

**State, Society and Governance in Melanesia Project  
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**Civil society, social capital and the churches:  
HIV/AIDS in Papua New Guinea**

**By**

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The churches are crucial actors in the response to Papua New Guinea's growing problem with HIV/AIDS, but often they excite ambivalence. While several have led the way in supporting people affected by HIV, Christianity tends to be identified with teachings about sexuality and an opposition to condoms that many people involved with prevention deplore.

In this paper I try to move beyond the glib assessment that the churches are 'bad at prevention, good at care'. I frame HIV/AIDS in terms of development, and broadly conceptualise the activities that can affect the course and impacts of the epidemic. Without venturing far into theoretical debates surrounding 'civil society' and 'social capital', I use these concepts – or ideas associated with them - to think about the churches. Although they are major institutions in PNG and other Pacific Island countries, very little secular analysis of their contemporary social capacities and roles is available.<sup>1</sup> Finally, I reflect upon the future roles of the churches in response to HIV/AIDS. These parting thoughts have some bearing on general issues concerning the role of churches in development.

***The epidemic***

Even before Papua New Guinea's first reported case of AIDS in 1987, observers recognized that conditions favoured the sexual spread of the virus.<sup>2</sup> Rates of other sexually transmitted infections were already among the highest in the world (Papua New Guinea 1996, 51; Hammar 1998; Jenkins and Passey 1998). Despite prevention efforts, notifications of HIV and AIDS rose steeply from the mid 1990s and, with more than 1% of antenatal attendees in the capital Port Moresby testing positive for the virus, PNG recently became the first Pacific Island country to report an epidemic of 'generalized' status (Jenkins 2002; UNAIDS 2003).<sup>3</sup> The National AIDS Council estimates that more than 20,000 people in PNG's population of just over 5 million are infected (Kone 2003; Papua New Guinea 2003). Cases ever formally reported are of course much fewer. By

end June 2003, they totalled 7,587, with 60% notified from the National Capital District (Anon. 2003a). While PNG's epidemic is still classed as in the early stages, commentators seem to agree that it will follow the sub-Saharan course unless rapid gains are made in prevention.

### ***AIDS and development***

AIDS and development have a two-way relationship. AIDS can hamper development through the sickness and death of young adults. The loss of work force, the disappearance of whole families, and the eventual decay of communities are entangled, in the worst epidemics, with declines in life expectancy, increases in infant mortality, lower than projected or even negative rates of population growth, and similar trends in other social and economic indices of development (Barnett and Whiteside 2002). These effects are starkly evidenced in several sub-Saharan nations and have been modelled for PNG too (CIE 2002).

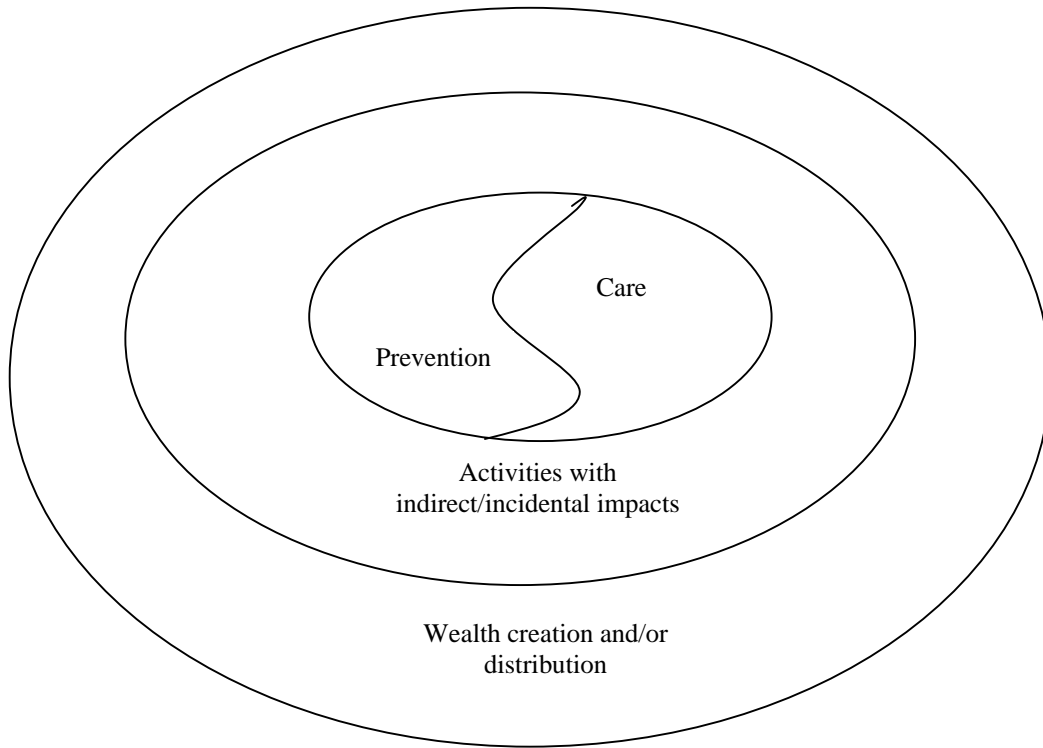
Development also affects HIV and AIDS. Broader social, economic and political factors were acknowledged in the 1990s when AIDS was recast from a health issue into a development issue for the poorer world, requiring a multi-sectoral response. This thinking shaped Papua New Guinea's first medium term plan, launched in 1998, at a time when a new potential tool in the global response to HIV/AIDS was emerging (Papua New Guinea and United Nations System 1998). From 1996, improved antiretroviral therapies (ARVs) were dramatically lowering the morbidity and mortality of infected people in wealthy countries. Efforts to make ARVs available to the vast majority of infected people who live in poor countries resulted in the World Health Organization's current '3 by 5' plan, which aims to provide ARVs to three million people who need them by the year 2005 (WHO 2003). Under this plan, PNG will receive some limited supplies of WHO-subsidized anti-retrovirals from June 2004 (Wakus 2003).

Yet ARVs are no simple panacea (Hammar n.d.). Even disregarding concerns about toxicity and cost-benefits, workers for this cause appreciate that more than just cheap drugs (and simpler regimens) are needed to administer ARVs effectively in the developing world: sustainable drug supplies must be ensured, personnel trained, and most health systems need to be greatly improved.<sup>4</sup> There are broader issues of enabling environments too, for social conditions must be fostered to allow equitable access to medication and to facilitate the cooperation of patients, health professionals, and others in the management of life-long treatments. This specialized, medical response is thus in itself a far-reaching development challenge.

The diagram below (fig. 1) is one way of imagining responses to HIV/AIDS in terms of development. The smallest, inner circle includes direct and deliberate interventions in HIV/AIDS prevention and care. The middle concerns those activities that may not primarily target HIV/AIDS, but can affect its course and impacts, or provide the particular resources and machinery on which targeted interventions depend. The third concerns wealth creation and/or distribution – for poverty combined with class inequalities (and compounded by gender inequalities) can promote the spread of HIV and

increase the destructiveness of AIDS, while simultaneously limiting the financial and human capital necessary for activities in both the middle and inner ring.

**Figure 1 Activities impacting on HIV/AIDS**



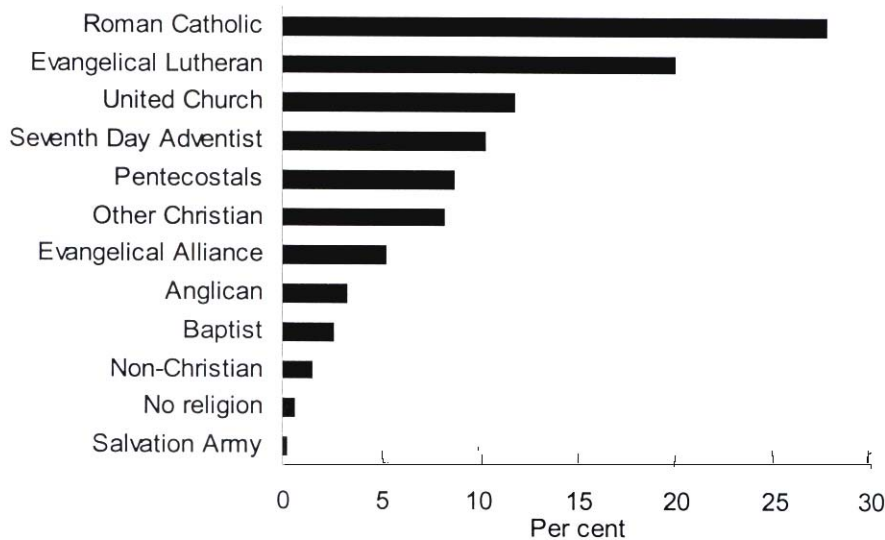
As important as this third ring is, I will not discuss it. Instead I concentrate on church activities in the inner and middle ring. These are complex and important, and relate to the roles that churches play in PNG society at large.

### ***The churches and PNG***

PNG has, by some criteria, a weak state.<sup>5</sup> Much of the population lives beyond the effective reach of government services, which are anyway eroding. More than 800 languages are spoken, and not everyone speaks Pisin let alone English. Nearly 50% of women and nearly 40% of men cannot read or write in any language (Papua New Guinea 2003, 42). Communication and transport infrastructure is patchy and deteriorating. Few institutions in the form of voluntary associations or major employers can bring people of different language groups together. Social and cultural change is accelerating – yet development has stagnated, if not reversed, over the last decade or so (Windybank and Manning 2003).

Against this background, some general remarks can be made about the churches. Nearly everyone in PNG belongs to one denomination or another. As can be seen from figure 2, the Catholic Church is the biggest. Catholics and Lutherans together encompass more than half of PNG's population. But many newer, smaller, evangelical or charismatic churches have proliferated, moving into geographically less accessible territory, and also winning converts from older churches.

Figure 2 Citizen population in private dwellings by religion, PNG, 2000



Source: PNG (2003): 26

The churches provide roughly 50% of PNG's education and health services (Gibbs 2000, 173; Stein-Holmes 2003, 31-34). Though heavily dependent on government funding to provide these services, they generally enjoy a better reputation for standards, efficiency and morale, and often have no government counterpart in a given locality. The Anglican,

Seventh Day Adventist, Uniting, Lutheran, and especially the Catholic Church have made great contributions to health and education infrastructure. Much of this consists in rural schools, aid posts, and clinics, but major hospitals, centres of further education, and urban facilities are also church-founded and run. Many of the newer churches too provide highly valued schooling and medical assistance.

The bulk of PNG's population depends heavily on churches for information and communication. Some churches run their own radio and television stations. Some provide telephone links to isolated communities. Christian bookshops are major suppliers of reading matter in English and Pisin, and the churches are still hard at work putting remaining non-literate languages into writing. More importantly, churches provide a range of occasions, places and networks for the formal and informal exchange of information; Christian ideals and stories provide a set of symbols that can be shared by people from different ethnic groups and used as contexts to make messages on a range of topics meaningful; and— despite the involvement of churches in technologically advanced media – most of the communication facilitated by the churches is interpersonal, and oral. Culturally, this is perhaps the most effective and trusted mode of communication (Papua New Guinea, 2002, 8-9).

### ***'Civil society' and 'social capital'***

'Civil society' and 'social capital' are terms used with varying degrees of precision in discourse on HIV/AIDS and development generally. Civil society, for instance, is said to be an essential actor in any effective response to HIV/AIDS (UN n.d.). Differing endowments of social capital have been invoked to help explain why the epidemic is worse in some countries than others (Barnett and Whiteside 2002, 88-123). Fostering social capital is one suggested means of containing the epidemic— while the creation of social capital is said to be a happy by-product of campaigns against HIV/AIDS in many societies (Pronyk 2002; World Bank 2003). Here I skirt debates about the concepts themselves.<sup>6</sup> Instead I work with James Manor's definition of civil society, and toy with two ideas associated with social capital as treated by Michael Woolcock – particularly 'networks', and 'dimensions of social capital' (Woolcock 1998; Woolcock 1999; Manor 2003). If theoretically naïve, the exercise does, I hope, bring certain assets of different churches into focus.

'Civil society', according to Manor, is an intermediary zone of voluntary association between relations of kin and formal government (and in some analyses, between government and business too).<sup>7</sup> The crude thesis is that civil society improves governance and, in poorer countries, assists development. Some types of civil society organizations (CSOs) are believed to benefit government through lobbying, dialogue and criticism; by developing in their members vision, knowledge and skills that can aid political process; and by bringing people together who might otherwise be divided. Certain types of CSO can also provide services and expertise to their members or those in need. Other supposed benefits include the fostering of trust, community norms, even optimism. The type of CSO that seems to figure as an ideal in the context of development engages with issues of

public concern; is formally organized; endowed with expertise; has strong relationships with its constituency or ordinary people; works across social divides; and does 'good'.

In literature and policy on HIV/AIDS, CSOs are acknowledged for their role in attracting political attention and resources to the issue; in providing services to people living with HIV and AIDS (PLWHA); in shaping and delivering prevention or other HIV/AIDS related programs on their own or with partners; and in trying to foster collective ownership of the epidemic.<sup>8</sup> More loosely, some analysts argue that the inroads and impacts of HIV and AIDS are thwarted in nations that enjoy a kind of social cohesion which CSOs help to create by networking people separated by, say, ethnicity, class, or place of residence (Barnett and Whiteside 2002, 90-97).

But not all civil society relations or activities conform to this type, and not all their effects are unequivocally 'good'. In PNG very few CSOs, apart from the churches, are large-scale, or formally constituted. Much CSO activity is locally and linguistically bounded, and (with the possible exception of sporting clubs) informally organized and uncoordinated. *Raskol* gangs could be described as the country's most notorious form of localized, but morally equivocal, (un!)civil society activity (Reilly and Phillipot 2002, 924). Non-government organizations (NGOs) do exist that are formally structured, incorporate people from different ethnicities or localities, and have specialized expertise, but these are usually associated with, or supported by, major international NGOs which appreciate that their offshoots in PNG are building capacity for a kind of 'untraditional' organization. In the 1990s, an important area of NGO growth, with the support of larger international NGOs, was within the environmental movement (Cox 1999).

Secular civil society engagement with HIV/AIDS in PNG illustrates some general difficulties. Many HIV/AIDS related activities in the zone of civil society are dispersed, small scale, and informal. The challenge is networking these people.<sup>9</sup> While the nationwide structure of committees under the National AIDS Council is intended to involve all sectors of society in a comprehensive response to HIV/AIDS, many interested, smaller parties are easy to miss while turning a structure into a living network can be hard. The activities of AIDS Holistics and 3 Angels Care, the linked initiatives of two friends in Port Moresby, is perhaps both typical and atypical of much small-scale civil society activity. They demonstrate how certain individuals, no matter where, can strike out alone; but their work is unusually visible due to AIDS Holistics' use of newspaper columns, radio broadcasts, and internet lists.<sup>10</sup> Most community-workers in PNG cannot exploit these media.

Many NGOs concerned with HIV/AIDS have found it difficult to take root and grow. Some were created with external funding, and perished when it ceased. Those associated with the Transex Project, which began in 1996 and initially targeted sex workers and their clients, suffered this fate (UNAIDS 2000, 19-55). In many countries, associations of PLWHA have been a great resource for members, who helped to found and manage them. In PNG, even informal support groups were slow to evolve. One worker described how it took her many years to get her first two PLWHAs to speak with one another (Bernard c. 1996). Among obstacles to overcome was a pervasive lack of trust.

The fate of the Friends' Foundation demonstrates the difficulties of underpinning and sustaining a high profile, locally grown, secular NGO. The Friends' was launched in 1989 and headquartered in Port Moresby. Donations came from home and abroad – and local businesses and prominent individuals were generous. The Friends' help to people and families affected by HIV/AIDS was of local and national import, since the majority of PNG's notified cases occur in the capital, but among people there from all over the country. However, financial difficulties and the founder's departure for studies overseas caused its activities to wane.

Internationally, the Red Cross makes an important contribution to efforts against HIV/AIDS, and the PNG Red Cross Society is expanding its HIV/AIDS work. Members however tend to be concentrated in urban and coastal centres and have only turned their attention to the epidemic in recent years. Currently one of the most active non-government organisations with a secular persona is STOPAIDS, but this is an initiative of the Anglican Church.

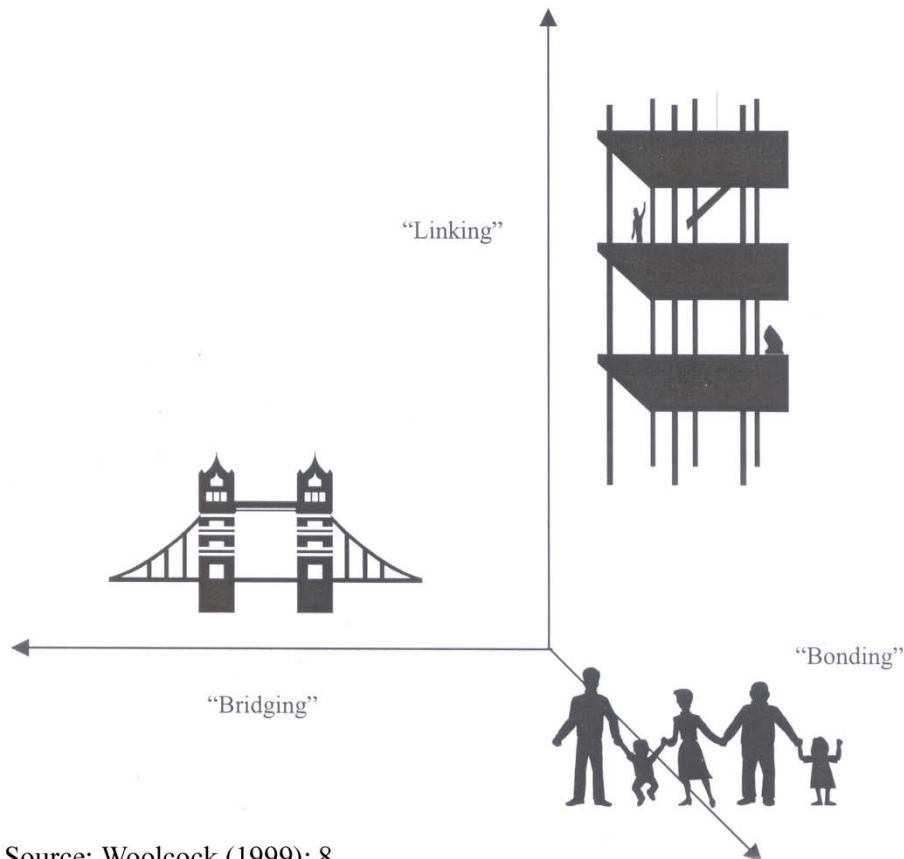
So the churches, almost by default, dominate PNG's civil society landscape. While the size, structures, cultures, and capacities of the churches vary, most are formally organized; nearly all offer a variety of services; they engage with issues of public and sometimes political interest (Gibbs 2000); despite many churches being strongly identified with particular localities, groups, or sub-groups, they are the main institutions for bringing people of different places and languages together; and in addition to local resources, churches can often draw upon overseas parent or affiliated organizations.

'Civil society' and 'social capital' overlap, as do their supposed benefits. Social capital inheres in networks, and these can be divided (following Woolcock (1998)) into zones of kin, voluntary association, government, and business. Civil society is therefore a zone of social capital. One set of criteria for comparing and contrasting the social capital of different networks consists in their bonding, bridging and linking dimensions, diagrammed below (fig. 3).<sup>11</sup>

Using these criteria, the social capital of kin (often glossed as the *wantok* system) can be contrasted with that of the churches. Both have bonding capacities – that is the ability to foster and shape family and micro-community norms and attachments. The strength of the *wantok* system in PNG is often praised as the great virtue of traditional culture, and described – even idealized - as the social 'safety net' (Lindstom 1998, 147, 166-170). Though churches contribute to bonding and are now in many respects indigenised institutions, in PNG as in other societies that have recently adopted Christianity, ancestral and Christian values on sex, marriage, child-rearing, and family may be difficult to harmonize, especially where ideological and social change are being influenced by other forces too. Christian influences in close social relations are perhaps rarely as strong as some church leaders in PNG might wish. Nevertheless, the *wantok* system is for most people in day-to-day life their most important form of social capital, and the churches are dynamically implicated.

But in addition to bonding capacities, some churches can bridge and link in ways that may both complement bonding and counter some of the potentially negative correlates of intense bonding, such as exclusivity, isolation, introversion, and limited resources.<sup>12</sup> The churches' bridging capacities – their abilities to bring church members into community with other people in PNG, and even with people from other countries – have already been highlighted. If, as one social scientist has said, a major drawback to development in PNG is most people's limited experience beyond their immediate community, the churches appear to be the most generous providers of these scarce opportunities for interaction with a wider social world (Baxter 2002, 8). Moreover many churches have the ability vertically to link some individuals and communities to resources – money, influence, tools, ideas, expertise – that would otherwise be hierarchically removed and possibly well beyond the pale of kin.

Figure 3: Basic Dimensions of Social Capital at the Community Level



Source: Woolcock (1999): 8

In terms of 'networks' some of the contrasts between church and government earlier mentioned can be recapitulated and elaborated. The churches, though here again I elide their heterogeneity, enjoy relative superiority in 1) geographic coverage: many churches

extend to communities beyond effective government range; 2) intimate interface: churches can connect to parts of life that are outside usual government business (churches, for instance, are generally better than government in relating to and servicing women (Dickson-Waiko 1999));<sup>13</sup> 3) resilience and robustness: in the face of adversities, some members are often highly motivated to continue church work, and capable of finding the resources to do so, thereby maintaining church networks; 4) superior delivery of desired goods – including information, health services and education – especially to the community level.

Much more could be said about networks, but even if the analysis were confined to their bonding, bridging and linking dimensions, the churches would emerge as perhaps the richest repositories of multidimensional social capital in PNG. Their capacities as civil society organizations in great part derive from this.

### ***Church activities and HIV/AIDS- the inner ring***

#### *Care*

Let us now return to the diagram of activities impacting on HIV/AIDS, and consider the inmost circle. Though prevention and care in practice enmesh, I address them separately. In the area of care, the record of the churches is varied. Certain charismatic congregations – promising for instance a cure to AIDS in Christ – have potentially harmful effects (Eves 2003). Other churches, including a few relatively large and well-endowed denominations, have been slow to act (Jenkins and Passey 1998, 247). But some, like sections of the Catholic Church, have taken the creative lead, well ahead of government and international donors.

Sister Rose Bernard, for instance, began working with PLWHA in 1990, when the first two cases of AIDS in the Western Highlands Province occurred within her local Catholic community (Anon. 1994). Since then her work, and that of her colleagues, in HIV/AIDS support, counselling, tracing, re-connecting geographically separated kin, community education, and inter-agency liaison has grown and diversified. The Shalom Care Centre, originally founded by Sister Rose with the needs of women in mind, now provides respite for men and women with HIV and AIDS, and is a model for similar initiatives elsewhere. In the National Capital District, the Simon of Cyrene Centre, the Bethany Hospice, and the Sisters of Mother Theresa also support PLWHA and orphans. The Salvation Army, the Anglican Church, and other denominations are expanding their existing involvement in care too.

Such activities are more than bandaids. Contrary to the idealized picture of the *wantok* system, many people affected by HIV or AIDS do not receive support from their kin. Misconceived fears of HIV/AIDS, the low community standing of some of those affected, or pre-existing hardship, can all be reasons for neglect. But some church workers enjoy the trust and authority necessary to dispel misconceptions about HIV and AIDS and to encourage love and care for those who need it, while a few can also give a measure of material assistance to straitened families. It is difficult to imagine who else, in

PNG, could perform these tasks as effectively. Because government and churches are unable to offer substantial substitutes for community-based care, the work of churches in assisting and promoting the care of PLWHA by their relatives is crucial for unlocking the main resources available: those within the relations and economies of kin.

Some churches are able to give medical care as well. As I write (January 2004) the Catholic Church is spearheading the provision of anti-retroviral therapies in PNG with its 'Born to Live' project, launched in September 2003 to prevent mother to child transmission at five sites throughout the country. For this project, the Church was able to draw on the resources and know-how of the Catholic Medical Mission in New York, a wealthy organization with extensive international experience in the delivery of anti-retrovirals (Cordeiro 2003). Nor was it hindered by some of the procedures and building requirements that the Department of Health has had to handle as it too moves towards some provision of ARVs in mid 2004.

The picture, then, of church involvement in care is varied, but achievements at both the 'low tech' and 'high tech' end demonstrate the ways in which church bonding, bridging and linking capacities can be exploited.

### *Prevention*

Within the inner circle, in the area of prevention, churches are often, as a group, blamed for handicapping prevention efforts through certain teachings on sexuality and their opposition to condoms. One Catholic bishop in PNG is a well known opponent of condoms, while a statement emanating from the Vatican in 2003, claiming that condoms are ineffective barriers to the transmission of HIV, caused international dismay amongst those promoting condoms as a protective measure (Bradshaw 2003). More generally, a disapproval of extra-marital sex often combines in PNG with a view that condoms only encourage sexual promiscuity. These ideas, frequently informed by or invoking Christian values, have no doubt stymied some efforts to distribute condoms (Jenkins and Passey 1998, 249).

Yet this blame should be qualified. Churches, for instance, are not the only problem for condoms. There are also issues of supply, the powerlessness of women to insist on their use, drunkenness, and the desire for fertile sex. Nor have all churches opposed condoms. Some have vigorously promoted them. Even within the Catholic Church in PNG attitudes to condoms in practice vary, and Pacific Island bishops accept the use of condoms in some circumstances for prevention (Parker 1995, 8). While Christian exhortations for abstinence and faithfulness may be criticized as unrealistic, they are nevertheless components of the ABC (abstain, be faithful, or use a condom) strategy that PNG and other countries follow, after Uganda established this approach as a model. Moreover, the work of some churches in HIV/AIDS care and advocacy feeds most importantly into prevention efforts. The first person with AIDS to 'go public' in PNG and assist community education on the issue, did so with strong church encouragement. Others have followed his example since, again with church support (Anon. 1994; Rarambici 2000).

The prevention work of two denominations deserves mention, not just because they contradict the stereotype of churches being anti-condom, but because one demonstrates, again, the international linking capacities of some church networks, while the other, in a sense, bridges religious and secular cultures. The Salvation Army (SA) is a tiny denomination in PNG, but its local, regional and international coordination is tight, and as a global organization it responded swiftly to HIV/AIDS.<sup>14</sup> From the early 1990s the Salvation Army in PNG, influenced by the Army's experience in Africa, became active in prevention, and in 1996 sent a PNG officer on a study tour of the SA's work in several African countries. The Zambian program was adopted as a model for the Salvation Army's prevention efforts in PNG and explicit instructional material about condoms has been used.

The Anglican Church, another small denomination, has been disproportionately active in prevention too. STOPAIDS was founded in 1999 under the auspices of Anglicare, a trust of the Anglican Diocese of Port Moresby. STOPAIDS is not explicitly Christian in the way it tries to address the underlying social structures of the epidemic and promote prevention in the broader context of gender relations, issues of family life, and sexual health. While STOPAIDS is non-denominational and draws widely on resources and skills from outside the Anglican community (including donors like AusAID), it simultaneously enjoys the financial and structural support of the church.

### ***Church activities in HIV/AIDS – the middle ring***

Lastly, a range of church activities in the middle ring indirectly or incidentally assist HIV/AIDS prevention and care. The importance of these activities is easy to overlook. While church services in health and education provide infrastructure and skills on which specific interventions against HIV/AIDS can build, some of these middle ring activities have in themselves preventive effects. So, for instance, the mere act of having children and teenagers in school is said to be one of the best prophylactics against HIV, and particularly protective of girls (World Bank 2002). Teaching literacy to adult church members so that they can read the bible may incidentally help them to read, say, posters or literature about AIDS. If people already use health services, they are more likely to receive information about HIV/AIDS from this source and to seek medical assistance if a problem occurs. The gathering and travelling of people for church activities provides networks through which information about the epidemic can – even accidentally – flow. And though church injunctions on gender and sexuality may vary, and be problematic, many can have positive effects.<sup>15</sup> Thus teachings that oppose sexual violence can reinforce efforts against practices that provide occasions for transmission of the virus – such as pack-rape, a common occurrence in PNG; promoting respect for women may similarly reinforce efforts to enhance the care of women with AIDS; and an emphasis on the ideal of monogamy can harmonize with the National AIDS Council's current 'partner reduction campaign'. Many women – and men – certainly see in Christianity the most readily available resources for changing gender norms and relations.

### ***The need for secular civil society engagement***

A few points are nevertheless worth stressing about the desirability of secular civil society involvement. First, there are crucial areas of prevention work – among for instance sex workers, men whose extensive sexual networking is influenced by certain occupations or environments, sexually active young people, and men who have sex with men - that are indeed problematic for those church workers who would first and foremost like to banish these activities.<sup>16</sup> NGOs –whether faith-based or secular - which accept and try to make these activities safer can often engage more successfully with those involved, as PNG's Transex project demonstrated (UNAIDS 2000, 19-55). Second, some scholarship suggests that a vigorous NGO sector, including both faith-based and secular organizations, is an advantage against HIV/AIDS. The case of the Philippines – with a strong Catholic Church as well as highly developed and diversified secular CSOs – is an example (Barnett and Whiteside 2002, 102-105).<sup>17</sup> Third, many people active in the response to HIV/AIDS in PNG perceive the need for a stronger, higher level demonstration of civil society interest in the epidemic – perhaps through a body of prominent persons drawn from different walks of life. While political leaders have recently signalled more vigorous support for the national campaign against AIDS – through the formation of a Parliamentary Advocacy Group and Prime Minister Sir Michael Somare's agreement to participate in the National AIDS Council's advertisements and broadcasts (Anon. 2003c) - the need remains for secular civil society capacities to be developed (Jenkins 2002, 23).

### ***The future roles of churches in the response to HIV/AIDS***

In the future, traditional church activities will continue to provide important indirect and incidental benefits to the response to HIV/AIDS, but as the epidemic grows, so will the scope for direct involvement in prevention and care. Early in the global epidemic, 'prevention' and 'care' tended to be dichotomised, but they are now more closely combined. In PNG and throughout the Pacific, growing numbers of pastors, priests, and church-workers, are being trained as HIV counsellors who integrate these concerns. The intimate influence these men and women can sometimes exercise in their communities and their belonging to living church networks are advantageous in this work.

The heaviest demands upon the churches are nevertheless likely to be felt in the area of care, and at three levels: assisting those affected by HIV/AIDS in their homes; offering day care, respite, and support to PLWHA in church-run centres, and providing accommodation for AIDS orphans; and finally, supplying more specialized medical assistance in church-run hospitals and clinics. Church-workers will also be in growing demand as go-betweens, brokers, and advocates. Specialised medical assistance of course requires professional and financial resources, but even if the bulk of church work will be in forms of labour-intensive but relatively low-cost community support, this too will need funds and expertise.

These needs highlight the importance of church capacities to link with and tap external resources. Though most churches in PNG have always relied heavily on time and goods donated by their congregations, local supplies of financial and professional assistance are limited. For these, relations with overseas parent or affiliated churches have in the past

been important and remain vital. Yet broadly speaking, this form of external aid is changing and often diminishing. With the exception perhaps of the Catholic Church, there is a general trend for expatriate church workers to commit to PNG for shorter periods than their predecessors. Papua New Guinea also competes for funds and personnel with newer mission-fields that churches in richer countries often view as more exciting, promising, even secure. In the shift from 'mission' to 'church', many denominations, while retaining relations with the parent church, receive from it less material assistance. Over the last decade, funding from the government for church-run school and medical facilities has been cutback too.

Links with donor organizations therefore provide churches with alternative sources of financial and skilled assistance. But three general points are worth making. First, despite the bridging capacities of many churches – and though instances of inter-denominational cooperation on HIV/AIDS are admirable (as one informant said 'We are working against a common enemy') – churches can also be prone to rivalry (Gibbs 2000, 167; Gibbs 2002, 174). Outsiders from secularised societies, where the spirit of inter-denominational cooperation seems to have grown in proportion to the declining influence of churches, may not appreciate the possible intensity of such strife. Related to it is the potential for church fission. The allocation of donor funds might in some circumstances fuel such divisive tendencies. Second, while much Christian care is given without obligation and in a selfless spirit, there are situations in which the recipient may feel directly or indirectly under pressure to subscribe to the denomination that provides the service. As Narokobi noted, the PNG churches have a history of 'sheep grabbing' (Narokobi 1980, 230). Finally, a secular donor may have difficulties with the world-view, social vision, and ultimate goals of a church, especially if these hijack a project both parties have agreed to. At the same time, churches have every reason to safeguard their independence and ideals.

These problems are neither new nor altogether unique to partnerships between secular donors and churches. Some have already been tackled in relations between state and churches within PNG over the provision of medical and education services (Gibbs 2000, 163-165). They arise in certain developed countries too, where, in addition to health and education, faith-based organizations increasingly compete for contracts with government to provide other welfare services (AAC 2003). Each of these issues also has parallels in development partnerships between secular donors and secular CSOs, among which competition, aggrandizement, and 'agenda hijack' are not unknown.

The churches in PNG and the Pacific may well be under-theorized and until recently under-recognized as civil society actors and agents of development (Senate Foreign Affairs 2003, 102-105; Stein-Holmes 2003, 3). Yet they have always done development work and a record of successful partnerships between churches and secular donors provides a foundation upon which further cooperation is building (Manuk 2003). As the shaping of PNG's next national HIV/AIDS medium term plan nears completion, there have been calls for greater church participation in the response. Although condoms and certain approaches to sexual behaviour change will no doubt remain difficult for many churches, the views held by Christians on these issues vary, and I have argued that many church activities contribute importantly to prevention more broadly defined. The

particular challenges created by this epidemic in the area of care - where churches have perhaps unrivalled capacities to cover the country, work with communities, bridge, bond, and link - clearly require the further evolution of these partnerships.

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<sup>1</sup> Stein-Holmes (2003) addresses this deficiency. Useful studies of the churches, their evolution, and social engagement include Forman (1982), Trompf (1991) and Breward (2001).

<sup>2</sup> The epidemic in PNG is usually described as 'heterosexual' though some researchers argue that this adjective belies the complexity of sexual practices. See e.g. Jenkins (1996), Hammar (n.d.), also NSRRT and Jenkins (1994).

<sup>3</sup> Definitions of a 'generalized' epidemic vary. Barnett and Whiteside (2002, 98) would class PNG's epidemic as 'concentrated'. For them, one of the criteria for a 'generalized' epidemic is an HIV prevalence of least 5% among women attending urban antenatal clinics. The latest figures from PNG are below this (Anon. 2003a).

<sup>4</sup> The toxicity of ARVs, and the need for trained doctors to administer them, have been highlighted by reports of people dying in Port Moresby General Hospital from the side-effects of ARVs privately acquired. See e.g. Gerawa (2003).

<sup>5</sup> For a more nuanced discussion, see Dinnen (1998), May (1998).

<sup>6</sup> At the conference where the first version of this paper was delivered, many participants discussed the difficulties they experienced in applying the concept of 'civil society' to Pacific circumstances. To a lesser extent, difficulties with the notion of 'social capital' were also raised.

<sup>7</sup> The business sector is not considered in my discussion, though large employers in industries such as mining, forestry and transport have important parts to play in PNG's response to HIV/AIDS.

<sup>8</sup> This was first demonstrated by the response of gay communities in many western countries to the epidemic. See Altman (1994).

<sup>9</sup> Steven Vete (pers. comm. 2003) stressed this point while recalling that, when he was involved with the *Pacific AIDS Alert Bulletin*, published by the South Pacific Commission (later Secretariat of the Pacific Community), individuals from all over PNG contacted the bulletin, suggesting considerable dispersed interest in HIV/AIDS.

<sup>10</sup> I have classed AIDS Holistics and 3 Angels Care as secular because these initiatives came into being outside any church structure, despite their founders' religious convictions.

<sup>11</sup> Woolcock's distinction between the 'bonding' and 'bridging' dimensions of social capital accentuates, and elaborates upon, some of the contrasts made by Putnam between weak and strong, civic and kin-based horizontal networks (1993, 173-176). Reilly and Phillpott (2002), in their work on social capital in PNG,

use Putnam's vertical and horizontal dimensions, without analysing the horizontal, as does Woolcock, into 'bonding' and 'bridging'. 'Bonding' networks can of course also be analysed in terms of intimate, vertical relations - between male and female; generations; birth-order; etc.

<sup>12</sup> For a discussion of some of the negative characteristics of kin-based social capital in PNG, see Reilly and Phillpot (2002).

<sup>13</sup> The relationships between women and churches are an important theme in Douglas (n.d.).

<sup>14</sup> The Seventh Day Adventists also responded swiftly as a global church to HIV/AIDS, but in PNG most of this work appears to have been done by the Adventist Development Relief Agency.

<sup>15</sup> One example of how Christianity can, in complicated and contentious ways, be invoked to authorise and promote change in gender norms is the recently founded Christian Men's Network. At its launch in August 2003 the Deputy Prime Minister Dr Allan Marat spoke against men who get drunk, beat their wives, and spend their pay-checks irresponsibly. He also argued that such behaviour gave 'ammunition' to gays, lesbians and feminists, and claimed that condoms and the National AIDS Council promoted promiscuity (John 2003).

<sup>16</sup> So, for instance, the PNG Council of Churches strongly opposed a recent proposal to decriminalize prostitution that had been intended to facilitate measures for preventing the spread of HIV. Instead the Council advocated giving training and education to women (Anon. 2003b).

<sup>17</sup> For a comparative discussion of the social strengths of PNG and the Philippines, see May (1998).

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