POLICY BRIEF

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HIV/AIDS: The Looming Asia Pacific Pandemic

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WHAT IS THE PROBLEM?

The international effort to control the spread of the HIV pandemic is failing: new HIV caseloads are rising alarmingly in many parts of the Asia Pacific. For over 20 years we have known how to prevent the transmission of the HIV virus by persuading young people to make simple and sustainable changes in sexual practices and other risky behaviours. Yet despite the scientific evidence, many national governments are unable or unwilling to act in time to avert the problem.

The resolve of national governments to act to prevent the spread of HIV has been prejudiced by the failure of the most influential donors and successive international agencies charged with the management of the HIV pandemic to agree on a single set of pragmatic and achievable prevention principles and policies and to fund them adequately.

The absolute size of the global HIV caseload threatens severe financial consequences and may also encourage the emergence of new, more virulent strains of tuberculosis.

WHAT SHOULD BE DONE?

Strategies that have failed to cap and reduce the growth in the global and regional HIV caseload should be abandoned.

Australia should use its prominence on HIV matters to persuade the international community of the crisis that is emerging in the Asia Pacific and to refocus energy, political will and, above all, funding on a massively upgraded HIV prevention strategy.

Australia should join with like-minded countries to reform international HIV/AIDS strategies and redirect funding priorities to support practical prevention and harm-reduction policies, especially in low-HIV prevalence countries.

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HIV/AIDS: The Looming Asia Pacific Pandemic

Overview: The HIV pandemic in 2007

> *'From a spiritual perspective, there are two ways of looking at the flood. One is the bad karma of both national and local leaders. The other is that it is now [the] rainy season.'*
>
> Permadi, a member of the Indonesian Parliament known for his mysticism, commenting on the aftermath of the disastrous 2007 Jakarta floods, quoted in *The New York Times* 11 February 2007.

The global HIV pandemic has not been brought under control. Strategies to contain the HIV virus have so far failed to curb its spread into new countries and regions of the globe, notably the Asia Pacific. Without major changes in strategy and significant increases in funding for behavioural prevention programs, the HIV outlook for 2007 and beyond is very grim. There is little prospect that an HIV vaccine, much less a cure for AIDS, will be developed or become broadly available within the foreseeable future.

Antiretroviral therapies for HIV infection (ART) have generated greatly improved outcomes for HIV-positive people by delaying the onset of AIDS and suppressing many debilitating consequences of earlier HIV treatments. While of undeniable benefit to individuals, the advent of ART has created a large, increasing pool of HIV positive people requiring indefinite access to costly treatments that are complex to deliver. The size of this caseload will have increasingly severe economic and systemic consequences. There is little prospect that sufficient funds can be found to ensure universal treatment access for the present global HIV caseload, let alone one that is likely to double within the next decade or so. There are also clear indications that in the wake of the HIV pandemic new strains of virulent tuberculosis are emerging. Tuberculosis is more contagious than HIV. It poses severe health risks to HIV-positive people, as well as to otherwise healthy individuals.

In short, the HIV pandemic has not responded to the strategies so far employed to contain it, and is poised to enter a new period of rapid and dynamic growth in the Asia Pacific region, with highly unpredictable consequences. There is a real, but rapidly shrinking, window of opportunity to avert the worst-case outcome in the Asia Pacific region.

The HIV pandemic in statistics[1]

The Human Immuno-Deficiency Virus (HIV) pandemic is dated from the first case of Acquired Immune Deficiency Syndrome (AIDS) infection reported in New York City in 1981. Since then, over 65 million people have been infected with HIV and 25 million people have died from AIDS caused by HIV infection. As at December 2006, an estimated 40 million people globally are living with HIV/AIDS infection. In 2006, 4.3 million people were newly infected with HIV and 3 million people died from AIDS. In 2006, half of all new HIV infections occurred in people under the age of 25.

The preponderant HIV caseload remains in sub-Saharan Africa but the disease is expanding rapidly into Russia, east and central Asia and eastern Europe. Between 2004 and 2006, in eastern Europe and central Asia there was a

70% rise in new HIV infections. In 2006, India had an estimated 5 million people living with HIV/AIDS and China an estimated HIV caseload of about 600,000, which is probably still incompletely reported. However, in 2006, the overall prevalence of HIV infection in east and south-east Asia remains at less that 0.1%, indicating there is still a window of opportunity for effective preventive action to be taken in the region as a whole.

The impact of the HIV pandemic in the Asia Pacific region varies widely between and within countries. Of particular concern to Australia is the rapid spread of HIV infection in Papua New Guinea.[2] Some 1.8% of the adult population of Papua New Guinea is infected with HIV and prevalence in urban areas may be as high as 3.5% which is comparable to the situation in sub-Saharan Africa. Rates of new HIV diagnoses in Papua New Guinea have increased at about 30% per year since 1997. The very high level of HIV infection in Papua New Guinea raises concerns about the potential for the rapid onset of HIV infection of neighbouring Melanesian societies, including West Papua, East Timor, Solomon Islands and other Pacific Island states. Recent anecdotal and other reports suggest that HIV prevalence rates in some parts of West Papua and Irian Jaya may be approaching those in Papua New Guinea.

In recent years, some regional countries, including China, Malaysia, Vietnam and Taiwan have begun to adopt realistic harm reduction measures especially in relation to the provision of clean injecting equipment for users of narcotic drugs. In 2006, confronted by rapidly rising new HIV infections among injecting drug users, Taiwan reversed policy by introducing a needle and syringe exchange program at 427 sites nationally. This decision resulted in a sharp decrease in the rising rate of new HIV infections reported to the Taiwan Centers for Disease Control. Such programs, however, encounter strong local resistance from police and security agencies. The public policy challenge is to translate in principle support for harm reduction measures into effective local action in time to forestall HIV transmission into the general community. Nevertheless, these are encouraging developments.

The drivers of the global HIV pandemic

The global HIV pandemic need not have happened. It was largely avoidable. The major driver of the spread of HIV was the failure of political will to translate scientific evidence into good policy in time to cap and control the spread of the virus. There is nothing inherent in the qualities of the HIV virus that made the global pandemic inevitable. The HIV virus is not nearly as contagious as, for example, the influenza virus. It cannot be spread by casual contact or in aerosol form. It is this quality of the HIV virus that means that individuals can protect themselves from HIV infection by simple measures – notably using condoms in penetrative sex and using sterile needles and syringes rather than risk sharing needles with other people whose HIV status is unknown.[3]

In the mid-1980s, countries (including Australia) that moved swiftly to implement national policies based around behavioural prevention strategies contained the spread of HIV. Generally, countries adopting pragmatic HIV containment policies tended to secure substantially better HIV outcomes than those

countries that promoted HIV/AIDS responses based on sexual abstinence, criminalisation of prostitution and zero tolerance for injecting drug use. This was certainly so in the case of Australia and the United States which from the early 1980s followed highly dissimilar HIV/AIDS containment policies. After 25 years, the per capita prevalence of HIV infections in the United States is well over ten times the prevailing rate in Australia.[4]

There is no evidence to suggest that harm-reduction measures increased overall rates of sexual activity or consumption of illicit drugs.[5] In fact, to the extent that honest information is made available about the consequences of such activities, there is every indication that people become more discriminating about such things.

The politicisation of AIDS and the failure of policy

Despite the scientific evidence, and some notable local successes, many jurisdictions have been unwilling or unable to introduce pragmatic harm-reduction measures to contain new HIV infections. Many governments are reluctant to offend deeply held social, cultural and religious beliefs surrounding sexual behaviour, drug consumption and sex work, especially among the young. In the 1980s, the most trenchant, organised and concerted resistance to sensible containment policies developed among political and religious leaders in the United States of America, supported by the Vatican and Saudi Arabia. In these quarters, the emergence of HIV was invested with religious and social meaning. Some highly influential political and religious leaders declared that HIV/AIDS was a sure sign of divine retribution for sin.[6] Such views are, of course, incompatible with the orthodox scientific explanation of HIV as a product of viral evolution. However, within a very short time after the emergence of HIV/AIDS, the theological explanation of AIDS began to inform political decision-making on HIV/AIDS within the United States of America. The theological view of HIV/AIDS prevailed in the United States Congress and in successive American administrations. In contrast, HIV containment strategies and policies as applied in most western European states, Canada, Australia and New Zealand, and adopted by United Nations agencies, were based on the application of accepted scientific methodologies and principles.

The emergence of this fundamental split over the nature and causes of HIV/AIDS prevented a global agreement on a single, coherent and effective strategy for containing the spread of the HIV pandemic. It created strategic paralysis in the international response to HIV/AIDS just at the time when swift action would almost certainly have contained the problem. This failure was especially perilous in the context of a globalising world, with rapidly expanding mass travel and the abandonment of general health checks and testing for travellers.

Only after the introduction of effective antiretroviral therapies from 1996 onwards could the United Nations system and the United States agree to focus on the relatively non-politically contentious area of HIV care and treatment. In 1996, continuing dissatisfaction with the World health Organization's mismanagement of the HIV pandemic resulted in the formation of a new specialised United Nations agency, UNAIDS, to

coordinate all aspects of the global response to HIV/AIDS. The challenges of financing and distributing new antiretroviral therapies gave a functional purpose to UNAIDS. UNAIDS has performed well, especially around care and treatment, but has been far less effective in relation to prevention strategies and outcomes.

The Bush Administration's establishment of the $US15 billion over five years (2003-08) President's Emergency Program For Aids Relief (PEPFAR)[7] did not resolve the deeper disagreement over HIV/AIDS containment strategies. In 2007, the Bush Administration remains adamantly opposed to the promotion and wide availability of condoms to prevent the spread of HIV/AIDS.[8] It refuses to support needle and syringe programs for fear of being seen to condone the use of illicit drugs. It counsels sexual abstinence, or failing that, monogamous marriage and fidelity as the only acceptable behavioural response to the disease. Only 20% of total PEPFAR funding is allocated to HIV prevention, with at least 33% of that to be spent on abstinence-based programs. The policies of the American administration have international consequences. The Bush Administration ties bilateral funding under the PEPFAR program to recipients' support for its policies on abstinence and the 'war on drugs'. With its supporters and allies, the Bush administration has opposed and undercut the adoption of harm reduction policies and promotion through UNAIDS and other international forums. Significant American political leaders continue to oppose HIV/AIDS policies and institutions that do not conform to their proscriptions.[9]

Behavioural prevention: the simplest, cheapest and most effective way to control HIV transmission

After two decades, it is incontrovertible that behavioural prevention remains the simplest, cheapest and most effective means of averting the spread of the HIV pandemic. Almost without exception, wherever sensible and pragmatic behavioural change policies have been funded and applied across the general population, they have worked to contain, and then to reduce, new HIV infections. On the other hand, HIV containment policies based on promotion of sexual abstinence, repressive drug control measures and limited or no access to condoms, honest information about sexuality or clean needles and syringes have demonstrably failed in their objective of reducing new HIV infection.

It is, of course, hardly surprising that national HIV control policies that for their success require young people to undertake dramatic and sustained changes in their behaviour (sexual abstinence, fidelity and monogamy and repudiation of illicit drug taking) have been far less successful than policies advocating relatively minor adjustments (use of condoms and clean injecting equipment).

In 2007, the structures are right but the strategies confused and the results unsatisfactory

Even though its record on HIV/AIDS has been less than stellar, there is no practical alternative to the United Nations system being responsible for overall strategic direction of the response to HIV/AIDS.

In 2001, the escalating growth of the pandemic and lack of faith in the United Nations system to administer a bewildering array of new HIV-related funds and programs led to a further upheaval in the global governance of the pandemic. The G7 countries acted on the 2001 United Nations Declaration of Commitment on HIV/AIDS by creating the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Global Fund is a so-called public private partnership (PPP) whose objective is to raise and disburse funds to combat the three diseases, and to monitor and evaluate the performance of Fund-supported national programs. The Fund seeks to operate with very low overheads and somewhat in the character of a bank, with no responsibility for actual program delivery. Its informal mandate is to impose private sector discipline on the disbursement and administration of the greatly increased level of funding directed by donors to the problem.

UNAIDS is therefore tasked to provide strategic direction and political leadership, while the Fund is a cost-effective administrator of funds. Increased donor confidence in UNAIDS and the GFATM has led to greatly increased funding flows and improved transparency and accountability in how these funds are spent. The quality of the experts and administrators employed in and around UNAIDS/GFATM is high, and they are sharply focused on the problems at hand. But no matter how effective these organisations might be, they are constrained by the total funds provided to them, which in turn reflects the level of political support for their aims and objectives. After ten years of UNAIDS and five years of the Global Fund, the performance and adequacy of the international response to HIV/AIDS must be judged against outcomes. These are decidedly mixed.

Since UNAIDS was launched in 1996, available annual funding for the response to HIV/AIDS in low- and middle-income countries increased 28-fold, from $US300 million to $US8.3 billion. However, the rate of increase in new funding is declining while the rate of increase in new HIV infections is rising. UNAIDS estimates that pledges and commitments to fight HIV/AIDS in low- and middle-income countries totalled $US8.9 billion in 2006 and $US10 billion in 2007. These amounts will be far short of meeting the estimated requirements of $US14.9 billion in 2006, $US18.1 billion in 2007 and $US22.1 billion in 2008 or $US55.1 billion for the period 2006-2008.[10] By the end of 2007, the GFATM expects to have received cumulative commitments of $US10 billion and to have distributed some $US6 billion in 6 funding rounds since 2002. Over half of the GFATM's disbursements are applied to HIV/AIDS programs.[11]

Since the inception of UNAIDS and the Global Fund, progress has been made in expanding provision of care and treatment to the rapidly expanding global HIV caseload. By the end of 2005, some 1.3 million people in low- and middle-income countries were receiving ART therapies. The Clinton Foundation has also played a valuable role in bringing down the prices of ART therapies and thus bringing more people under treatment and care. But there is little prospect of sufficient funding becoming available to meet UNAIDS target of providing ART coverage for 80% of urgent cases (that is 9.8 million people) by 2010.[12] The overall shortfall in global funding for HIV/AIDS means that the need to provide HIV/AIDS care and

treatment has diminished the flow of resources into HIV prevention. There is far greater political support for care and treatment than there is for prevention, at least of the type most likely to produce the best results.

So notwithstanding deep restructuring, new players and increased funding, the inconvenient truth remains that the rate of new HIV infections has continued to rise at accelerating, and in some countries of east Asia and the Pacific, explosive, rates. It is outstripping the rate at which the new and improved HIV/AIDS governance structures can apply additional, but inadequate, funds to the problem. Most worryingly, strategic direction is not being reviewed and changed quickly enough to respond to the new threats emerging as a result of the speed at which the HIV/AIDS pandemic is expanding.

The need for a reformed international strategy to control HIV/AIDS

The provision of universal access to HIV/AIDS care and treatment remains one of the major, sensible and relevant goals of the United Nations HIV/AIDS grand strategy.[13] The realisation of this goal is life-saving and transforming for people with HIV/AIDS. Under PEPFAR and United Nations and other programs, the pharmaceutical industry is being subsidised to produce ever-increasing quantities of new and improved ART treatments. The short-term benefits are obvious.

But in the rush to do the right thing, little thought has been given to the fundamental question 'Who pays?'

Size matters

It is increasingly clear that the world cannot afford, or will not meet, the real costs of treating even the present HIV/AIDS caseload. This caseload exists because of the failure to prevent the spread of HIV/AIDS infection through harm reduction and behavioural prevention measures. The sheer size of this caseload is transforming the threat posed by the HIV/AIDS pandemic. The present and projected global caseload threatens to impose immense new financial costs on national economies and the international system. The costs of providing ART therapies to even a significant proportion of a global caseload that may number 80 million people within a decade are staggering. The costs of providing genuine universal access to necessary HIV treatments for the entire global HIV caseload do not seem to have been fully assessed even in the most recent UNAIDS and other actuarial calculations.

Assuming, conservatively, that each course of ART therapy requires an investment of $US1,000 per person per year, the cost of providing ART to a caseload of 40 million is $US40 billion per year.[14] These costs take no account of the expanded human and capital infrastructure required to deliver such treatments, or the opportunity costs involved in treating HIV/AIDS cases at the expense of other priorities. Notwithstanding the good intentions of the United Nations, the political reality is that these direct costs of ART treatment are beyond the capacities of governments and donors to fund without diverting resources from other critical development areas and/or recourse to increased levels of taxation and coercive measures.

The escalating costs of providing HIV treatment access to its 600,000 HIV-positive citizens was a crucial factor in the Thai government's decision in January 2007 to break the patent on the HIV/AIDS drug Kaletra to produce a generic alternative. In announcing the decision, Thai Public Health Minister Mongkol said that as Thailand had a budget of $US112 million for the treatment of HIV/AIDS patients, it could only afford to provide medicine for 108,000 patients at the price charged for Kaletra by its manufacturer Abbott Pharmaceuticals.[15] Under similar pressure from rising HIV caseloads, many other governments will be tempted to follow the Thai example.[16]

A large and growing caseload also increases the threat that the HIV virus will both increase its resistance to drug therapies and facilitate the spread of new strains of dangerous pathogens, especially highly drug resistant tuberculosis. These new strains of tuberculosis are dangerous to people with HIV/AIDS and risky to otherwise healthy individuals. Already, outbreaks of extremely drug resistant (XDR) tuberculosis have been reported in South Africa, South Korea and the United States of America.[17] In Cambodia, which has brought its rate of new HIV infections under some control, some 53% of people living with HIV/AIDS also have tuberculosis of one form or another. It is a sad fact that there seems to be an inverse correlation emerging between success in prolonging the lives of HIV/AIDS-infected people, and the emergence of new, virulent forms of tuberculosis.

The paradoxical spiral

We are caught in a paradoxical spiral: the size of the global HIV/AIDS caseload demands that available resources be applied to care and treatment at the expense of prevention. But the less emphasis there is on prevention, the faster the global caseload will expand. In a perverse way, the commitment to universal access to ART therapies and treatment has therefore made matters worse, rather than better.

This spiral can only be broken if new and adequate resources are devoted to prevention rather than to the care and treatment of those with HIV/AIDS. If adequate resources cannot be applied to both effective behavioural prevention and to the achievement of the universal access to treatment objective, then logic and morality dictates that the commitment to universal treatment access should be subordinated to the imperative need to cap the caseload through behavioural change.

The two HIV/AIDS pandemics: the actual and the potential

There is not one HIV/AIDS pandemic but two. Current international HIV/AIDS strategies fail because, in practice, they recognise and respond only to the historical pandemic and not to the looming one.

The actual HIV/AIDS pandemic is the one that emerged in the last 25 years, predominantly in sub-Saharan Africa. This pandemic is an 'after the event' pandemic, largely concerned with the care and treatment of those infected with the disease. It is more about AIDS than HIV. Its

needs have led to the development of effective but expensive treatments and political consensus around devoting the resources necessary to deal with a large, but inherently manageable, caseload. As devastating as its impact has been on the 65 million people so far infected with HIV/AIDS, for the past quarter-century the impact of HIV/AIDS has fallen mostly on individuals in small and impoverished countries without the resources and structural depth to contain the pandemic. Until now, this has meant that the pandemic has not had global, systemic effects. The response to the pandemic has been characterised by humanitarian concern and charitable intentions. The toll of dead, dying and infected from HIV/AIDS has been great, but clearly insufficiently large to precipitate effective prophylactic action.

The second HIV/AIDS pandemic is the one that looms in the Asia Pacific region. This pandemic is potential rather than actual. It is, in 2007, more about HIV than AIDS. It is being driven by a massively large pool of present infections that is spawning new and virulent co-infections. Because those who are infected will not die from AIDS provided treatments are made available, the pandemic may have great financial implications that will strain the budgets of even the most prosperous and largest regional economies. The looming pandemic will appear first in the most vulnerable social groups and countries. In the Asia Pacific region, these first affected societies are scattered throughout the region. They are connected to adjacent societies by links of trade and tourism and by large legal and illegal migration and refugee flows. It is only a matter of chance and time before HIV spreads across the region from the areas that were first affected by it.

But to prevent the potential pandemic becoming an actual one, Asia Pacific policy-makers must face some uncomfortable truths. Behavioural prevention remains the best, cheapest and most viable strategy for averting the spread of HIV/AIDS in the Asia Pacific region. There must be much greater emphasis and funding given to primary prevention.

The HIV/AIDS strategy promoted by the United Nations and accepted as orthodoxy by the international community is an unwieldy and unsatisfactory compromise. It is not generating sufficient political support and funding to both treat the present and projected HIV caseload, and to implement effective behavioural change programs. It is time for a more sophisticated, flexible and appropriate set of strategies to meet the challenges of containing HIV/AIDS in the Asia Pacific region.

Despite immense efforts, medical science is not on the verge of developing, in any time frame that maters, an effective HIV vaccine, cure for AIDS or useful biomedical prevention measures such as vaginal microbicides. (However, the armoury of primary prevention measures to contain HIV/AIDS may be augmented by recent findings that male circumcision may greatly improve resistance to HIV infection.[18]) Even in the welcome event that new therapies emerge, the burdens of cost, complexity and controversy will be immense.

Policy-making should not be based on false hope, faith or charity. Science provides the only basis for sound HIV/AIDS policy-making.

What should be done?

Australia has an outstanding record of achievement in bringing its own HIV/AIDS epidemic under control.[19] Under successive national governments, Australia has sustained practical and innovative policies that have kept new HIV infections and AIDS cases and deaths at a fraction of the level of comparable countries, notably the United States of America.[20] Australia possesses a deep well of expertise and experience across the management of all aspects of the pandemic. In recent years, the Australian government has greatly increased both multilateral and bilateral funding for HIV/AIDS, including prevention, care, treatment and research.[21]

Australia is a generous donor to, and supporter of, the key international institutions that collectively manage the global response to HIV/AIDS – the World Health Organization, UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Clinton Foundation, and the Bill and Melinda Gates Foundation, as well as many other philanthropic organisations fighting HIV/AIDS at national and local levels.

Australia has a clear national interest in limiting to the maximum extent possible the prospective impact of HIV/AIDS in the Asia Pacific region, and especially in its immediate neighbourhood.

In 2007, Australia will host two important international meetings at which the current state of the HIV pandemic in the region may be examined. These are the International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention in July and the APEC leaders' meeting in September, which will be preceded by an APEC Health Ministers' meeting in June 2007 that will consider the present state of the regional HIV pandemic.[22]

At and around these conferences, and in the relevant international forums, Australia should press for the effective implementation of policies with the medium-term goal of capping the rise of new HIV infections globally and regionally.

Australia should frankly acknowledge the deficiencies in present international strategies for HIV prevention that have contributed to the present unstable and unacceptable level of new HIV infections.

Australia should use its prominence in HIV matters to persuade the international community of the crisis that is emerging in the Asia Pacific and to refocus energy, political will and, above all, funding on a massively upgraded regional HIV prevention strategy.

And beyond containment, it is time for the international community to endorse the overarching goal of eliminating HIV/AIDS by a certain date, but no later than by the end of the 21st century. Australia should consider how to have this goal adopted by the international community.

Together with like-minded countries, Australia should encourage relevant international agencies, regional governments and institutions to focus on defining clear strategic goals for the reduction of new HIV infections, implementation of practical, effective and sustainable national HIV prevention policies. It should do so because an Asia Pacific HIV

epidemic at or near sub-Saharan African levels would create great human suffering and misery, impose severe strains on the economies and health systems of sometimes fragile states, encourage internal and cross-border population movement in search of access to treatment and care, and generally divert scarce resources away from other pressing areas such as education, transport and basic service delivery. Should the HIV pandemic continue unchecked, Australia will almost certainly bear a disproportionately large part of the burden of providing HIV treatments to the region, particularly the south Pacific.

Australia should press for reforms in the international strategy that provide for a clear separation between the goals, principles and policies that must underpin HIV prevention. Goals and principles should be consistent and fixed, while policies change in light of developments and experience.

The **first goal** of Australian HIV policy should be to **cap and contain**, and then to **reduce** the total number of new HIV infections in the Asia Pacific region and globally. The **second goal** should be the **eradication of HIV/AIDS** by the end of the 21st century.

The achievement of these goals should be informed by the following basic principles:

- the primacy of empirical research and evidence in making policy;
- the need to minimise risk to the general population;
- recognition of the importance of research especially epidemiology, clinical treatment, retrovirology and social science;
- respect for human rights buttressed as required by legislation;
- collaboration and partnership between all stakeholders;
- long-term over short-term thinking.

And the policies based on these principles should include:

- timely, peer-based, direct and explicit preventive education campaigns directed both at high-risk groups and the general public;
- widespread introduction of subsidised needle and syringe programs and rapid expansion of methadone maintenance treatment;
- access to free, anonymous and universal HIV testing;
- subsidised access to anti-retroviral treatments;
- general advocacy of the need to adopt safer sexual practices, especially the use of condoms;
- widespread availability of condoms and targeted safe sex messages;
- creation of an enabling political environment encouraging socially marginalised groups (injecting drug users, homosexual men, sex workers) at risk of HIV infection to be involved in the national response;
- removal of political and legislative barriers to enable effective preventive education and action – for example, the passage of legislation to prevent discrimination on the grounds of sexual orientation and HIV-status;
- the building of strong national scientific and social research capacity and institutions.

There must be a renewed commitment to preventing the spread of HIV infection through behavioural changes that are practical and acceptable to local social and cultural norms and practices.

The present United Nations strategy conflates HIV prevention with a utopian social agenda that is not greatly relevant but that distracts and discourages many countries from formulating practical HIV containment policies. Absolute respect for the human rights of those with HIV and at greatest risk of HIV infection produces greatly better HIV containment outcomes. But it is not clear that containing the HIV/AIDS pandemic requires states to undergo dramatic social and cultural upheaval as the precondition of bringing the threat under control. Those elements of both United States and United Nations HIV prevention strategies that entangle HIV prevention with broader social and cultural changes should be set aside wherever these goals complicate the development and speedy implementation of practical and locally workable HIV prevention strategies.

The present United Nations HIV prevention strategy dictates a uniform model for the combined delivery of all national HIV prevention, care and treatment services. This is expensive and administratively complex, especially in small jurisdictions. The uniform structural model also tilts the bureaucratic contest for scarce resources too far towards meeting the urgent needs of care and treatment and away from the more important requirements of prevention. There is no overriding need to pursue a single structural model for its own sake. Jurisdictions should manage their affairs to secure the best outcomes, and in the way that best suits their circumstances.

HIV prevention should be reorganised around the same set of market-based principles and procedures that govern the delivery of HIV care, treatment and research – namely clear targets, accountability for agreed evidence-based outcomes, generous incentives and the promise of a satisfactory return on investment.

The HIV pandemic is at a tipping point. Present outcomes are a result of present strategies that have produced deplorable outcomes. The consequences of not acting now to prevent a regional HIV pandemic will be severe, unpredictable and greatly exceed the costs of so doing. But an Asia Pacific HIV pandemic is not inevitable. It is almost certainly avoidable if proven policies and tried technologies can be applied in time to prevent and contain the spread of the virus.

NOTES

[1] *UNAIDS/WHO AIDS epidemic update*, December 2006.

[2] *Impacts of HIV/AIDS 2005-2025 in Papua New Guinea, Indonesia and East Timor*, AusAID Report, February 2006.

[3] *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users*. Evidence for Action Technical Series, World Health Organization, Geneva, 2004.

[4] 2006 Annual Report, National Centre in HIV/AIDS Epidemiology and Clinical Research.

[5] Alex Wodak and Annie Cooney. Do needle syringe programs reduce HIV infection among injecting drug users: a comprehensive review of the international evidence. *Substance Use & Misuse 41* 2006, pp 777-813.

[6] 'AIDS is the wrath of a just God against homosexuals. To oppose it would be like an Israelite jumping in the Red Sea to save one of Pharaoh's charioteers . . . AIDS is not just God's punishment for homosexuals; it is God's punishment for the society that tolerates homosexuals.' Rev. Jerry Falwell circa 1991.

[7] www.pepfar.gov

[8] United States Government Accountability Office. *Spending requirement presents challenges for allocating prevention funding under PEPFAR*, Report GAO-06-396 April 2006: www.gao.gov

[9] Rev. James Dobson and others. Focus on the Family letter to US Congress opposing allocation to Global Fund 23 May 2006: www.focusaction.org/pdfs/Global_Fund_Coalition_Letter.pdf

[10] Chapter 10, *UNAIDS 2006 Report on the Global AIDS Epidemic*.

[11] www.theglobalfund.org

[12] *UNAIDS 2006 Report on the Global AIDS Epidemic*.

[13] World Health Organization and Joint United Nations Program on HIV/AIDS (UNAIDS). *Treating 3 million by 2005: making it happen: the WHO strategy*. Geneva, 2003.

[14] This calculation ignores a host of proper actuarial assumptions. Not all cases of HIV/AIDS require or respond to currently available therapies. New therapies may be cheaper (or more expensive). The caseload over the coming decade may be smaller (or larger) than predicted. But UNAIDS budgets and projections do not encompass the entire global pandemic as UNAIDS is properly concerned with low- and middle-income countries. A rising HIV caseload in richer countries will impose large costs on individuals and national health budgets. These are real costs that must be paid for somehow.

[15] Associated Press report 29 January 2007.

[16] Thais warn of switch to generic medicines. *Financial Times* 18 February 2007.

[17] TB's extreme new face. *Sydney Morning Herald* 21 September 2006.

[18] Male circumcision to cut HIV risk in general population. *The Lancet* 24 February 2007.

[19] Bill Bowtell. *Australia's response to HIV/AIDS 1982-2005*. Lowy Institute for International Policy, 2005.

[20] National Centre in HIV/AIDS Epidemiology and Clinical Research: www.web.med.unsw.edu.au/nchecr

[21] *Australia's global HIV/AIDS initiative*. AusAID, 2006: www.ausaid.gov.au

[22] www.ias2007.org

POLICY BRIEF

HIV/AIDS: The Looming Asia Pacific Pandemic

ANNEXURE

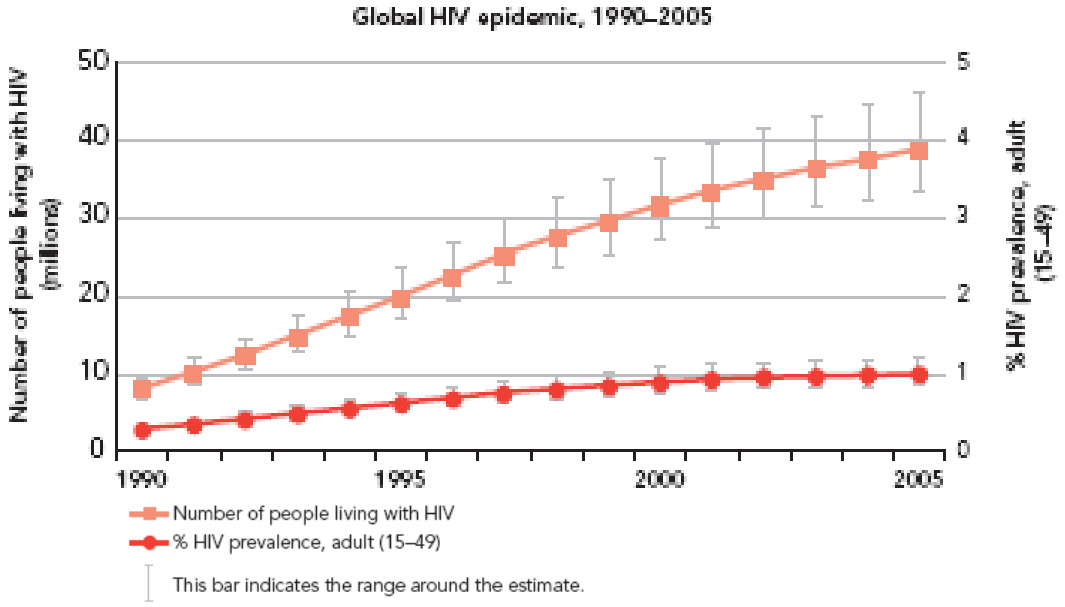

Figure 1. Estimated number of people living with HIV, and adult prevalence, globally, 1990-2005
Source: UNAIDS, *2006 report on the global AIDS epidemic*

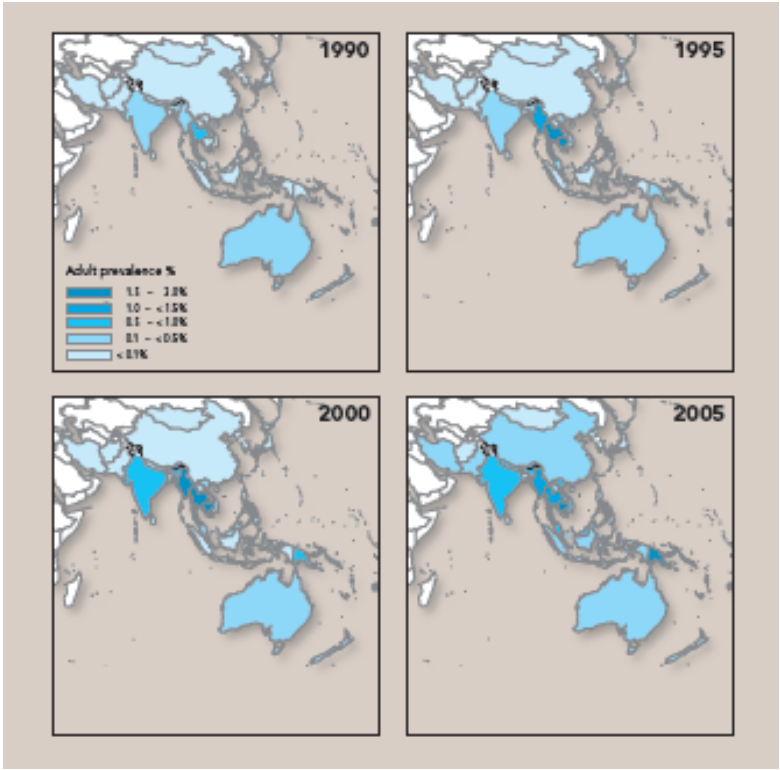

Figure 2. Asia Pacific HIV prevalence
Source: UNAIDS, *2006 report on the global AIDS epidemic*

ANNEXURE

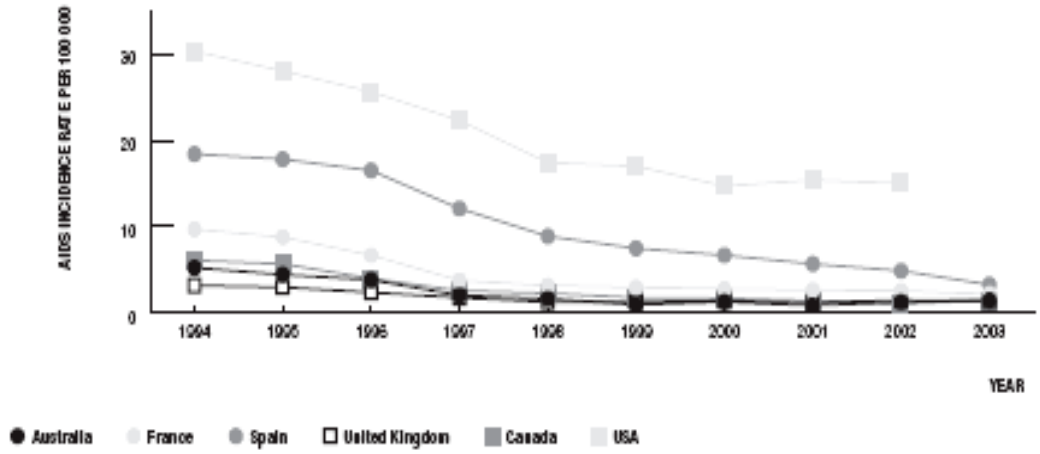

Figure 3. AIDS incidence in selected industrialised countries by year
Source: 2004 annual surveillance report, National Centre in HIV Epidemiology and Clinical Research

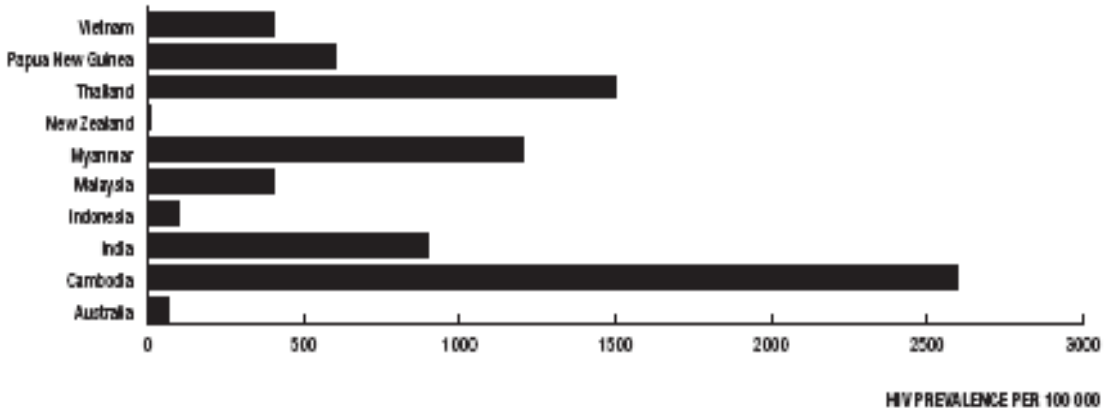

Figure 4. HIV prevalence in selected countries in the Asia Pacific region in 2003
Source: 2004 annual surveillance report, National Centre in HIV Epidemiology and Clinical Research

About the Author

Bill Bowtell is a strategic policy adviser, with particular interest in national and international health policy structures and reform. He trained as a diplomat, with postings in Portugal, Papua New Guinea and Zimbabwe.

As senior adviser to the Australian health minister, Bill Bowtell played a significant role in the introduction of the Medicare health insurance system (1984). He was an architect of Australia's successful and well-regarded response to HIV/AIDS.

Between 1994 and 1996, Bill Bowtell was senior political adviser to the Prime Minister of Australia.

Bill maintains a close interest in the potential impact of the HIV/AIDS epidemic, and the other communicable diseases, on the social, economic and political development of the Asia Pacific region. He has written and broadcast widely on HIV/AIDS and participated at high level in international and national HIV/AIDS advisory bodies and conferences.

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