MISSING THE MARK?

Women and the Millennium Development Goals in Africa and Oceania

EDITED BY

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2.
Second Chance

Caring for HIV-Infected Mothers and Their Children in Mendi, Papua New Guinea

PHILIP GIBBS AND WINNIE WILLIAM

CHILDBEARING IN PAPUA NEW GUINEA (PNG) is a risky business: reports over the last twenty-five years have made this clear. It is estimated that 1500 PNG women and girls die each year in relation to pregnancy and childbirth (*Ministerial Taskforce on Maternal Health* v). Demographic Health Survey data for PNG estimate the maternal mortality rate (MMR) to be 773/1000 in 2006 (*Papua New Guinea Demographic and Health Survey*). Estimates based on mathematical models give a figure of 250 in 2008. In a study based on facility-based survey data and Health Ministry Information System Records from 2009, Drs. Glen Mola and Barry Kirby estimate the national MMR to be 450 (Mola and Kirby). Despite their variance, all these figures indicate a serious health situation for mothers in PNG and an urgent need to improve maternal health outcomes.

This paper is about maternal health and how care for pregnant mothers can ensure healthy children. The focus is not on all mothers but rather on mothers whose health has already been compromised by the HIV virus and whose health is further stressed by pregnancy. Among the concerns of pregnant women infected with HIV is whether they will survive to carry their pregnancy to term and if their child will be born infected with HIV. In the Papua New Guinea Highlands, Catholic Health Services in the diocese of Mendi has taken these concerns seriously and has sought ways to ensure that infected mothers can remain healthy, that they can have supervised delivery, and that their child will not be infected with HIV. Our paper focuses on efforts by Catholic Health Services

and their partners to improve maternal and child health outcomes in the Southern Highlands (SHP) of Papua New Guinea. This paper tells the story of an attempt to take seriously MDG 5 (improving maternal health) in the context of implementing MDG 6 (combatting of HIV and AIDS).

The Southern Highlands Province is situated in the interior of the mainland of Papua New Guinea. In 2011, the former Southern Highlands Province was divided into two parts: one part retained the name Southern Highlands, and the second, western part was named Hela Province. The 2011 census recorded populations of 510, 245 in Southern Highlands Province and 249,449 in Hela Province (*Papua New Guinea Demographic and Health Survey*). The majority of the population in both provinces lives in scattered hamlets and supports itself with subsistence horticulture.

SERVICES FOR MATERNAL CARE

Care for mothers and newborn babies is inadequate throughout much of PNG. Demographic and Health Survey data (*Papua New Guinea Demographic and Health Survey*) show that although about 71 percent of women make one antenatal care visit, only 50 percent complete four or more antenatal visits. Similarly, only about 50 percent of women deliver at a health facility or with a skilled provider.

Compared with national data, the situation in SHP and Hela is even more limited. The Southern Highlands has the lowest antenatal coverage and lowest supervision of births in health centres and hospitals in the whole of Papua New Guinea (*Ministerial Taskforce on Maternal Health* 10-11). This is mostly due to geographic and infrastructural barriers, limited availability of health services, shortage of human resources, and lack of equipment. Mendi Hospital is the only hospital in the SHP with qualified doctors and facilities for dealing with severe birth complications requiring surgery or transfusion. There are only fifteen registered midwives in the province, most working out of Mendi Hospital—some of these are not working now as midwives but in administrative positions as matrons and supervisors.

Most rural women continue to give birth at home where only a small fraction of maternal deaths are reported. The most common

reason for giving birth at home is due to lack of money and (transport) infrastructure, which makes it difficult for them to come to an operating health facility. About half of all rural health services in Papua New Guinea are provided by church-based groups. Southern Highlands is typical in this regard. Catholic Health Services from the Catholic Diocese of Mendi, which covers both Southern Highlands and Hela provinces, provides services with six health centres and seven aid posts.[1] There is a day clinic at Tari secondary school, a community health worker training school, stand-alone voluntary counselling and testing (VCT) centres at Tari and Lake Kopiago, and an urban clinic in Mendi that also serves as a VCT centre. This study focuses on the services at the Mendi urban clinic, better known as the Epeanda clinic at Kumin Catholic Mission in Mendi.

TRADITIONAL PRACTICES ASSOCIATED WITH CHILDBEARING

The Southern Highlands is one of the few provinces in Papua New Guinea where in some cultures, a woman is expected to deliver alone (Townsend).[2] Custom allows another woman to call out to the labouring woman from outside the delivery hut, but another woman is not allowed to enter (Alto et al. 613). The practice is hazardous because it does not allow women assistance while giving birth, which means that women only get experience about childbearing through their own deliveries. The reason for this is that woman's blood is considered dangerous to both men and women and that contact with blood is believed to result in illness or death.

Sister Gaudentia Meier, a trained midwife from Switzerland, first came to Mendi in 1969. She describes the practice when she first arrived at Det, near Mendi.

> *The standard practice was that there was a house behind the women's house, which she also used [for seclusion] when she had her period. The mother would go in there when she started labour and no other women were allowed to go in. They just could tell her … the grandmother or someone … tell her what to do … that was the way it was here. In Tari, they had birth attendants, usually the hus-*

Mother and child at Nipa in late 1960s.
Photo from collection of Olddenbank Sisters. Used with permission.

> *band's mother. What they did here at Det was the way it was in the lower Mendi area.* (Meier, Personal interview)

As a midwife, Sister Gaudentia thought that supervised delivery would be beneficial, and she invited women to come to the aid post for childbirth. She tells of the first mother she assisted to deliver in 1969.

> *Father Ben was here, and he knew the language, and he told them that there is someone here, so you don't have to deliver by yourself. When the mothers came for clinic,*

> *we would learn how many babies had died or that some children would be adopted because the mother died. We started in a bush house to "fix sores" [medicate tropical ulcers] or whatever. Then the catechist's wife was the first one that I assisted to deliver. She sent a message down, so I went to her village and walked to where she was. She was quite in labour. I walked back to the car with her. We had to stop because of strong contractions. I was rubbing her back and everybody was watching me. A lot of women came along, and they were talking to each other. I brought her to the car, got to Det [the mission aid post], and she delivered. The husband was happy, but then I asked what the women had been talking about … it seems they were saying, "How does she know where the pain is when she has never had a baby herself. She says she has no baby." When I heard that, we got the mothers around, and we talked about it. I told them that I learned it, and that is how I know. I had three more deliveries the same month. By the end of the year, I had fifty-six deliveries.* (Meier, Personal interview)

At the same time, Sister Gaudentia engaged with local practices associated with birth. Customarily, women give birth in a kneeling position. The mission health centre provided a bed, but women were free to choose their own position.

> *I asked them, "which would you prefer," and they said, "we prefer our way and position." So I would let her because that's the way she feels better. She would kneel with her head against a post and her feet against something firm so she could really get some pressure. We would put a towel or a piece of plastic on the floor for hygiene purposes.* (Meier, Personal interview)

Mothers wanted to take home a piece of umbilical cord, which they would hide in the roof of their house in the belief that this would prevent them getting pregnant again quickly.[3] Traditionally, after some weeks, when there was no more discharge, a woman

Mother and child at Margarima in the late 1970s.
Photo from Oldenbank Sisters collection. Used with permission.

was required to jump over burning leaves in order to "dry the blood" and, thus, be allowed to be seen with her baby in public. When asked if they should have a similar practice on leaving the mission aid post, the people said that was not necessary, and the mother could simply return home. Word went around and soon, in the early 1970s, there were over two hundred births a year at the small Det aid post. In one month, there were thirty-nine births.

In the twenty-eight years Sister. Gaudentia was at Det, she assisted several thousand mothers and none died. "We had to send a few mothers for Caesarean section in Mendi, but none died (Meier, Personal interview).[4]

Two decades later, health workers were alarmed to hear that HIV had arrived in PNG.[5] In 1994, after (Lady) Margaret Anjo from Ialibu in the Southern Highlands went public over her seropositive status, Sister Gaudentia started providing awareness training in high schools and through community health worker (CHW). The module on HIV that she developed for the CHW training curriculum was adopted for home-based care throughout the country by the National AIDS Council in PNG. The first case of HIV was recognized in Mendi in 1998, and Sister Gaudentia moved to Mendi that year to work with hospital staff at Mendi Hospital. [6] Stigma ran high, and Sister Gaudentia recalls how the first woman found to be infected with HIV was hiding in a shelter for pigs.

At that time, there was no antiretroviral therapy (ART) and, although ARTdrugs were available by 2002, nobody was trained to administer them. The "Born to Live" program to train health workers on ART began in 2003 at Mingende Hospital in Simbu with the help of Dr. Ann Doherty who previously had been working in Kenya. In 2003 and 2004, Sister Gaudentia went for Prevention of Parent to Child Transmission (PPTCT) training. By Easter 2006, with the help of Dr. Arun Menon of the Australasian Society for HIV Medicine (ASHM), they started HIV rapid testing, and Dr. Menon put four people on treatment, including one pregnant mother.

The Epeanda urban clinic at Kumin Mission in Mendi started in 2005.[7] In 2006, Sister Gaudentia, along with the Epeanda staff, started the practice of having all HIV-infected "friends" together for some days at Kumin Mission twice a year.[8] Infected people would support one another (for example, giving advice about what to do when rats chew the teat on a feeding bottle!). Now some of these people have become "mentor mothers," sharing their own experience as infected mothers with other infected women.

HIV AND MATERNITY

The risk of pregnancy-related death is six to eight times higher for

HIV positive women than their HIV negative counterparts (Gathigah). Studies in Africa reveal that pregnant women with HIV die at much higher rates than women who do not have HIV. Indeed, HIV increases maternal mortality directly, from the progression of the HIV disease itself and indirectly through higher rates of sepsis, anemia, and other pregnancy-related conditions (Gathigah).[9] Hence, the health workers in Mendi were very concerned about how the spread of HIV would affect the mothers they were caring for.

HIV in Papua New Guinea

HIV spread exponentially in PNG during the 1990s, and by 2003, the prevalence of HIV among women attending the Port Moresby General Hospital antenatal care clinic surpassed one per cent (UNGASS, *Country Progress Report 2010* 4). The recorded increase began to level off in recent years, partly due to more accurate ways of recording data in different parts of the country. Recognizing the varying sources of data, figures are now given as ranges. According to the most recent United Nations Global Report in 2013 (UNAIDS):

> •In 2013, there were between 20,0000 and 31,000 people living with HIV in PNG (UNAIDS123);
> •The estimated prevalence in 2012 was 0.4–0.7 percent (120);
> •Estimated AIDS deaths in 2012 was <1,000–1,600 (128;)
> •HIV-infected female adults in 2012 estimated at 10,000–16,000 (183);
> •The coverage of antiretroviral prevention services for pregnant women living with HIV in PNG in 2012 is less than 50 percent. (40)

Data from the Southern Highlands in 2009 gives an estimated HIV prevalence rate of 4.7 percent through VCT centres, 0.1 percent from blood bank tests, and 0.4 percent from antenatal testing (*Ministerial Taskforce on Maternal Health* 34). Table 1 below gives prevalence rates of those tested from Epeanda. Mothers testing seropositive have the choice of going to Epeanda or to the Nina clinic at Mendi Hospital for follow-up visits.

Table 1: Antenatal Catholic Health Services Mendi

Year	Reactive HIV	Total Tested	% Reactive	Comment
2006	5	365	1.37	3 repeat test
2007	6	1603	0.37	1 tested twice
2008	6	336	1.79	
2009	9	1418	0.64	
2010	4	1069	0.37	
2011	9	1470	0.61	
2012	8	1777	0.45	
2013	7	737[10]	0.95	

COMPREHENSIVE STRATEGY FOR ENSURING HEALTH OF MOTHERS AND BABIES

With the growing danger of HIV (and other STIs), Catholic Health Services Mendi developed a comprehensive strategy for improving the health of mothers and babies. This included special training of health workers, education for mothers about STIs (including HIV) and treatments available, antenatal clinic with testing, provision for those testing seropositive to receive prompt treatment, facilities for mothers close to term to come and wait near health facilities, and a follow-up program for infected mothers to ensure that their children remained healthy.

Training of Health Workers

All Catholic Health Services (CHS) health workers were trained in STI syndromic management, voluntary confidential counselling and testing (VCCT), provider initiated counselling and testing (PICT) and home-based care (HBC). Hence, the task of identifying and caring for affected people was not left to a few specialists but was expected of all health workers within the Mendi Catholic Health Services.

Other health workers were selected for specialist training, including rural laboratory assistants (RLA), the use of CD4 count equipment, and antiretroviral therapy (ART) prescribers. Since

2010, working with the CHW school at the mission and supervision from Sister Gaudentia, some Community Health Workers have been trained as ART prescribers resulting in more health workers qualified to prescribe ART treatment. In other parts of PNG, this service is reserved only for registered nurses. Feedback from health workers whom we interviewed spoke of how the most important outcome of the training was a reduction in fear associated with HIV and a reduction in stigma and discrimination on the part of the health workers. There was also the realization that the essential ingredient in care is just that, care.

Education for Mothers

Antenatal clinics offer an important opportunity to educate mothers (and the few fathers who attend) on STIs, including HIV and clinics, which were organized so that this educational component was not missed. Education information also dealt with healthy attitudes and practices. For example, previously there was a practice for mothers in the Southern Highlands to under-eat during pregnancy thinking that this would mean a smaller baby and a smaller baby would be easier to deliver. Health workers spoke about the importance of healthy foods that would assist both mother and baby. Attitudes are important too, and in Papua New Guinea, where pigs represent wealth and status, some mothers needed convincing that their own health is more important than that of their pigs. Mothers in polygamous marriages who perceive that their husband is giving more attention to another wife might think, "Who cares [about me], the father [of my child] is looking out for another woman" (Meier, Personal interview). Sister Gaudentia has impressed on health workers the importance of health worker's attitudes, since to ensure mothers return for care, depends very much on their first therapeutic communication. A mother who trusts a health worker will return to that health worker.

GREATER COVERAGE OF ANC CLINICS AND TESTING

In 2011, of the estimated 210,000 pregnancies for the whole of PNG, 125,892 pregnant women had at least one antenatal care visit (60 percent) and HIV testing was offered to less than 50,000

of them (National AIDS Council Secretariat, *Global AIDS Report 2012* 75; UNAIDS). There is less coverage in the Southern Highlands according to the Southern Highlands Health Department, as only 39.6 percent of pregnant women made at least one antenatal clinic visit for 2012 and only 1,927 women between 15 to 49 years of age were tested for HIV at these clinics. This is because HIV testing is normally available only to those attending town (as opposed to rural) clinics and when test strips are available, only a minority of pregnant women in the province attending ANC clinics are offered tests for HIV.[11] The majority of those tested were at clinics run through CHS Mendi or at outreach clinics also run by CHS Mendi.[12]

Provision for Mothers Who Test HIV+

Clinical examination and CD4 count results can help the health worker to assess the health of the person infected with HIV. However, with mothers, CHS Mendi has a policy of "test and treat," so all pregnant women who test seropositive are put immediately on antiretroviral therapy. This has required considerable management work to ensure that medication is available. The program involves more than medication, however, as it also includes confidential counselling and clean daycare facilities. The program is designed to help mothers physically, mentally, and spiritually.

Due to geographical distance and poor or non-existent roads, many mothers are not able to reach a health facility once they feel the signs of labour. CHS Mendi thus offers facilities for infected expectant mothers to stay at the Epeanda clinic when they come close to full term or when they feel the need for medical care. When labour begins, they are provided with free transport to the maternity ward at Mendi Hospital for a supervised birth. After they have recovered, the mothers return with their baby to the Epeanda clinic.

Follow-Up Program

Mothers are advised to give exclusive breastfeeding for four to six months (depending on when the child would start putting things in its mouth). Then they were given solids with Lactogen for three weeks with sweet potato water and other soft foods, which ensured that babies would not be infected with HIV. Previously,

mothers were instructed to wean the child as soon as the child started on other foods, but, now, those mothers on ART treatment can continue mixed feeding with breast milk and other food.

RESULTS

As of July 2015, 133 HIV positive mothers have given birth to 144 healthy babies (one had twins and another triplets).[13] No mothers coming through the Epeanda clinic have died from childbirth complications and all babies were born without HIV infection.[14] This is a better result than the national figure for healthy mothers.[15] Without interventions such as PPTCT, transmission rates range from 15 percent to 45 percent (WHO, "Mother-to-Child"). One mother did die months after giving birth to a healthy baby but this was due to her joining a Revival church that convinced her to stop taking ART medication.[16]

Some of the mothers coming to the Epeanda clinic have had to travel very long distances. Those coming from the Kopiago area have to walk two days and then travel a full day on a bus. Some have survived very traumatic experiences. For example, one of the first to attend at Epeanda was a young woman who had been gang-raped, infected with HIV, and was made pregnant at the same time. She came for help three weeks after the incident, which was too late to start post exposure prophylaxis (PEP). A health worker recalls her saying, "How will I cope? I did not plan to have a child. Besides, I am HIV positive." When this occurred in 2005, ART was not widely available; however, with the help of Sister Tarcisia of the National Catholic HIV-AIDS Services in Port Moresby, the young woman started ART at thirty-two weeks gestation. She was helped to deliver a healthy baby girl and she remains HIV-positive but continues with treatment; she is now married with a second child.

A sixteen-year-old girl was carried to the Epeanda clinic. She had been ill for a long time, and her legs were contracted from being left in a sitting position. She tested positive for HIV. With care and treatment, she was able to able to walk and even to play basketball within two months. On returning to the village, she became pregnant by the same person who had infected her. She came back to the Epeanda clinic for help during her pregnancy,

and her son was not infected. However, he was hydrocephalic and died after a year. She has since remarried. She would surely have died if she had remained in the village.

Another woman was brought from her home village to the Epeanda clinic gravely ill with a serious skin infection and TB. Upon testing, she was found to be HIV infected. With treatment she recovered, married, and became pregnant, at which point her husband rejected her and sent her away. She returned to clinic for help during her pregnancy and had a healthy baby. But then her husband's sisters came and took the baby from her, and she was left to return childless to her home village where she remains.

Dealing with some cases can be traumatic for the staff at the Epeanda. Occasionally infected mothers become aggressive due to HIV psychosis (toxoplasma). After punching and threatening health workers, one infected woman had to be locked in a room for a week. With treatment and care, she recovered and gave birth to a healthy daughter. Since then, the woman developed TB of the spine and could walk only with the help of crutches. She was convinced that her illness was caused by sorcery or witchcraft, defaulted in taking her medication, and subsequently died. There is little that the health workers can do when a person refuses to believe that they are infected with HIV.

LESSONS LEARNED

There have been a number of lessons learned through the PPTCT program at the Epeanda clinic. Training for health workers is very important. It is through the health workers that mothers and their partners receive sound counselling on how to live healthily despite HIV infection. They are prescribed medication to reduce the viral load, and this is followed up with the help of "mentor mothers." These women, also infected with HIV, have volunteered to help other HIV+ women and mothers. If someone fails to come to the clinic for new ART supplies, a mentor mother will go to their homes to check on them and to encourage them to come to the Epeanda clinic for their medicines.

Reliable staff personnel are also important. Sister Gaudentia has worked out of Mendi since 1969 and her co-worker Clare

Kopipi has been with CHS Mendi since 1981. Clare seldom needs to consult records, as she knows all returning mothers personally and remembers their case history and personal information. The long-term commitment of other locals in the small group of health workers attached to the Epeanda clinic, such as Maria Koke and Clare Andawa, all contribute to a sense of teamwork, which carries over in service to their clients. CHS Mendi has been fortunate to have assistance from the Oil Search Company, which is part of the oil and gas extraction industry in the area. When reagents run short or the CD4 count machine is out of action, Oil Search has come to their aid. "They are doing CD4 cell count, so now we send our blood samples directly to Kutubu, to Oil Search. They do the full blood count. They do even hepatitis B, they do everything. So we are really fortunate" (Meier, Personal interview).

Perhaps the most important lesson learned concerns the attitudes of mothers. For a woman who comes to the antenatal clinic and finds out that she is HIV positive, it seems to her like the end of everything. "Once the PPTCT program is introduced into her life, she sees that she has chances of living positively and having another child, and she participates in the program with all her heart" (Meier, Personal interview). For positive mothers, being healthy and having a healthy child becomes a priority in their lives. When they have trouble, they know where they can go to get caring assistance. After giving birth at Mendi Hospital, mothers call the Epeanda staff to help make sure that the baby receives the right medicine. Co-author Winnie William notes that "we have over a hundred committed mothers. They have a second chance to have a child and they are one hundred percent committed."

This second chance makes a big difference to a marriage. N[17] was infected with HIV through her first husband. She remarried and with the program for discordant couples run through the Epeanda, they were able to have children and her husband remains HIV negative. "My husband takes care of me and our daughter so that we may not get other infections. Last week after getting the DBS [dry blood spot] result from the Epeanda clinic, for our last daughter, my husband was so happy with the result that he suggested we should have another child again, this time, a son."

P and L commenced ART treatment in 2007. P now serves at the Epeanda as a mentor to others who test seropositive. P and L had a healthy child in 2009, who is now four years old, and L is expecting again. P says, "We are happy and confident that by following the program at the Epeanda, our child will be born HIV free."

DIFFICULTIES

There have been difficulties, too. During a medication supply crisis for several months in 2012, staff had to change the treatment for clients who had been on regular ART. Some patients went onto oral suspension, a medication meant for children. Fortunately, Dr. Menon from the Australasian Society for HIV Medicine (ASHM) could give advice.

Confidentiality is a big issue. Because of the fear of stigma and discrimination, there are people on treatment who do not want to be seen coming to get their supply of medicine. Some ask to meet in a quiet place in town; they open their bag to allow the Epeanda health worker or mentor mother to discretely drop the medicine in the bag. There have been crises over confidentiality. For example, on one occasion after a man died, his wives were accused of practicing witchcraft [*sanguma*] to cause his death, leading others to call for burning them them alive (Gibbs, "Engendered Violence"). Fortunately, the health workers were able to convince the infected person to disclose, so as to save the lives of the accused women. Stigma and discrimination appear to be lessening, and some people reveal their status to their community; as a result, most now often get support in that community.

APPLICATION

The "Second Chance" PPTCT program is running successfully with high-risk mothers in a high-risk rural province. Since 2005, of the 133 mothers participating in the program, there have been no maternal deaths for those who stay with the program. This is an example of what can be done to reduce maternal mortality in PNG. What is to prevent similar measures being offered to all

pregnant women? A report from the National Department of Health (*Ministerial Taskforce on Maternal Health*) lists the first four characteristics of a successful public health program:

> 1. A package of evidence-based and cost-effective interventions contextualized for PNG;
> 2. An adequate supply of trained, competent, and willing workforce who have
> 3. A functional, supplied, enabling environment that is
> 4. Supportively supervised and managed (*Ministerial Taskforce on Maternal Health* 9).

The PPTCT program run by CHS Mendi through the Epeanda goes a long way to fulfilling these characteristics.

Staff running the PPTCT program tell how they have MDG 5 and MDG 6 in mind when doing annual performance reviews based on the National Health Plan 2011–2020. Key Result Area 5 of that plan is to improve maternal health, with objective 5.2 being "increase the capacity of the health sector to provide safe and supervised deliveries." Health workers say that numbers and percentages do not mean great deal to them; rather, human behaviour, such as women coming for antenatal clinics or delivering in a health facility, means a lot. Health workers do all they can to encourage such practices and to provide safe deliveries and, in this way, contribute to implementing MDG 5.

Aside from interventions specifically for HIV infected mothers, such as ART treatment, other aspects of the Mendi program—in-service training for staff, education programs for mothers, access to facilities, adequate supply of functioning equipment and necessary medicines—which have worked through CHS Mendi, could be made more widely available with sufficient political and managerial resolve. Increased funding would surely help. Papua New Guinea spends 0.6 percent of GDP on health expenditure, compared to 4.1 percent in Fiji and 8.8 percent in Australia (*Ministerial Taskforce on Maternal Health* 25). In fact, the PNG government funding on health decreased 9.4 percent in real terms between 1997 and 2004 (*Ministerial Taskforce on Maternal Health* xii).

A 2011 report recommends the establishment of family and community health care (FCC) with village health volunteers (VHVs) (Byrne and Morgan). Village birth attendants were being trained and were working in the SHP in the 1980s but this stopped in 1989 during a tribal fight in Nipa (Townsend; Alto et al.). This program, begun by the Tiliba Mission, was taken over by the government but has not resumed in the years since 1989. If the government were to restart the program, it would be wise for the National Department of Health to learn why the VHV program stopped and the PPTCT program continues.

The most important lesson from the CHS Mendi program is the culture of care that continues to sustain the program. It is hard to imagine how any program can function effectively without it. The culture of care obviously applies to dedicated and long-serving health workers and mentor mothers. One HIV infected mother noted, with a tone of admiration, *marasin ol i save holim long han na givim mipela* [they give us the medicine (personally) with their (bare) hands]. As Sister Gaudentia notes, "if a mother has a good experience the news spreads and she will tell the other mothers, that 'we have to go'" (Meier, Personal interview). However, as noted by the health workers, the culture of care also applies to the mothers themselves. Forty-five years ago, the mothers at Det were concerned enough to break with cultural tradition to deliver their babies at the mission aid post because they considered it safer for themselves and their child. Now, mothers who discover they are infected with HIV and, thus, are faced with the prospect of a grave threat to their child respond by making their own health care and the health care of their child a priority. Apart from finance, facilities, and political will, the development of a culture of care with all health workers and those who assist them will go a long way towards implementing MDG 5 and to reducing maternal mortality in Papua New Guinea.

ENDNOTES

[1]The six health centres are at Det, Wiliame, Tamenda, Yepi, Purani and Hiwanda. The seven aid posts are at Karanda, Mapenda,

Kema, Waip, Tiri, Tugiri/Lake Kopiago and Topani.

[2]Bryant Allen recorded the following description of village birthing:

> *We had children by ourselves, and we cleaned and cared for them after the birth.... In childbirth, we got on our knees and hands to have the baby. The other women made magic for me. We fasted before birth. We had the child by ourselves in a small house. Nobody else stayed with us. Other women who had had babies told us what to expect and how to have the baby. Some women died. One every now and again. We stayed in the small house for eight days. Other women brought food only. We were afraid of the new child in those days. Those that died, died because the child became stuck inside them. We had our babies using our own strength and if we were not strong enough we died.* (Allen, Personal interview)

[3]Sister Gaudentia refutes the account by Leanne Merrett-Balkos of a protest in 1970 over placentas taken from mothers, with the compromise of them being given a few inches of umbilical cord (Merrett-Balkos). Sister Gaudentia, who was there at the time, says that a problem arose from mothers rubbing ground on the umbilical cord stump with the intention of having it dry and detach more quickly. She discouraged that practice after one baby developed tetanus and encouraged the mothers to wait three or four days for the umbilical cord to detach naturally before they took the child home.

[4]Sister Gaudentia gives an example of the challenges some women face:

> *I identified a woman who was to have twins—her first babies. She said, "I have so many pigs I have to look after." One afternoon, a truck comes and that woman comes off from the truck holding a baby. And I said, "why did you not come early?" And she laughed, and said, "one is still inside." She told me that as soon as the pain started she began to walk and she must have walked about three hours. And then her pain got so strong, she went into the bush and somebody helped her to deliver the first baby and then the other didn't come. So still connected with the chord she got to the road and stopped a truck and they brought*

her here. So then, we delivered the next baby—the other twin. (Meier, Personal interview)

[5]HIV was first detected in Papua New Guinea in 1987 (UNGASS, *Country Progress Report 2008* 17).

[6]In 2001, a massive tribal fight erupted in Mendi. In one month, there were seventeen cases of rape. Concerned about HIV infection for the rape victims, Sr Gaudentia tried to send blood serum to Mt. Hagen for testing but bandits on the road stole it, and she had to try to follow up and get the blood samples all over again.

[7]The name means "good house." There are seven positions at the Epeanda clinic. One position is paid by the government. The other positions are supported through the National Catholic HIV and AIDS office.

[8]The "friends" gathering is shown in the film directed by Philip Gibbs, "World AIDS Day in Mendi 2010."

[9]A study in Zambia showed that rates of maternal mortality increased eightfold over the past two decades, despite better obstetric services. Indirect causes of maternal mortality were responsible for 58 per cent of deaths, with malaria and AIDS-related tuberculosis the most common of these. In the Rakai district of Uganda, maternal mortality was five times higher in HIV-positive women than in HIV-negative women, reaching rates of over 1,600 per 100,000 live births in the infected group. In Malawi and Zimbabwe, pregnancy-related mortality has increased 1.9 and 2.5 times in parallel with the increasing AIDS epidemic (McIntyre).

[10]The record of numbers tested in 2013 is lower because testing at the Mendi town clinic was done by staff from the Clinton Foundation during part of that year.

[11]According to the Health Department records, in Mendi, four women (0.2 percent) of those tested in 2012 were confirmed seropositive. I note the difference between the Health Department records and those records from the Epeanda clinic in Table 1 above. Sister Gaudentia estimates that, at clinics offering testing, after pretest awareness talks, 90 percent of mothers agree to be tested for HIV (Meier, Personal interview).

[12]Catholic Health Services Mendi runs between four and six outreach clinics each quarter to rural areas.

[13]Of these mothers, six are returning to give birth to a second child,

and one is returning to give birth to her third child supervised through the PPTCT program.

[14]The result is similar to that from Mingende Rural Hospital run by CHS Kundiawa (Prasanna).

[15]Subsequently, three babies died, two from pneumonia and one due to gross deformity (hydrocephalic and downs syndrome).

[16]The Revival Church convinces people to stop taking medication and to rely solely on faith for their continued health. Unfortunately, many HIV-infected people die after trying to follow this policy.

[17]Letters were given to all participants to protect their identity.

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