consensual and pleasurable practice that sustains the flows of reciprocity between clans, maintaining the relations of difference that activate social reproduction” (2007, 15). In contrast to the Western model that assumes the unidirectionality of transmission, local cosmology considers sexual activities as a form of exchange that entails the mixing of differences (Lepani 2012, 167). Local peoples have shown interest in addressing issues surrounding the epidemic, however, the deeper motive behind this interest is not only to stop the transmission of the virus but also to negotiate a middle ground between sexuality and health.

In addition, even in Gogodala where ‘faithfulness’ and monogamous relationships are embraced, there still exists a dilemma in the negotiation between individual agency and social relationships. ‘Sex’, in this sense, is not considered solely in its behavioural sense, but also entails other aspects of sociality. For example, the perceived promiscuity and infidelity that condoms entail have resulted in the unwillingness to use condoms. Not using a condom during sex has become a way of showing trust and faithfulness.Wilde’s survey (2007, 64) shows that there is a significant prevalence of extramarital relationships amongst married men despite this. In addition, Wilde also reports that some of his interviewees do not consider extramarital sexual intercourse as ‘real sex’; one man reports that he had extramarital encounters only to ‘relieve pressure’ from his marriage.

## Local Response

To gain a more holistic understanding of local societies’ reception of HIV/AIDS not only as a national/global discourse, but as a social phenomenon that entered local societies’ cultural landscape as a whole, I now briefly turn my attention to examining how local societies respond to the pandemic in their everyday life. Specifically, I articulate the degree to which the Christian explanatory framework is at play amongst local communities in making sense of the pandemic.

Christian moralism has a significant influence on how people engage with national campaigns. For example, the Lelet people of the Lelet Plateau of Papua New Guinea, who belong to the Pentecostal denomination of Christianity, consider revelation as the necessary step to prevent and cure illness. The strong moralism of the Pentecostal discourse has put many people in fear of seeking biomedical care for the potential accusation of immorality and promiscuity. Whilst there is heterogeneity between Churches on their views towards condoms, the very existence of Pentecostal preachers who preach ‘those who use condoms will go to Hell’

has to a great extent prevented believers' engagement with national campaigns and caused them to turn to alternative means of prevention and care (Eves 2003, 260).

Christian explanatory frameworks are also influential in how local people make sense of and respond to the HIV epidemic; however, there exists a multitude of views on the role of God that are in disagreement with each other. Amidst the failure of both biomedical as well as local healings, many local people embrace the born-again Christian apocalyptic narrative that considers the pandemic as a warning from God due to moral corruption, and believe the 'Last Day' might be imminent without an immediate moral reform (Eves 2003, 254). As a result, discourses on conversion and the healing power of Christianity have been produced (Hammar 2007, 77).

On the one hand, Eves (2012, 65) reports that many of her interviewees who are born-again Christians subscribed to the view that AIDS is "a curse unleashed by God to punish sinners, especially sexual sinners". Under such contexts, AIDS symbolizes a severe transgression; the only way to receive a cure is through conversion and revelation of previous sins, as people believe that "God can easily cure a severe affliction such as AIDS" (Eves 2003, 259). If a person eventually dies, it is understood that the person's death is equivalent to their unfaithfulness.

On the other hand, some voices argue against the apocalyptic explanatory framework. For example, Frank, a religious leader who also manages an HIV programme from the Southern Highlands Province, argues that individuals have the agency to make choices and be responsible for their consequences. He believes God wishes the best for people and does not punish (Shih et al. 2017, 56).

Eves (2012) argues that the Christian and biomedical bodies of knowledge about HIV/AIDS are incommensurable. Further, "[t]he local understandings and explanations that differ from the master discourse of science are not addressed in HIV prevention messages because these are 'misconceptions' that the messages will readily correct" (Eves 2012, 65). Nevertheless, I contemplate that there might be a common ground where local, Christian and global knowledge could perhaps come together and respond to the HIV/AIDS pandemic more constructively.

For example, national campaigns have indeed disseminated relevant knowledge that is designed to raise AIDS awareness amongst local communities, however, the agency of comprehending this knowledge and making informed choices accordingly lies entirely upon the individual. Instead of solely focusing on the individual aspect of behavioural control, Christian healthcare workers incorporated global HIV knowledge with Christian pedagogy on moralism. As a result, self-control over sexuality has been represented not only as an individual choice, but also symbolizes religious fidelity desired within the community (Shih et al. 2017, 54). Here, Christian-informed moral surveillance has elaborated on the moral dimension of national messages that view the moral person "as a 'unique centre of rationality and free will' who is subject to a set of moral principles that transcend particular social relationships"; instead, it

embeds the individual "within social relationships" and, as a result, one's social behaviour is regulated in accordance with Christian morality (Barker 2007, 5).

## Disease *contra* Illness

I now turn my focus back to national campaigns and further examine their deficiencies in addressing the socio-cultural aspect of HIV/AIDS in Papua New Guinean cultural landscapes. Whilst many national campaigns arguably overemphasize the behavioural aspect of prevention that underlines individual agency of choice, and to a great extent disregard structural factors, in actuality, healthcare workers and government policies are aware of the need to respond to these factors. A staff member at the Garden Programme (which aims to modify socioeconomic conditions for urban female sex workers) explains: *"In terms of biblical ways, [sex work is] totally against God's way of understanding. [But] female sex workers for instance, they need food to sustain themselves, they don't have money to look after themselves …"* (Shih et al. 2017, 55).

Despite the recognition of the role in which structural determinants play, many healthcare workers lack the skill and resources to address them (Shih et al. 2017, 57). For example, Holly Wardlow (2012, 411-15) analyzes the process through which the national discourse is translated into local knowledge by a translator in an awareness workshop. The translator Anna, who delivers the knowledge at the workshop, elaborated on the handbook that is provided by the NAC and further reflected on her personal interpretation of the epidemic. Departing from the behavioural ABC model that is the main intent of the handbook, Anna further discussed larger socio-structural factors that she thought to be attributable to the epidemic, such as intertribal violence, men's infidelity, and childcare practices. These socio-structural factors, which are informed by the lived realities and wisdom of the locals, had not at all been addressed in the handbook Anna was provided.

The incommensurability shows that the messages from the national campaign have been largely based on the global biomedical discourses in which biological and behavioural rationalities of care have been firmly based. However, these messages have failed to consider local cultural contexts. Kleinman (1978) discusses the nuanced differences between *disease* and *illness.* Diseases are abnormalities in the physio-structural human body, whereas illnesses are the holistic, lived experiences of changes in social and physical functioning. Biomedicine is competent at treating diseases, whilst patients suffer from illnesses that biomedicine considers to a lesser extent. HIV is arguably the most prevalent illness in the Papua New Guinean (even in the global) epidemiological and cultural landscape. Its inseparability with human sexuality (and thus sociality), both within a single locale as well as in the translocal realm, secures its significant need for consideration at the frontier of different meaning-making processes. Focusing solely on the biomedical aspect of prevention and care is insufficient. Whilst global messages tend to assume that biomedicine is the most accurate and universal way in which natural phenomena such as HIV/AIDS can be explained, biomedicine itself "is based upon particular Western

explanatory models and value-orientations, which in turn provide a very special paradigm for how patients are regarded and treated" (Kleinman 1978, 255).

National campaigns have to a great extent either failed to address or dismissed the legitimacy of local forms of meanings. Confusion and distortion can be produced at the frontier of two explanatory frameworks. For example, Dundon (2009, 176) says that "terms such as 'virus', 'disease', 'condition' and 'transmission' can be as much a source of confusion as they are of education or information". Patti Shih and colleagues (2007) also suggest that current counselling services focus mainly on behavioural changes that rely upon individual choice, whereas social-economic factors that encourage concurrent relationships such as migrant labour and gender inequality are beyond the agency of an individual, and are largely unaddressed.

How, then, can we mingle the two seemingly incommensurable knowledge frameworks to produce more effective prevention programmes? Eves suggests that the "problem with the global AIDS discourse [is] because it is not delivered through a reciprocal process of listening and speaking" (2012, 72); the key to a more integrative approach lies in cultural reciprocity. An examination of how Christianity managed to enter local cultural contexts might shed light on how to 'treat' the '*cultural myopia'* from which current national campaigns suffer. Whilst national HIV campaigns have taken on an interventionist's approach that has positioned themselves in a higher standing in terms of validity and thus delegitimize local knowledge, Christianity, on the other hand, entered the local cultural landscape through emphasis "on doctrines and dogmas in terms of the local reception" (Barker 2014, S179). The individualistic behavioural model of most national campaigns is incommensurable with local explanatory frameworks (Eves 2012), whilst the more collectivist nature of Catholic Churches, in addition to their ideals of reciprocity, resonate better with local cultural contexts and thus experienced a smoother entry into local societies (Barker 2014, S176).

## Conclusion

The complex geographical landscape of Papua New Guinea hosts a nation with immense cultural diversity. However, due to geographic isolation and the complexity of culturally contextualized knowledge, national campaigns on HIV/AIDS prevention and care have gained varying, but generally unsatisfactory, degrees of success. National campaigns have adopted mainly the global biomedical forms of knowledge on HIV/AIDS epidemiological processes, whereas local socio-structural contexts have largely been unattended. Such a singular approach has perhaps changed towards a more favourable direction, however, as the new 2018-2022 national STI and HIV strategy expanded upon the 2011-2015 strategy and included the Church and many socio-cultural aspects (i.e. the law, welfare, justice) into its strategic directions (cite) . However, the efficacy of the new strategy is yet to be examined. The incommensurability between different explanatory frameworks of illnesses has not been sufficiently addressed through reciprocal communication. The case of Christianity's entry to Papua New Guinea has provided a vital point of consideration for developing potentially more effective and integrative

programmes on HIV/AIDS prevention and care, in a way that does not *intervene* but *cooperates with* the local people.

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