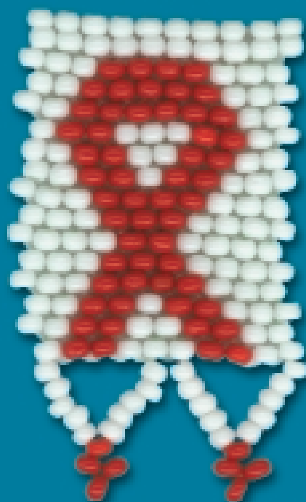

HIV/AIDS AND DEVELOPMENT IN ASIA AND THE PACIFIC

A LENGTHENING SHADOW

HEALTH, WEALTH, AIDS AND POVERTY

ASIA PACIFIC MINISTERIAL MEETING

9–10 OCTOBER 2001 MELBOURNE AUSTRALIA

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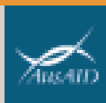

The Australian Government's Overseas Aid Program

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This briefing paper represents a summary of a longer paper on AIDS, Asia and Poverty, which is in draft form. Author contact details are as follows:

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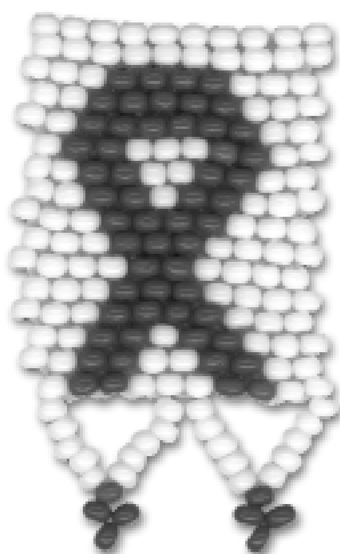

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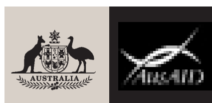

The Australian Government's Overseas Aid Program

The importance of health

In 1978 in the Declaration of Alma Ata, the international community committed itself to achieving health for all by the year 2000. Clearly, that goal has not been reached, although most countries have achieved significant health improvements. Now, with the UN Security Council discussing the implications of AIDS for global security, the leaders of the Group of Eight Countries signing up to new disease reduction targets, and the UN Secretary General, Kofi Annan, calling for an increased global response to HIV/AIDS at the recent UNGASS, health is again at the heart of international debate.[1]

The renewed interest in health has three main causes. First, good health is of profound importance to people, topping the United Nation's Millennium Poll as the thing that people most value in life.[2] In rich and poor countries, voters place pressure on democratic governments to improve health standards, while internationally, the health problems of developing countries provides one focus for discontent at the perceived inequities of globalisation.[3]

Second, we now know more about the importance of health to economic and social development.[4] Healthy societies are more likely to become wealthy societies — an effect that was felt especially strongly by the Asian tigers. Healthier people make more productive workers; they have greater incentives to invest in their education and in that of their children; they are likely to save more in expectation of a long retirement; and childhood cognitive development is more efficient. Healthy populations can also be a powerful magnet — attracting direct foreign investment, new technology, and jobs. Health improvements also help speed the demographic transition from high to low rates of both mortality and fertility. Health improvements accounted for as much as one–third of East Asia's economic miracle, with formal analysis suggesting that a country can, on average, expect to see per capita incomes grow by an extra 0.3-0.5 per cent for every five years it adds to its life expectancy.[5]

Third, health poses a complex series of challenges to national governments. While richer countries generally experience better health than poorer ones, the market does not automatically deliver health improvements.[6] Major shifts in health status are built on the same foundations as economic growth — new knowledge and technology, exploited through new practices and institutions, new investment, and new labour requirements. But the process by which health is improved is *parallel* rather than identical to economic development, needing specific policies and a serious political commitment to the goal of better health. Markets are insufficient providers of universal health care.

The ability to respond to major health challenges, in other words, depends on the health of institutions themselves, at local, national, regional and global levels. Can we match the supply of health technology to *need*, rather than just market demand?[7] Can we find significant investment

today in the expectation of avoiding much greater costs in the future? Can effective new partnerships be formed to make a 'cross-sectoral' response more than a theoretically desirable dream?

These profound and complex questions are given ever-greater urgency by the knowledge that the threats to our health do not stand still. Ageing populations, increasing drug resistance, and the growing burden of chronic disease in rich and poor countries, all mean that policy-makers must try to solve a problem that is continually mutating. New diseases do most to mutate the battlefield, however. Around 30 new diseases have emerged in the past 20 years, including Ebola, Hepatitis C, the Hanta virus and new variant Creutzfeldt-Jakob disease.[8] But the most serious new threat has been HIV/AIDS. This has now killed around 22 million people, with more than 36 million people currently living with the disease.[9]

AIDS and future prospects

HIV reached Asia and the Pacific in the late 1980s. According to UNAIDS, East Asia and the Pacific currently has 640,000 people living with HIV/AIDS, an adult prevalence rate of 0.07 per cent. There were 18,000 deaths in 2000. South and South-East Asia, meanwhile, have 5.8 million people infected with the virus, an adult prevalence rate of 0.56 per cent, while 470,000 people died in 2000.[10] Although HIV rates have not grown to African levels, Asia's infection rate is growing faster than anywhere else in the world, and the large populations of many Asian countries mean that even low percentage rates of HIV infection such as India's 0.7 per cent rate translate into large numbers of infected people — India currently has 3.7 million people living with HIV/AIDS.[11]

There are wide variations in infection rates. So far, only Cambodia, Myanmar and Thailand have adult HIV prevalence rates higher than 1 per cent, with many other countries having rates below a tenth of 1 per cent. In East Asia and the Pacific, the epidemic has until now remained largely among high-risk groups (only 13 per cent of HIV-positive adults in the region are women, implying a low rate of heterosexual transmission), while in South and South-East Asia women comprise 35 per cent of infected adults. There are also pockets of high infection within countries. Rates are so high among certain high-risk groups (China's injection drug users, for example, and Cambodia's female sex workers[12]) that the Asian Development Bank has warned that 'many Asian countries are potential incubators for a rampant spread of the infection' if the virus succeeds in crossing over into mainstream groups.

There continue to be disputes about the extent to which AIDS is likely to spread beyond high-risk groups, with James Chin leading those who believe that there are relatively few routes for transmission from high-risk communities to the general population[13]. However, sentinel surveillance data from urban areas in India has shown that more than 1 per cent of pregnant women — a low-risk, monogamous group unlikely to indulge in high-risk behaviour — are HIV-positive, suggesting that the virus is beginning to cross over to the mainstream population in

some areas.[14] The doubling of infection rates in Vietnam, the Philippines, Nepal, Indonesia and India between 1993 and 1997 means that few governments can afford to be complacent.

Government-level response to AIDS in Asia and the Pacific, however, has been mixed. Many political leaders have not acknowledged that HIV/AIDS is a threat to their countries, and few have put in place strategies for action at a national level. Some programs that have been put in place, such as Bangladesh's program to 'disperse' communities of illegal sex workers, may actually contribute to the spread of the virus. Others, such as Vietnam's 'Eradication of Social Evils' policy, could potentially raise the stigma surrounding AIDS and hamper more enlightened efforts.[15] Only Thailand, which has managed to curb STI rates and visits to sex workers and increase condom use, stands out as a beacon in the fight against HIV.

The scale of the AIDS epidemic and its status as a new problem has led many to predict that the disease will have dramatic effects on national wealth. The United Nations Development Programme (UNDP) has argued that HIV/AIDS has caused 'falling labour quality and supply, more frequent and longer periods of absenteeism, losses in skills and experience, resulting in shifts towards a younger, less experienced workforce and subsequent production losses'. These effects have been felt 'throughout the economy, from the macro-level to the household'. Research early in the epidemic failed to substantiate this intuitive link, with the influence of AIDS on per capita income growth shown to be statistically insignificant (though negative) during the period 1980–1992.[16] However, AIDS has now had a significant negative impact on life expectancy in many countries, with this expected to act as a drag on growth.[17]

Data predicting general economic immiseration deserves to be interpreted cautiously, especially in Asia and the Pacific, which have not experienced an epidemic of the ferocity felt in sub-Saharan Africa. Even within Africa, we do not have good estimates of the role AIDS plays in economic stagnation, alongside other negative factors, such as civil war, corrupt governments, undeveloped institutions, inadequate education and other health problems. However, it would be equally rash not to consider AIDS as a truly national problem. Modern development thinking increasingly emphasizes the interactions between sectors, with 'virtuous spirals' developing as, for example, improved health and education lead to enhanced growth, which in turn increases the availability of investment for these sectors, and the capacity to ensure increased investment delivers value.[18] The opposite is also possible, of course, as deterioration in one area acts as an invisible drag on others.

In summary, then, a balanced view of the effect of AIDS on Asia and the Pacific's prospects should be encouraged. AIDS will have a range of direct and indirect impacts across a broad swathe of a nation's life and, without intervention, the vast majority of these impacts will be negative. The challenge to policy-makers, therefore, is to design the kind of policy interventions that will not only tackle AIDS impacts, but will also see the opportunities that action against AIDS presents to make improvements that will have broad and beneficial collateral impact. Use of condoms, for

example, will protect against other sexually transmitted diseases (STDs), which will in turn reduce the incidence of drug-resistant strains encouraged by the common practice of self-medication with antibiotics. Lowering HIV rates will help to reduce the spread of tuberculosis (TB) among non-HIV positive people (TB is the biggest killer of people with AIDS and, as HIV/AIDS spreads, TB rates rise and the disease is passed on to non-HIV positive people).[19] Curricular reform aimed at improving health education, meanwhile, will likely lead to improvements across the education system, while efforts to improve the way the government system copes with AIDS will help build capacity to meet other cross-cutting problems in our increasingly 'joined up' world.

AIDS and poverty reduction

Many developing countries are focusing on poverty reduction as a key component of their overall development thinking. Poverty reduction strategies are now a key to accessing a growing proportion of multilateral and bilateral donor funding, with the World Bank encouraging countries to build strategies based on a comprehensive understanding of poverty and its determinants, a portfolio of policy actions that will have a targeted and cost effective impact on poverty reduction, and the selection of clear indicators that will enable national governments and donors to track progress.

HIV/AIDS clearly has an impact on the prospects of poor people who become infected with the virus and, as such, it needs to be given careful consideration in any poverty reduction strategy. Data on the extent of this problem proves elusive, however. The most striking figure is also the simplest: 95 per cent of those infected with HIV live in developing countries, home to around 85 per cent of the world's population. There is a strong positive association between HIV globally and the absolute poverty rate (at both $1 and $2 a day levels), with this correlation still significant even if Africa is removed from the equation. Regionally, however, findings are less clear. Within Africa, the association at a country level between poverty and HIV is significantly *negative*, in other words the poorer countries have less HIV and the epidemic is disproportionately affecting richer, more mobile populations. For Asia, as for other continents, there is no statistical association between AIDS and poverty either way, with the disease *income neutral* from its inception.

Averages, of course, hide as much as they reveal. Across the world there is evidence that, as the epidemic matures, HIV/AIDS is becoming increasingly concentrated in poor populations. While wealthier groups learn to protect themselves (in the early 1980s in Brazil, three-quarters of people newly diagnosed with HIV/AIDS had a secondary education; by the early 1990s this share had fallen to one-third[20]), the poor have less access to information and health care services, and are more likely to be forced by hardship and marginalisation into making sub-optimal choices.[21] The disease therefore proves harder to tackle among poor people.[22]

The epidemics in most Asia Pacific countries are comparatively under-developed when compared to Africa. There is already evidence; however, that new groups are becoming more vulnerable to

infection, even as the initial high-risks groups (principally commercial sex workers and their clients) learn to protect themselves.[23] Evidence from Papua New Guinea, Bangladesh, Nepal, Indonesia and Vietnam suggests that the least educated face relatively high risk, with knowledge that condoms prevent transmission markedly lower among women with no education than those with primary education who, in turn, know less than those with secondary education or higher.

Recent demographic and health survey data surveying 15,557 adult women in Cambodia, the country with the most advanced epidemic in Asia, emphasises the extent to which Asia's poor are at greater risk of HIV infection than better-off sections of society.[24] The women were asked about a range of issues from education to sexual habits to HIV awareness. The results, after splitting the women into five wealth quintiles, are instructive:

- The poorest young women (aged 15-19) are 50 per cent more likely to have had sex than their wealthier counterparts (an early age of first sex is an important risk factor for HIV).

- The wealthiest women are twice as likely to practise safe sex than the poorest women.

- The wealthiest women are twice as likely than the poorest segment to know how to prevent HIV transmission.

- Although 30 per cent of women in all wealth quintiles want to be tested for AIDS, women from the wealthiest quintile are almost four times more likely to know where to get tested than women from the poorest quintile.

Knowledge and behaviour, therefore, are dramatically different among the poorest sections of society, and it is clear that AIDS has the potential to have a major impact on development efforts. Although most women from all groups have heard of AIDS and know it is transmittable, the more detailed knowledge which is crucial to preventing HIV transmission is lacking among the poor. Interventions targeting the poor, therefore, should focus on education that goes beyond mere awareness-raising, and on increasing access to condoms and testing facilities.

A second concern for those interested in poverty reduction should be the additional — and sometimes unbearable — burden that caring for someone with AIDS places on already poor households. People with AIDS are subjected to a long and ultimately hopeless illness, during which they will be unable to work for protracted periods of time. However, patients are frequently not provided with diagnosis or prognosis, and many spend large sums on treatment of marginal or no worth (one study in Cambodia found expenditures equal to many times an extended family's annual income, funded by sale of assets and debt at high rates of interest).[25] The effects of one illness can therefore be widespread, as a family, for example, sells its land, removes one or

more children from school, and diverts expenditure away from other essential areas. A cycle of impoverishment is also common, as a family member leaves home to find work, becomes infected, and returns home when sick, which will further drain the family's assets and may encourage another family member to migrate.

A third area of concern is the possibility that measures intended to help reduce poverty may be unsuccessful because they increase the vulnerability of the beneficiary population to AIDS. Disease feeds on change, with migration and the breakdown of social structures especially important in creating the conditions by which HIV spreads. Development, of course, also relies on change, and it is not surprising that it is often areas where development is occurring that develop into hotspots for the disease. Inward investment, for example, brings factories and much needed jobs. However, the workers who migrate for these jobs are likely to have increased numbers of sexual partners, whether they are men visiting sex workers, women engaging in informal sex work to supplement their income, or men or women experiencing a form of sexual 'liberation' when freed from the norms of their place of origin. Again, those planning and facilitating development face the challenge of turning risks into opportunities. An army, for example, can be an exceptionally effective tool for spreading all kinds of sexually-transmitted disease. On the other hand, it is also possible for an army to offer poor young men a standard of health education and health care beyond any they have experienced in their childhood. As well as a more effective army, the latter would be likely to lead to significant benefits for poverty reduction as soldiers seek and achieve similar standards of health for their partners and children.

AIDS *within* health *within* development

This paper has underlined the importance of health to a country's development and its vital role in improving the lives of the poor. It has stressed that AIDS should be treated as one of many health problems, rather than in isolation, but that there should be broad action at all levels of societies to ensure that general health standards are improved.

An attempt to consider AIDS *within* health, and health *within* development, will mean facing many different problems in different countries. However, some consistent areas can be identified:

- The need for peace, stability and good governance. War leads to sudden increases in mobility, the destruction of infrastructure, and the diversion of human capital from development to destruction. Peace and political stability, guaranteed by strong democratic institutions, must therefore be the foundation of any broad effort to tackle AIDS. Even within a peaceful society, the importance of effective governance cannot be over-emphasised.

- The need for data-driven decision–making. Part of the process of improving governance involves ensuring that decisions are made using data that is reliable,

relevant, and available. A genuine multi-sectoral approach requires judgments to be made about the competing claims of quite different interventions — a process that can only intensify as issue after issue attempts to 'mainstream' itself across government. Only data and clear processes can begin to discriminate between competing claims in any rational fashion. Ongoing measurement of the effectiveness of interventions also enables policy-makers to keep track of the changing nature of the HIV virus. Although Thailand has achieved remarkable results in reducing HIV rates among sex workers and their clients, the profile of the virus is currently changing, with rates among children and drug users increasing and rates among pregnant women either stable or rising in most areas.[26]

- The need to build broad partnerships. Government — in its broadest sense — has traditionally been atomised, with government ministries working in narrow channels, each cultivating a constituency of interested NGOs, professionals, lobby groups etc. In developing countries, these divisions have often been mirrored and emphasised by intense competition among donors for influence and the 'right' to spend funds on pet projects. Broad action on a subject such as AIDS requires a concerted attempt to break down these barriers. It will also require a clear assessment from government of where it can act effectively, and where it is better facilitating action from the private or civil sectors. The structure of government will almost certainly need to change, so that international funds channelled through governments are not absorbed by administrative bureaucracy.

- The need for health sector reform. There are a growing number of people in the Asia Pacific region who are in need of AIDS care and this is exposing the weakness of the health systems in many countries. Health sector reform therefore becomes increasingly urgent and it, in turn, should be seen in the context of broader public service reform in many countries. For example, in some countries where public servants are paid extremely low wages many charge the public unofficial fees for their services to survive. Such institutionalised corruption bedevils *all* government initiatives and dramatically distorts the country's health service. Without some attempt to tackle these problems, many improvements in the lives of poor people and those ill with AIDS will happen despite, rather than because of, government action.

- The need for private sector involvement. Public sector reform is a long-term strategy, but innovative, well-targeted actions may have a more immediate impact. Simple, inexpensive actions can have far-reaching effects. The drug Nevirapine, for example, has been shown to be effective in reducing mother-to-child transmission of HIV during labour and through breastfeeding.[27]

Pharmaceutical company Boehringer Ingelheim provides this drug free to developing countries. In order to ensure wide access, major food and drink manufacturers, who have strong distribution networks in place in the developing world, may be persuaded to work with governments and NGOs to distribute Nevirapine to women in high-risk areas. If Nevirapine is offered to all pregnant women in at-risk populations, the promise of preventing HIV transmission to their babies is likely to encourage many more women to present for HIV testing. At the same time, the women can be given information about the virus. The relatively simple, cost-effective distribution of Nevirapine can therefore have the much wider effect of indirectly strengthening the knowledge of these key gatekeepers of family health.[28]

- The need for special consideration of the role of women. Although men suffer disproportionately from HIV everywhere except Africa, women remain an irreplaceable key to fighting the epidemic. Their education is vital to ensuring better health for whole families, while their empowerment will give them a better chance of avoiding infection with HIV as the epidemic matures and their risk of infection continually increases. They are also likely to bear the main burden for providing care. Perhaps more than any other intervention, progress towards national targets for the major indicators of female welfare (ie educational attainment, maternal mortality and general health status, role in the labour market, access to birth spacing technologies and use of condoms etc) has the potential to deliver benefits to a country's fight against AIDS, its attempt to improve health standards, its poverty alleviation work, and its general development.

- The need to increase the participation and involvement of poor people. Targeting of high-risk populations has been a valuable strategy in the fight against AIDS. However, the adoption of this strategy has been encouraged by the fact that most of these groups have been concentrated in urban centres (often, indeed, in the capital). If governments are to take seriously the possibility that AIDS epidemics will become 'stuck' in poor populations even as overall prevalence rates decline, they will need to confront a generalised inability to target poor people. Both geography and politics have played a part here. Rural areas have always been neglected, mainly due to distance, while the poor generally exert the least political pressure and therefore can easily be ignored. Strategies to encourage participation remain the answer, especially as prevention campaigns switch from the provision of information to an attempt to give people the tools to understand the risks they face and to make better decisions, both individually and collectively.

Conclusions

The international community is increasingly aware of the importance of health to a society's economic development. Although AIDS is potentially the biggest health threat to developing countries in Asia and the Pacific, it remains to be seen whether AIDS will have a serious macro effect on their economies. It *will* however, have a broad range of impacts on a country's health. Policy will determine whether action on AIDS will lead to vicious or virtuous development spirals. Without action, the number of poor will increase, development efforts will be hampered, and those who are already poor will be pushed deeper into poverty traps. Well-targeted, innovative policies, on the other hand, may have a collateral impact with far-reaching beneficial implications for the health of a society as a whole. AIDS, like health in general, is a test of the overall health of a society. Policy-makers in Asia and the Pacific will decide whether their countries pass that test.

FOOTNOTES

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