HIV/AIDS in PNG

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Global response to HIV/AIDS
a time of retooling and rethinking

• ‘Prevention fatigue’
• Growing numbers of people affected by HIV and AIDS
• Wreckage caused by epidemic
• Anti-retroviral Therapy (ART)
Policy shifts & more funding

- WHO’s ‘3 by 5’ plan
- GFATM – PI Multi-country Global Fund
- SPC & AusAID’s regional plans
- AusAID- to review policy in 2004
- PNG –shaping new NSP
HIV/AIDS in PNG
Some thoughts – and questions - about….

- Numbers
- Stage of epidemic
- Prevention
- ART: as prevention?
- Households, women
- Research base for policy
Numbers – in Pacific context

Certainties:

• Need for good numbers, problems with data

• PNG highest absolute notifications
Probabilities

- PNG highest prevalence in region
- PNG most dynamic epidemic
## Highest cumulative reported HIV/AIDS cases per 1000 adults

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<tbody>
<tr>
<td>PNG</td>
<td>2 491 000</td>
<td>2.824</td>
<td>7036</td>
<td>Mar-03</td>
</tr>
<tr>
<td>New Cal.</td>
<td>114 000</td>
<td>2.158</td>
<td>246</td>
<td>Jul-02</td>
</tr>
<tr>
<td>Guam</td>
<td>83 854</td>
<td>2.063</td>
<td>173</td>
<td>Oct-02</td>
</tr>
<tr>
<td>Fr. Polyn.</td>
<td>125 400</td>
<td>1.802</td>
<td>226</td>
<td>Dec-02</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>6 160</td>
<td>1.461</td>
<td>9</td>
<td>Aug-02</td>
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</tbody>
</table>

Source: Update on HIV/AIDS in the Pacific, Meeting of Ministers of Health for the Pacific Island Countries, Nuku’alofa 9-13 March 2003
HIV/AIDS infection 1987-31/03/2003
year of diagnosis and sex

Source: HIV/AIDS quarterly report, March 2003, NACS & Dept. of Health
Stage of PNG’s epidemic

• ‘Generalized’ - 1% (more than 50,000); spread to low risk groups

• But not yet advanced.
## Stages of the epidemic

<table>
<thead>
<tr>
<th>Stage</th>
<th>Epidemiology &amp; Prevention</th>
<th>Impact and Response</th>
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<tbody>
<tr>
<td>1. No AIDS cases identified; some HIV infections.</td>
<td>HIV prev. &gt; 0.05% in high risk groups, targeted prevention.</td>
<td>Planning only needed.</td>
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<tr>
<td>2. A few cases of AIDS seen; more people HIV infected.</td>
<td>HIV prev. &lt; 5% in high risk groups, targeted prevention.</td>
<td>Impact on medical demand &amp; facilities: plan for this.</td>
</tr>
<tr>
<td>3. Medical services see many AIDS cases; some policy-makers aware of HIV and AIDS</td>
<td>Prev. &gt; 5% in high risk populations; targeted prevention and general info.</td>
<td>Impact still mainly medical, but begin HR planning &amp; targeted mitigation.</td>
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<tr>
<td>4.</td>
<td>AIDS cases about to overwhelm medical services; awareness of HIV/AIDS wide</td>
<td>Prev. &gt;5% in ANC women. Info. available to all, but targeting of high risk groups.</td>
</tr>
<tr>
<td>5.</td>
<td>Unusual levels of sickness &amp; death 15-50 age group cause coping problems for more &amp; more households.</td>
<td>Prev. &gt; 20% in ANC attenders and has been for 5 yrs. Max. prevention possible.</td>
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<tr>
<td>6.</td>
<td>Households, communities, enterprises, districts struggling to manage &amp;/or provide. Responses range from creative coping to failure of economic &amp; social entities.</td>
<td>Prevalence &gt; 15% in 15-49 year old and has been so for 5 years.</td>
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</tbody>
</table>

Can PNG prevent a grave epidemic at this stage?

Theoretically yes; targeted prevention still possible.

And some hopeful signs: condom usage in transactional sex in Port Moresby.

But – epidemic could still progress very quickly (cf South Africa)
HIV prevalence among ANC attendees, South Africa

Based on Dorrington et al. (2001), Fig. 3, p. 20
But few models for success

- Ingredients for success often lacking.

- And some ‘success stories’ (e.g. Uganda’s) come at great human cost.
But few models for success
New models of prevention with ART?

Two arguments:
1. ART in itself, a form of prevention (by lowering viral loads to negligible levels).
2. ART may reinvigorate behaviour change programmes (an incentive to be tested, and thus opportunities to counsel and educate.)
But ARVs given after initial period of infection

<table>
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<tr>
<th>High risk to both casual &amp; regular partners</th>
<th>Higher risk to regular partners</th>
<th>Usually sexually less active</th>
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<tbody>
<tr>
<td>High viral loads</td>
<td>Lower viral loads</td>
<td>High viral loads</td>
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<tr>
<td>Initial infection</td>
<td>Weeks/months</td>
<td>AIDS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.5 - 2 yrs</td>
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<td>antiretrovirals</td>
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</table>
Two Cons

1. Will not help in the initial period, before the person may even know s/he is infected (and this period is crucial: most spreading can occur then through casual multi-partnering)

2. May even act as a disincentive to behaviour change in this period, if people think they can get ARVs if they get HIV (cf recent trends in western homosexual transmission).
Three Pros

1. If administered early enough, ART may prevent transmission in some circumstances (e.g. from husband to wife)
2. Can prevent parent to child transmission
3. Prevent destructive social impacts

Range of impacts, but especially on families

• As reproductive units
• Production units
• Disproportionate impacts on women
• Intergenerational effects
Practical problems

• Affordability
• Complexity of treatment
• Expertise, infrastructure

But also other factors

• Cultural, physical access (e.g. gender/residence)
• An unsupportive social context (e.g. breakdowns, law and order problems)
Beginning of ART in PNG

- Some citizens have already been accessing ART from Queensland
- Anecdotally, now dispensed by private practitioners here.
- ‘Born to Live Project’ (ART to prevent PTC) launched by Catholic Church Sept.’03
- Limited availability from to adults and mothers next year
The future response?

- ART likely to play a small role in the foreseeable future
- An outsider’s thoughts
  - the need to work with men
  - to appreciate ideals of fertility
  - keep kids at school
  - see HIV/AIDS as a family disease
Finally

- Good policy needs a good base of local research.