‘HIV IS OUR PROBLEM TOGETHER’: DEVELOPING AN INDIGENOUS-LED RESPONSE TO HIV IN TANAH PAPUA

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IN BRIEF 2015/5

This *In Brief* reports on a multiday workshop on HIV that was held in Manokwari, West Papua province, Indonesia, from 27–29 November 2014. The workshop, called Developing an HIV Prevention and Control Strategy for Papuans in Tanah Papua,[1] represented the culmination of over a year of preparatory work, and something new in Tanah Papua’s HIV response: the mobilisation of a broad base of community and provincial-level actors committed to responding to epidemic levels of HIV among indigenous Papuans.[2] Based on comparative data obtained from the World Health Organization, Tanah Papua faces the fastest growing HIV epidemic in the world, and one of the highest HIV prevalence rates in the world outside of Africa.

The idea for the workshop emerged from a capacity-building activity funded by the Canadian government in 2011–12 that was focused on developing community-based HIV services in West Papua. The activity took place amidst increasing criticism of a public health approach to HIV prevention and treatment that minimises or avoids issues related to local cultural and religious values, development conditions, and ethnic tensions and fails to leverage either Papuan expertise or other research (Munro and Butt 2012; Simonin et al. 2011). The aim of the workshop was to bring together diverse stakeholders from around Tanah Papua to share experiences, define priorities for action, and work towards a strategy that targets HIV among Papuans. Participants represented indigenous communities and traditional councils, religious groups, NGOs, researchers, and government health and HIV agencies.

Dr Arnoldus Tiniap from the West Papua Department of Health opened the workshop by presenting new data from the 2013 Integrated Bio-Behavioural Study — the first Tanah Papua-wide survey of HIV prevalence and other indicators since 2006. Key findings include:

- HIV prevalence is 2.9 per cent among Papuans compared to 0.4 per cent among non-Papuans.[3]
- HIV prevalence is 3.1 per cent among youth aged 15–24, nearly double the prevalence in adults.
- HIV prevalence is significantly higher in hard-to-access coastal and highland areas (even more remote sites) than more easily accessible coastal sites. Active syphilis is prevalent in 4.5 per cent of participants, but 7.1 per cent among those in the highlands.

These new data led to discussion about sustaining indigenous culture and vibrancy in future generations, and many participants spoke of their fears of depopulation resulting from the HIV epidemic. An NGO leader from the central highlands described the rapid expansion of a local cemetery, where, ‘the headstones all read: born in 1981, 1985, 1990’. He shared a recent experience of being told by a doctor that a group of young women he had brought in to a clinic to be tested for sexually transmitted infections would likely never bear children because of the acuteness of their infections. For researchers, policy-makers, and development practitioners who work on HIV in other societies, it is perhaps a shock to hear that even in the era of HIV interventions — including antiretroviral drugs and hopeful global policies such as the UNAIDS’ strategy Getting to Zero (zero new infections, zero deaths, zero discrimination) — there exists a place where the local population feels, on the contrary, that it is likely to be extinguished by AIDS.

Summing up the group’s discussion of the HIV threat, Dr Tiniap commented, ‘Our understanding of key populations in Papua has to shift because our whole population is at risk …’. He questioned whether the key populations focussed on internationally in the context of HIV such as commercial sex workers, men who have sex with men, and high-risk males, are the categories that are of real importance in Papua. Discussion of which ‘key populations’ are relevant in participants’ respective communities led to the conclusion that, ‘HIV is our problem together’.

Participants spoke of responses to HIV that will address broader conditions fuelling the HIV epidemic, proposing, for example, that the priority in all government policies must be to ensure the conditions for a sustainable, secure life for indigenous

Papuans. One theme of discussion centred on how poorly planned, unregulated, and/or illegal resource development brings negative impacts to surrounding communities. The rapid development of remote towns, including as part of the government's decentralisation and village development agendas, leads to significant population mobility and commercial activities including sex work and illegal alcohol sales, but without corresponding health services or infrastructure (see Reckinger and Lemaire 2014).

In terms of programming, participants wanted to know more about neighbouring Papua New Guinea's responses to HIV, and how community-based organisations there have tackled some of the underlying issues. Related to HIV leadership, participants felt that Papuan leaders and organisations have been sidelined in responding to the epidemic because they have been slotted into exogenous programs and roles, rather than being allowed to exercise leadership, make decisions, or set priorities. Other participants disagreed with this assessment, saying that traditional leaders had rejected opportunities to participate in the HIV response. The consensus was that indigenous peoples should be repositioned as the main actors in Tanah Papua's HIV response.

Whether or not government actors and development agencies will support an indigenous-led HIV agenda is an important question. Development agencies may support indigenous-led approaches because these tend to be aligned with and emerging from non-state actors and groups, which could diversify and decentre the HIV response from poorly functioning government AIDS commissions. However, state actors fear being displaced from the HIV response, thus development agencies must carefully negotiate political concerns. If provincial governments are mobilised towards an indigenous-led strategy, they may set up development agencies for an unwelcome showdown with Indonesian authorities who are eager to avoid any approach to HIV that raises questions of indigenous identity or inequalities. Nevertheless, there are models of indigenous-led HIV prevention and treatment approaches that are navigating these complexities well.

Further recommendations from the workshop will follow in a future *In Brief*. For now, one of the most significant results of the workshop is applicable beyond HIV or Tanah Papua. Several participants noted that this was the first opportunity they had had as frontline HIV workers to come together and discuss HIV among indigenous Papuans without an overt donor or government agenda. Sharing knowledge and experiences within and across regional or even national boundaries, especially in face-to-face interactions, enables a powerful homegrown agenda to emerge organically, and is essential for effective community mobilisation and local ownership.

Author Notes

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Endnotes

1. Tanah Papua (Land of Papua) is often used to denote the western half of the island of New Guinea, currently comprising the provinces of Papua and West Papua.
2. The workshop implementation committee was led by local NGO partner Pt. Peduli Sehat (The Community Healthcare Association), and supported by Todd Biderman, Lynn McIntyre (University of Calgary, Canada) and the author. It was funded by the Canadian Institutes for Health Research, the State, Society and Governance in Melanesia Program of the Australian National University, and Pacific Peoples Partnership.
3. To obtain this result, the survey defined 'Papuan' as having two Papuan parents, and 'non-Papuan' as having no Papuan parents.

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We acknowledge the Australian Government's support for the production of *In Brief*.