**Paper prepared for Australian Agency for International Development (AusAID)
Special Seminar, November 22, 2000:**

It's Everyone's Problem: HIV/AIDS and Development in Asia and the Pacific

HIV/AIDS – a global overview with emphasis on Asia and the Pacific

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Executive Summary

Over 15,000 new HIV infections are now being contracted each day across the globe, compared to 8,500 per day in 1996 and 4,000 in 1990. In Asia, it is estimated that over 7 million people are infected. India has the second highest number of people infected with HIV of any country in the world – an estimated 3.7 million.

There is little doubt, on the basis of the history of HIV/AIDS spread to date, that it will continue to worsen in Asia and the Pacific in the foreseeable future; thus long-term, well resourced, and well coordinated prevention, treatment and care efforts are required.

HIV/AIDS is not simply a health issue. It affects virtually all aspects of human development. It erodes human, social and financial capital. It hits hardest those countries that can least absorb its impact. It affects the manufacturing sector, the professional and academic sectors, agriculture, education, defence, let alone the health care and social welfare sectors. It can threaten national stability and security, as it is now doing in central and southern Africa.

And, as in Africa, HIV/AIDS has the potential to undermine Australian aid programs in several Asian and the Pacific countries. Development aid agencies, governmental or non-governmental, ignore HIV at their peril.

This paper suggests several ways Australia can play an important international leadership role in HIV/AIDS, particularly in the Asia and Pacific region.

- Ensure HIV/AIDS assistance supports and is supported by the moral, humanitarian, economic and national security concerns of Australia's foreign policy.

- Develop long term, well-resourced (financially and intellectually), trusting relationships with a select number of partner countries.

- Develop a comprehensive range of aid pathways for HIV assistance.

- Focus on supporting high level political and bureaucratic mobilisation, so important in effective national responses

- Ensure there is well trained, cross culturally effective staff to support Australian aid projects.

- Ensure that Australian aid assistance in HIV/AIDS is well integrated into the broader social, economic and health care needs of countries.

1.   Introduction

Why is it, 20 years after the discovery of HIV, we are faced with a seemingly inexorable rise of the death toll and infection rate due to HIV/AIDS? And why is this toll so heavy on those countries that can afford its impact the least?

Why, if we have known what to do for many years, is preventing HIV so difficult? Why have we not been able to apply systematically and evenly across the globe what we have known and learnt in the last 20 years?

This paper aims to answer some of these very difficult questions whilst providing reasons why Australia can and must play an important international role in HIV/AIDS, particularly in the Asia and Pacific region.

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But whilst the picture is bleak in many countries, 1999-2000 has also seen a major shift in global response to AIDS. For the first time a special session of the UN Security Council has focused on HIV/AIDS. At the Okinawa G8 meeting in July 2000, the EU, Japan and the USA announced major new HIV/AIDS initiatives. In particular the US response and financial commitment to AIDS globally has begun to rise rapidly with a focus on Africa. Australia has pledged a major commitment to HIV/AIDS in the region over the next five years.

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Australia is well placed to play a major role in assistance in Asia and the Pacific, by ensuring that the region is not neglected by the understandable focus on Africa and that lessons learned from the Europe, Australia, North America and from Latin America are increasingly made available to countries and communities in the Asia and Pacific region.

This paper examines the evolution of HIV/AIDS over the last 20 years and looks at future scenarios of spread, both from a global view and then with emphasis on our region.

It then discusses the many determinants of its spread, and discusses the reasons why HIV/AIDS is so difficult to control.

It examines major issues such as the impact of HIV/AIDS on human development, on national economies, and on national security, and looks at the difficulties in access to prevention, treatments and vaccines.

We then outline the key elements in successful responses to date and present future scenarios for development aid programs, including the role of the international community and donor aid, and Australia's comparative advantages in HIV/AIDS aid assistance.

We conclude by outlining some of the critical challenges that face Australia in the provision of aid assistance in the area of HIV/AIDS over the next ten years.

2.   The worsening evolution of HIV/AIDS

Since 1981 almost 19 million people have died with AIDS. UNAIDS estimates show there were 1.5 million AIDS related deaths in the year 1996. In 1999, there were 2.8 million.

Over 5 million new HIV infections are now occurring every year, compared to 3.1 million in 1996 (UNAIDS 2000a), and an estimated 1.4 million in 1990 (Chin 1995).

> *Over 15,000 new HIV infections are now being contracted each day, compared to 8,500 per day in 1996 and 4,000 in 1990. (UNAIDS 2000a, WHO 1998, Chin 1995)*

There are now well over 34 million people living with HIV infection. Most of these can be expected to die over the next 10 years or so.

These figures indicate the full impact of the epidemic is only beginning.

AIDS is now the fourth leading cause of death, surpassed only by disease groups such as ischaemic heart disease, cerebrovascular disease and lower respiratory infections which are typically causes of death for old people. AIDS is highest in young men and women in their most productive years. (WHO 1998)

> *AIDS is the fourth leading cause of death.*

The epidemic is worst in sub-Saharan Africa. Almost 25 million people are estimated to be infected with HIV. In other words, nearly one in ten adults from 15-49 years of age is already living with the virus. While the first major epidemics were described in central and eastern Africa, HIV/AIDS is now far worse in the southern part of the continent. In South Africa, infection rates increased from less than 1% in the adult population at the beginning of the 1990s, to about 20% in less than 10 years (UNAIDS 2000a).

Women in Africa are more affected than are men: about 55% of all adults living with HIV/AIDS are women. In particular the risk of being infected with HIV is far greater for women below 25 years of age, than for men in the same age group.

Several Caribbean Island states have more severe epidemics than any other countries outside Africa. The countries of the former Soviet Union have seen a rapid growth in HIV infection, driven primarily by an epidemic of (unsafe) drug injecting practices.

In the developed world infection rates dropped significantly in Australia, NZ and Japan, North America and Europe after early prevention campaigns, and mortality rates are declining due to better care and treatment. However, risk behaviour especially amongst injecting drug users and some gay communities has not been eliminated and in some communities may be increasing (UNAIDS 2000a).

Asia and the Pacific

In Asia, it is estimated that 7 million people are infected. HIV epidemics in the region are diverse, localized, and have different trends over time (MAP 1999). These trends are outlined in Appendix 1. Infection rates vary widely but Cambodia, Myanmar, Thailand and some states of India are worst affected to date with prevalence rates of 2-3% among the adult population (15-49yrs). The major driving force of the pandemic is heterosexual transmission; factors that strongly influence the course of the epidemics in this region include patterns in sex work and sexual networking, and patterns of injecting drug use (MAP 1999). In addition mobility within countries and between countries of long distance truck drivers, commercial sex workers, seafarers, migrant workers and illegal migrants, plays a very important role in HIV spread in the region (Hsu, de Guerny, 2000).

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In Cambodia, rapid increases in HIV transmission have been reported since the first case of HIV infection was notified in 1991. Prevalence among those aged 15 to 49 years is estimated to be 3.7%, with the estimated reporting rate of HIV being low (8%). (UNAIDS 2000c) Prevalence rates are expected to continue to increase with extensive heterosexual spread.

Infection rates in Myanmar are around 2%, and extremely high in some sub-populations, particularly drug users. (UNAIDS 2000d)

In India, despite relatively low prevalence rates overall, a population of 1 billion means that there are more HIV infected people than in any other country except South Africa - an estimated 3.7 million people (UNAIDS 2000a). The increase in the estimated number of HIV infections from a few thousand in the early 1990s to the current figures, in a context of very limited information about prevailing sexual risk-taking behaviours, creates great uncertainty about the future course and impact of the epidemic. (MAP 1999)

> *India has the second highest number of people infected with HIV – an estimated 3.7 million*

Thailand seems to have concurrent, but largely independent, epidemics among men who have sex with men (MSM), injecting drug users and heterosexuals. (UNAIDS 2000a).

Other countries such as Malaysia, Nepal and Vietnam have rapid increases of HIV incidence in various population groups, particularly injecting drug users, while overall the general population prevalence rates are low.

In the South Pacific, rates again vary but PNG in particular has a major problem. Since the HIV epidemic in the Pacific began, the number of new infections reported each year has increased steadily, with PNG contributing the majority of annual increases. The population of PNG is 4 million; in 1999, PNG *reported* 5400 people living with HIV/AIDS, up from less than 1000 in 1996. (UNAIDS 2000a, SPC 1997) It is estimated that in PNG only one-fifth of all cases is reported; therefore possibly 25,000 people are living with the virus. Isolated communities, more than 800 languages, and deep religious and cultural taboos are factors which combine to make HIV prevention and education difficult. As well, programs operating in PNG are limited by lack of resources.

> *"We in Papua New Guinea have the most difficult place to work in HIV/AIDS in the world. We've got a very diverse society. We have 800 different languages, and people have maybe the similar number of thoughts and ways of thinking about general issues in life, and sex is one of those issues. There's also other issues of development … accountability of leaders … the cash economy … [people] put[ting] themselves at risk in trying to have a decent way of life … if we don't do things innovatively and proactively … we will definitely have maybe much more problem than what's faced in Africa, I believe" – Dr. Clement Malou, PNG National AIDS Council (ABC 2000)*

It is widely acknowledged that HIV/AIDS is under-reported in Pacific island countries. It has been stated that the HIV epidemic in the Pacific is considerably more serious than the available data suggest (SPC 1997). Pacific island countries do not support the high populations of Asian countries, but this does not make the potential spread of HIV any less significant. The unique social, economic and cultural factors of the Pacific leave communities vulnerable to HIV infection.

Sharp and sudden increases of HIV incidence have and can occur in Asia. Examples of the evolution of the infection in countries such as Myanmar, Cambodia and Thailand show HIV has the potential to spread fast and widely. However, the Monitoring the AIDS Pandemic (MAP) network, in its report to the 4th International Conference on AIDS in Asia and the Pacific (4th ICAAP) in 1999, stated that it was difficult to predict the future course of HIV epidemics even in countries such as Nepal, Vietnam and Malaysia where there are rapid increase in HIV among some populations, but not all. MAP calls for urgent increase in the collection and analysis of quantitative, qualitative epidemiological, social and behavioural information to predict epidemic trends and target prevention to factors that result in populations being vulnerable to rapid HIV spread. (MAP 1999)

> *There is little doubt, on the basis of the history of HIV/AIDS spread, that it will continue to worsen in Asia and the Pacific in the foreseeable future, and thus requires long-term, well resourced, and well coordinated prevention, treatment and care efforts.*

3.   The many determinants of HIV/AIDS and why it is so difficult to control.

As we have seen above HIV continues to spread uncontrollably in many countries across the world. HIV is much more difficult than we could have ever imagined 20 years ago. Despite all the wonderful advances in prevention, diagnosis and treatment it continues to trick and taunt us from so many different perspectives. Below we consider some of these perspectives – technical, behavioural, socio-economic, and perhaps the most the most important – political.

Technical Issues

Examined from the technical and virological point of view the virus is elusive and evasive. It is a unique human pathogen that has learnt to kill off the immune system. Notwithstanding recent advances in therapy, an effective vaccine lies many years in the future (see below). It has a long 'silent and invisible' period between infection and illness; unless tested and counselled a person may be unaware of their infection, and can unknowingly infect others.

Behavioural Dilemmas

HIV is every bit as complex from a behavioural perspective, because it is spread by deeply ingrained human behaviours that are elusive and evasive to deal with.

The infection is predominantly transmitted sexually – for most people, a private sphere, and in many cultures a topic not discussed openly, if at all.

> *In many countries sexual intercourse is intimately associated with rites of passage and with the symbolic union of families, let alone its associations with procreation, pleasure, power and survival.*

Historically, religious and political leadership in many countries has been reluctant to promote condom use, 'safe sex', or even lead more open discussion, and thus be seen to encourage promiscuity or immorality. For example, the Confederation of India has been quoted as saying that in India people 'are as promiscuous as anywhere in the world, but they don't want to talk about it' (Vaughan 1996).

Discrimination and prejudice have surrounded the issue of HIV/AIDS since the beginning, associated as it is with behaviour which can be branded 'immoral' or may be illegal (drug injecting, prostitution). Because of the shame and fear surrounding this fatal disease, people are still reluctant to acknowledge the relevance of AIDS to their own lives. (UNAIDS 2000a)

Culture and religion have proven to be complicated, and at times convenient, barriers to effective prevention and control of HIV/AIDS, as they are in other areas such as reproductive health and girls' and women's health. Thailand's leaders realised that they would have to 'clash with culture' to get effective programs up and running. In many countries, the major roadblocks are those that prevent female education and participation outside the household, and discriminate against women with regard to nutrition, medical care and schooling (Mechanic, 1992).

Young people may be at particular risk if they are unable to inform themselves about or protect themselves against HIV. While virginity at marriage may be an ideal in many cultures, the reality can be widely different. Studies indicate that in a number of countries where the adult HIV prevalence rate is higher than 10%, a fifth or more of older teenage girls knew too little about the virus to protect themselves. (UNAIDS 2000a). Contrary to popular belief, teaching young people about sex does not produce higher levels of sexual activity, as a UNAIDS review has shown (Grunseit 1997)

> *Because of the shame and fear surrounding this fatal disease, people are still reluctant to acknowledge the relevance of AIDS to their own lives. (UNAIDS 2000a)*

HIV is driven by a second epidemic amongst injecting drug users. Injection is an even more efficient way of spreading HIV than sexual intercourse, enabling the virus to spread with astonishing speed. Risk behaviour – sharing injecting equipment – appears to be common. For example, HIV infection among injecting drug users in the Ukraine rose from virtually zero in 1994 to 31-57% in less than two years. (UNAIDS 2000a).

Social and socioeconomic obstacles

HIV thrives where social and economic vulnerability is greatest. Some groups tend to be at a greater risk because of their position in society and the limited opportunities available to them. Structural features for example gender relations, voluntary or forced migration, ethnic relations, or variations of income are amongst the difficult factors when dealing with HIV/AIDS because they "imply that broader social changes may be necessary if we are to do something lasting about the epidemic." (Piot, Aggleton, 1998)

Women in particular are vulnerable. Issues such as economic dependence on men, domestic violence, and double standards of sexuality, illustrate the lack of control women have in their sexual relationships. Simply being married is a major risk factor for women; "studies in Africa show many married women to have been infected by their one partner – their husband." (UNAIDS 1997).

Other issues, for example unequal access to education or training, reinforce women's lack of autonomy and control over their own lives.

> *For young women in rural Thailand or Laos or Myanmar who end up in the sex industry, their main risk factor is simply being poor.*

As well, women with HIV infection are likely to experience more social blame and stigma than men, and are most likely to carry the burden of care.

> *Winnie Chikafumbwa discovered she was HIV positive after the birth of her child. The day she informed her husband he left. When she informed her employer, the national government, she was sacked. As a result she set up the first People Living with AIDS Group in Malawi. Winnie died in 1998.*

The complex matter of human movement – tourists, migrant workers, migrants, students, seafarers, armies, refugees fleeing from war and civil disruption – influences the spread of the HIV virus; movement not only across international borders but within countries, particularly in Asia. For example, people moving from rural to urban situations may be placed in higher risk situations than in their home environment. The mobility and movement of people is not so much important as the behaviour of those people [when they move]. (Skeldon, 2000)

The small 'p' political dimension

From the political perspective HIV is enormously challenging, as effective national programs often require quite dramatic cultural shifts and challenging of long standing taboos. Open and honest government acknowledging the spread of HIV, and political foresight and leadership are required to deal with issues of sex, drugs and discrimination. Australia's multi-partisan political response has provided leadership in the region, by developing successive national strategies underpinned by a long-standing partnership between affected communities, people living with HIV/AIDS, researchers, health and social services, and government.

In the United States, despite studies showing that needle exchange programs significantly reduce new HIV infections amongst drug users without encouraging drug use, federal funding of such programs is banned because of political opposition. One study estimates that failure in implementing widespread needle exchange programs between 1987 and 1995 will cost the US at least $244 million in medical care for HIV cases which could have been prevented. (UNAIDS 2000a)

In Africa, some political leaders are beginning to follow the wonderful example set by President Yoweri Museveni of Uganda, and speak out and acknowledge the existence and danger of AIDS, with many countries launching five-year plans against the infection. In Kenya, after many long years of silence, denial of the seriousness of the epidemic and opposition to condom use, President Daniel arap Moi in his New Year's address this year reversed his position by stating "Anything that can be said or done to halt the progress of the disease must be said and done". (UNAIDS 2000a) Less promisingly, others, such as South Africa's President Mbeki, are derailing efforts to fight HIV/AIDS, with comments calling into question the origin of AIDS.

In Thailand declining HIV levels in sex workers and their clients have occurred as a result of a society that is willing to openly discuss and deal with the determinants and

the consequences of unsafe sexual behaviour. A good example of this openness was the 100% condom program, where with government support, sex workers and brothel owners enforced maximum condom use in brothels (Visrutaatna, et al 1995). This was further reinforced by media campaigns to encourage respect for women, discourage men from commercial sex, and literacy and vocational programs to prevent young women from having to join the sex industry. It was former Prime Minister Anand who created the environment for such programs to flourish in Thailand.

This success in Thailand has inspired a similar program in Cambodia, where the Prime Minister has approved a national policy requiring implementation of "100% condom use" in all entertainment establishments. There is evidence the program is leading to increases in condom use amongst sex workers, and that this is being reflected in reductions of HIV prevalence among young brothel-based sex workers. (WHO 2000)

3.   Major Issues
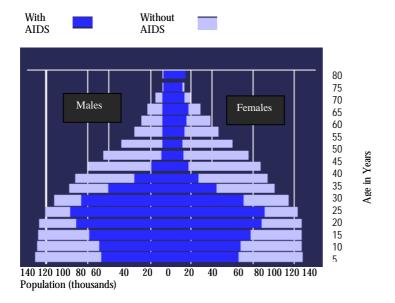

Impact of HIV/AIDS

The impact of HIV/AIDS reverberates from an individual household level to national and international levels. The United Nations is convening a special session of the General Assembly in 2001, to review and address the problem of HIV/AIDS in all its aspects, and to co-ordinate and intensify international efforts to combat it. Delegates at the 55th session of the UN General Assembly were told the "rapid spread of HIV/AIDS was a global health and social problem" requiring "the mobilization of international forces to work together to battle the disease." China's delegate Huang Xueqi called upon the international community to show political commitment and to pledge financial support in fighting the global epidemic. (Xinhua 2000)

> ***As in Africa, HIV/AIDS has the potential to undermine the very aid programs in Asia and the Pacific that Australia supports.***

In the hardest hit region of sub-Saharan Africa, there are scenarios of shocking impact: AIDS has generated a crisis in human development in many countries. Years of progress in public health are being reversed, but AIDS is not simply a health issue. Education, industry, agriculture, transport, human resources, and the economy in general are affected by the decline in an economically productive workforce. The premature death of adults at an age when they have formed their own families has resulted in a generation of orphans.

A new demographic structure, the "population chimney", has been used to describe the demographic effects of HIV/AIDS. Fewer babies are born to HIV-infected mothers who die or become infertile before the end of their reproductive years. Possibly as many as a third of the infants born to HIV-infected mothers will also acquire and succumb to the disease. People infected with HIV early in their sexual lives begin to die around the ages of 30-35, and as only those not infected survive to older ages, the usual "population pyramid" shape becomes a chimney. The results of

this demographic restructuring indicate a small number of young adults supporting large numbers of children and older people.   (UNAIDS 2000a)

Projected population structure with and without the AIDS epidemic, Botswana, 2020
Source: UNAIDS (2000)

HIV has particular ramifications for the military, given the high rates of casual sex engaged in by military personnel, as well as the implications of rape.   The possibility of large numbers of defence force personnel becoming infected has consequences for political and social stability, in countries where the military is the source of political power.

The effect on productivity and savings makes HIV/AIDS a threat to economic growth, affecting as it does predominantly younger adults, the most productive members of society. Having a family member ill with AIDS results in a dramatic decrease in income, as well as loss of time given up to care.

A Thai study showed that one-third of AIDS affected rural families had to cope with a halving of their agriculture output, threatening their food security. In addition another 15% were obliged to take their children out of school, and over fifty percent of the elderly people had to fend for themselves.   On average families spent US$1000 during the last year of an AIDS patient's life – the equivalent of an average annual income (UNAIDS 2000a).

Business and industry suffer from the epidemic, with impacts on productivity, costs and markets. Business expenditures are increased by health-care costs, burial fees and replacement of employees, while revenue is decreased by absenteeism due to illness, caring for the ill, attending funerals and time spent on training new employees. Studies in Africa show that profits have decreased from 20 to 7 per cent as a direct result of HIV/AIDS. (UN Economic and Social Council 2000) Another Thai study, that of a small company, found that AIDS was causing a loss of US$80,000 annually,

whereas a prevention program would cost only US$11,500.   Pension funds, also, are being hollowed out by premature deaths. (UNAIDS 1998b)

> *A survey in Thailand, that of a small company, found that AIDS was causing a loss of US$80,000 annually, whereas a prevention program would cost only US$11,500*

But applying economic and monetary terms alone does not adequately account for the human development issues on which HIV/AIDS impacts. These include the removal of education opportunities for young people, the loss of years of acquired knowledge through premature death of well-trained or skilled workers, the impoverishment of families and the effect on community cohesion, and the loss of 'human security' as defined by the UNDP. (UNDP 1994)

National Security

Military preparedness can no longer determine national security. Threats such as the AIDS epidemic will not be contained by national boundaries.

We have already discussed how the HIV virus flourishes where social and economic vulnerability is greatest, thus exacerbating crises which threaten civil order and stability.   Internal instability in turn reduces the capacity of a country to contribute to a stable region.

Where a government may be depending on a particular status quo to hold on to power, it will be unwilling to empower marginalised or disenfranchised groups, unlikely to encourage questions about allocation of resources, unwilling to provoke organised religion. One such country could be Burma, where the government is aware of the threat of the epidemic, but "for its own survival places considerable obstacles in the way of both domestic and international efforts to create meaningful [HIV/AIDS] programs." (Altman 2000) Effective responses to the AIDS crisis need the support and involvement of national governments.

Why is it important to see AIDS as a security issue? If AIDS is seen as a health-only issue, the health ministry – often already over-burdened or without much political thrust – is left to respond to the epidemic. But if AIDS is redefined as a security issue it assumes a far more important distinction on government agendas. Perhaps when governments come to realise national survival depends on halting the epidemic they will begin to provide the resources and political will required.

Difficulties in access to prevention and treatment

Despite the enormous publicity surrounding HIV/AIDS, it fundamentally remains a silent, invisible epidemic in most countries. While it is estimated that more than one in a hundred sexually active adults across the world are infected with HIV, only a small fraction of these people have the access to testing and counselling that would actually inform them they are infected. (UNAIDS 1998a) Nearly 95% of all new infections, mostly due to heterosexual intercourse, occur in developing countries, sub-Saharan Africa and South East Asia bearing much of the brunt. Paradoxically, the

silence and invisibility of the HIV epidemic tends to be greatest in countries where the infection is most prevalent.

Major obstacles in access to prevention and treatment stem from lack of resources – including issues surrounding the high cost of drugs – and from matters of fundamental human rights – including the impact of discrimination.

- Information provision: Despite the high levels of general knowledge about HIV/AIDS, millions of people are still vulnerable to HIV because they do not know the basic facts. Misinformation survives even in worst affected populations. In a study in South Africa, not even half the respondents knew an infected individual could live for many years without any outward sign of the virus. (UNAIDS 2000a)

- HIV testing and counselling services: in the developing world these are far from adequate, especially in rural areas. It may not be possible to get a test, or quality counselling is unavailable. There may be issues with lack of confidentiality. If testing is not supported by counselling, treatment and care, there is little incentive to be tested.

- Basic resources: no matter how good communication and information provision is, to prevent infection people have to have access to affordable condoms, needles and syringes, and AZT/novirapine to prevent mother-to child transmission.

- Health services infrastructure: AIDS increases the demand on the health sector. The ability to secure finance for health care is very limited in developing countries. Access to drugs is made difficult by cost, management of supply and inadequate health care provision. WHO estimates that access to essential drugs for health conditions of all kinds – including pain relief and respiratory distress, essential to alleviate suffering from HIV-related infections – is guaranteed for only 50% of the population in developing countries. (UNAIDS 2000a)

- Meeting the needs of people living with HIV/AIDS: the vast majority of people living with HIV/AIDS (PLWHA) in Asia and the Pacific have insufficient access to treatments. One of the major problems is, not surprisingly, the high and inflated price of drugs set by international pharmaceutical companies. (AFAO 1999) Local models of support for PLWHA need to be developed which respond to local economic, social and cultural factors.

Denial, fear and shame also discourage people from accessing prevention or care services. Where people with AIDS risk rejection or discrimination, individuals suspecting they have HIV may avoid testing, or not take precautionary measures with partners, for fear of revealing their infection. People will lose precious opportunities for further prevention, or warding off their own illness, if they are afraid to acknowledge or even find out if they are infected. Stigma and discrimination are very difficult to deal with at the individual level. They have to be managed at the societal level – anti-discrimination laws which must be enforced; community education to diminish stigma; and support for PLWHA and other self help groups.

In particular, marginalised population groups such as injecting drug users, commercial sex workers, or men who have sex with men may not access services where they do exist, because of a reluctance to risk exposure by participating.

Vaccine Development

Development of a vaccine will take time and even if an effective vaccine becomes available, it will not replace other preventive measures. It is likely that initial vaccines will not be 100% effective and [must] be delivered as part of a comprehensive prevention package (UNAIDS 2000a). Vaccine development is complicated by the number of virus subtypes circulating, and also by the variety of human populations which need protecting.

While the first Phase III (large scale human testing) trials are under way, the majority of these trials focus on strains of HIV circulating in industrialized rather than of those in developing countries. However, since 1998 there has been increased emphasis on vaccine designs applicable to HIV strains in the developing world and new AIDS vaccine designs should be entering Phase I and II clinical trials in the next 1-2 years. (Berkley, 2000)

The important challenge is not only to create a safe and effective vaccine but also to make it available to all those who need it in a timely fashion. HIV vaccine is needed most in developing countries where most of the new infections occur and where there is also least access to current therapeutic interventions. (Berkley, 2000) This will raise extremely important issues surrounding the cost of the vaccine as well as the immediate need to support the development of durable and effective vaccine delivery systems.

Ethical issues related to research in HIV/AIDS also raise concern. Who should be responsible for decisions about trial recipients, given that vaccine efficacy trials inevitably involve exposure to HIV by trial participants? UNAIDS released recommendations that have created considerable controversy, and leave many issues to be resolved. Countries are encouraged to create their own ethical review mechanisms (Berkley 2000).

In 1998 the World Bank set up a task force to look at ways to accelerate the development of vaccines. The task force recommended strategies to enable developing countries to become better partners in AIDS vaccine work, including support for capacity building and applied research; to expand coverage of existing vaccines; and improve delivery infrastructure. It also aims to create new knowledge about the economics of AIDS vaccines and to create new mechanisms for financing the purchase of AIDS vaccines. It recommended a one billion-dollar revolving IDA fund to support international public goods in the communicable disease with HIV vaccines to be priority. (Berkley 2000)

Microbicides

The introduction of microbicides into HIV prevention programs could affect the epidemic by offering a degree of protection to women who can make the decision to

use the microbicide themselves, if necessary without the knowledge or co-operation of a partner. Recent testing of microbicides in Africa and Thailand has given disappointing results, however there are a number of products under development. As with any HIV vaccine, microbicides may fill important gaps in HIV prevention, but they would still be part only of an overall prevention package.

Compared to the pharmaceutical investment in anti-HIV therapies there is still surprisingly little investment by private companies in the development of microbicides and vaccines.

5. Successful Responses

Effective national programs often require quite dramatic cultural shifts and challenging of long standing taboos. Open and honest government acknowledging the spread of HIV, and political foresight and leadership is required to deal with issues of sex, drugs and discrimination.

By examining the experiences to date in Northern Europe, Nth America, Australia, New Zealand, Uganda, Senegal and Thailand we can identify the key elements of a successful response. Uganda in particular shatters the myth that some countries are simply too poor to respond effectively. President Museveni has been constantly and openly discussing AIDS and its impact since he came to power in the mid 1980s. This in turn supported community-based projects, attracted, maintained and increased international donor support and has been rewarded by a quite dramatic turnaround in one of the most heavily affected and infected countries – so much so that Uganda has brought its estimated prevalence rate down to around 8% from a peak in the early 1990s of close to 14%. (UNAIDS 2000a)

As UNAIDS (UNAIDS 2000a) explains there are a number of characteristics of successful national responses

- Political will and leadership
- Societal openness and determination to fight against stigma
- A strategic response
- Multisectoral and multilevel action
- Community-based responses
- Social policy reform to reduce vulnerability
- Longer-term and sustained response
- Learning from experience
- Adequate resources

We will come back to a number of these as challenges for Australian aid assistance.

Let us now look at the major elements of a successful strategic response. They include:

Surveillance and research

Good science must underpin good public health. This includes:

- description of the scope and distribution of HIV and AIDS at each appropriate level of analysis (eg community, province/state, nation) in the problem
- fundamental public health research to understand the local determinants of HIV
- monitoring of the progress of interventions
- measuring the effectiveness of the interventions.

Communications

This consists of

- 'broadcast' awareness campaigns through a variety of mass media, focussed on accurate information
- destigmatising of HIV and AIDS
- 'narrowcast' approaches using highly targeted messages for groups at higher risk such as sex workers and injecting drug users, men who have sex with men
- communications through schools, community organisations, women's groups, workplaces, credit and farmer co-ops, and so on
- group and one to one peer education programs.

Service provision

This relies on the presence or development of primary level infrastructure, such as the primary health care system. Thus investment to improve the HIV/AIDS infrastructure must also improve and be seen to improve the overall primary health care infrastructure. Specific HIV/AIDS services include:

- voluntary counselling and testing for HIV
- quality control of blood transfusion systems
- STD diagnosis and treatment
- condom (male and female condoms) distribution through public, private and social marketing systems
- prevention of mother to child transmission

- treatment of opportunistic infections

- needle and syringe exchange, methadone, drug treatment programs

- community and home based care programs.

Legislation, regulation

This covers a number of areas from the 'macro' such as debt relief to the micro, such as taxes on commodities such as condoms.

It also includes such areas as:

- anti-discrimination legislation

- workforce legislation

- education policy, especially education of women

- health policy, access to medications

- micro credit policy

- illicit and licit drugs policy

Mobilisation

No countries have yet been successful in controlling AIDS without significant mobilisation of communities. In virtually all countries it has been community-based organisations that have led national responses.

Governments thus have to support and underpin the development of community based organisations, including those that support people living with HIV/AIDS. The Uganda, Senegal, Thailand and developed country (such as Australia's) successes have come about not only because of approaches that are 'top-down' governmental driven policy, but also because of 'bottom-up' community-based and private sector initiatives. These two approaches must work synergistically. Former President Ramos of the Philippines borrows a local metaphor to explain this. He talks about the way *bibingka*, a kind of rice cake is prepared. *Bibingka* is baked in a clay oven, with heat applied from the bottom and from the top. Skilled *bibingka* makers have to learn how to apply the heat evenly. In talking about HIV/AIDS he said so often programs fail because of the lack of 'even heat'. (AIDS Society for Asia and the Pacific, 1998)

6.   Future scenarios for development aid programs

AIDS is spreading inexorably, and globally we are losing the war and many of the battles. Even if a vaccine arrived tomorrow it would only be effective if introduced as one strategy among the key elements presented above. We currently have to work on the assumption that there will be ***never*** be a **magic bullet** for HIV/AIDS**.**

Each nation has its own particular political, social, economic and cultural features. As these vary so does the epidemiology of HIV/AIDS from country to country and also within countries. So the response appropriate to individual countries and individual communities must be determined locally. We have already had the opportunity to learn from experiences of HIV/AIDS around the world. The greatest lesson is that of openness.

> *We currently have to work on the assumption that there will be NEVER be a magic bullet for HIV/AIDS.*

The major reason for the frustrating lack of progress is the lack of willingness of national political and governmental systems to openly acknowledge the scope of the problem or to respond to it with honesty, imagination and resources. Everywhere, there are countless people working effectively in community groups, hospitals and clinics, research institutions, religious organisations and government departments. Yet, in many countries, there is little support from the political leadership.

So the role of the international community and donor aid has to be in areas of 'peer group' education and support with and among politicians and senior government officials. Effective national policies on AIDS require a large dose of political courage, political risk-taking and foresight. And it is difficult for these to be developed and nurtured in isolation.

Just as we have used peer education in changing attitudes and behaviours of those at risk, we must use similar mechanisms in the political sphere – of politicians talking and working with other politicians.

In this way international aid must also continue with support for mobilisation of communities, again something not supported by many governments, particularly those with a short or non-existent history of democracy. This is best achieved by both peer education with and among politicians from the region, as well as enhancing exchange among community-based workers, policy makers and government officials and researchers.

The international community can also contribute by developing better and better evidence for policy change. Often this evidence has to be reproduced in each country – local evidence is needed to reinforce the messages local decision-makers are hearing from their peers in other countries.

What is Australia's comparative advantage in HIV/AIDS aid?

Considerable experience has been gained in Australia in a number of key areas in HIV/AIDS control over the last 15 years. This applies both to HIV/AIDS control in Australia and to assistance provided in the region and elsewhere, particularly Africa.

These key areas include HIV/STD surveillance, social science research, organisation of community responses, and development and maintenance of PLWHA groups, HIV

counselling and testing, STD treatment, broadcast and narrowcast communications and harm reduction.

It also includes, as mentioned above, multipartisan political leadership, the development and implementation of four successive national strategies, and the ongoing maintenance of workable partnerships across a diverse range of stakeholders.

6. Critical challenges for Australian HIV/AIDS aid programs in our region

> *Despite what we have heard about HIV/AIDS in the last 15 years, HIV still remains a silent, invisible epidemic. And, paradoxically, the silence and invisibility are greatest in countries where HIV is most prevalent. We are winning some of the battles against HIV in developed countries and a few developing countries, but globally we continue to lose the war.*

1. *Ensure HIV/AIDS assistance supports and is supported by the moral, humanitarian, economic and national security concerns of Australia's foreign policy.*

Evidence from Africa, Eastern Europe and some parts of Asia shows that HIV/AIDS is a threat to economic development and national stability let alone being the harbinger of enormous personal and societal suffering, hardship and death.

Australia has a great opportunity to align its work in HIV/AIDS with foreign policy considerations for more than health or humanitarian reasons, as more and more evidence emerges about the effects of HIV/AIDS on manufacturing, agriculture, education, defence and national security. As in Africa HIV/AIDS has the potential to undermine the very aid programs in Asia and the Pacific that Australia supports. But to be able to lead, to contribute effectively it will need the organisational capacity both within and without government to do so.

Given that Australia also has a major role to play in the 'big picture' issues such as debt relief, and bargaining with large pharmaceutical companies to lower prices and increase access to treatments, it needs to take every opportunity for aid diplomacy at bilateral, regional and global levels. It will also need to develop a coherent policy response among the different branches of government, including trade, labour, and defence in addition to health, development assistance and foreign affairs.

The Government's aid program should ensure that each of the five priority sectors for development assistance takes into account the implications of HIV/AIDS.

HIV/AIDS has become such an important problem globally that we should ensure that all Australian international volunteers and diplomatic staff are well trained as AIDS educators.

2. Develop long term, well-resourced (financially and intellectually), trusting relationships with a select number of partner countries.

Effective national programs do not develop overnight. Australia's investments need to be thought through beyond the election cycle, and thus need multipartisan support to ensure consistency. It should focus on developing long-term relationships, and encourage twinning of agencies, organisations and institutions, for example, government to government exchange, NGO to NGO, researcher to researcher, political exchange. This can be between Australian and Asian/Pacific institutions as well as among Asian/Pacific countries.

3. Develop a comprehensive range of aid pathways

Effective aid has to use a mix of aid pathways, such as direct bilateral aid, multilateral aid, NGO to NGO aid, CBO to CBO aid, and now corporate aid (as businesses increasingly see the economic effects of HIV/AIDS). All of these avenues have their own advantages and have to complement each other.

Obviously where 'recipient' governments are responsive and facilitatory then bilateral aid is effective, but where they are in fact blocking responses, NGO to NGO aid or CBO to CBO aid is required to ensure that aid is actually reaching the group or groups that most need it.

4. Focus on supporting high level political and bureaucratic mobilisation, so important in effective national responses.

To increase the effectiveness of Australian aid consideration must be given to work with the political and bureaucratic institutions and agencies to maximize the potential for the implementation of what is already known.

It is no coincidence that UNAIDS lists 'political will and leadership' as THE number one determinant of a successful national response. Uganda and its neighbour Kenya represent a good example of countries with similar levels of socio-economic advantage/disadvantage yet the response in Uganda, led by President Museveni has far outstripped that of his Kenyan colleague President Arap Moi.

The strategic elements presented above can only be effectively delivered in an environment where national political and bureaucratic leaders support their implementation.

Australia can also help ensure that the international donor response is well co-ordinated, demonstrates results, and supports wider health priorities of recipient countries at meetings of international donors (eg the Programme Coordinating Board of UNAIDS, and the management boards of the World Bank, UNICEF, UNDP, UNDCP, UNESCO, WHO and UNFPA). Australia should also ensure major level input into the UN General Assembly Special Session on HIV/AIDS in June 2001.

5. *Ensure there is well trained, cross culturally effective staff to support Australian aid projects*

Australia will have to continue to encourage and invest in the development of 'extra' capacity to support aid assistance in HIV/AIDS. Australian agencies involved in their state and community-based work of HIV/AIDS also have to be supported and encouraged to take regional and international HIV/AIDS work as part of their responsibilities.

6. *Ensure that Australian aid assistance in HIV/AIDS is well integrated into the broader social, economic and health care needs of countries.*

> ***Other more pressing needs might seem to logically take precedence over a problem that will only appear some time in the future: 'If your housing is poor, with inadequate water supply and no electricity, and your clothes are old, having a supply of condoms would seem a strange sophistication' (UNDP 1996).***

Programs that address the specific issues of HIV/AIDS can be improved by ensuring they are integrated into broader needs. For example, improvements in systems for condom distribution can be copied or used for increasing distribution of other public goods eg oral rehydration therapy, mosquito nets. Similarly, programs that protect the human rights of people with HIV/AIDS can be used to protect the human rights of other marginalised groups. On the other hand investments in basic infrastructure eg primary health care services to pregnant women are vital if mother to child transmission is to be reduced.

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