HIV/AIDS in the Asia Pacific Region

ANALYTICAL REPORT FOR THE WHITE PAPER
ON AUSTRALIA'S AID PROGRAM

Prepared by
Annmaree O'Keeffe, John Godwin and
Dr Rob Moodie

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Preface

This Report has been produced by AusAID to inform the development of the White Paper on Australia's Aid Program, which is to be tabled in Parliament in early 2006.

The Report describes the key issues likely to shape Australia's response to the HIV/AIDS epidemic in the Asia Pacific region over the next decade (2005–2010). The purpose of the Report is to define the key HIV/AIDS issues to be considered by the Australian Government in developing the White Paper, and to stimulate public discussion and debate regarding these issues. The Report includes recommendations regarding areas for possible future investment by the Australian Government and suggestions on new ways of working to respond more effectively to future needs. These recommendations were considered at a Community Consultation meeting on the HIV/AIDS aspects of the White Paper convened in Sydney in September 2005.

A major focus of the Report is the Australian Government's role in responding to the global epidemic; however consideration is also given to the important roles played by non-government actors in the response. Where the Report refers to Australia's role, it is intended to refer to the entirety of Australia's multi-sectoral response to the epidemic— comprising the efforts of the Australian Government, the state and territory governments, the medical and research sectors, NGOs, and community groups.

The views contained in the Report are those of the authors and do not represent the position of the Australian Government.

The Report was informed by input from an Expert Reference Group convened by AusAID, the membership of which is as follows:

Don Baxter, Executive Director, Australian Federation of AIDS Organisations
Bill Bowtell, Lowy Institute for International Policy
Levinia Crooks, Executive Officer, Australasian Society for HIV/AIDS Medicine
Nick Crofts, Chief Executive, Turning Point
Professor Suzanne Crowe, Head of HIV Pathogenesis and Clinical Research Program, Burnet Institute
John Rock, International Portfolio Convenor, National Association of People Living with HIV/AIDS
Dr David Wilson, Senior Lecturer, Centre for International Health, Curtin University

This Report was developed by Annmaree O'Keeffe (Australia's Special Representative on HIV/AIDS and Deputy Director General, AusAID), John Godwin (AusAID's HIV Adviser) and Dr Rob Moodie, Chief Executive Officer, VicHealth.
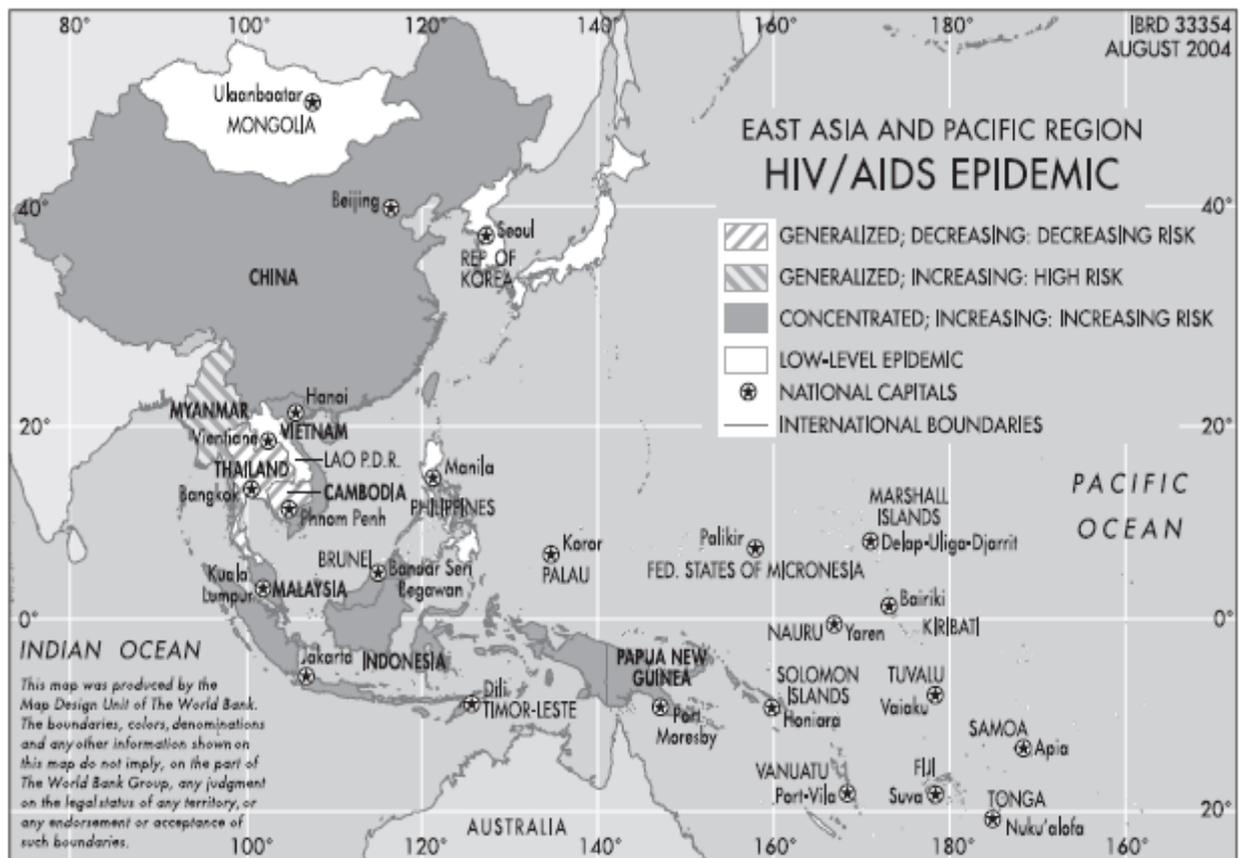
Source: *Addressing HIV/AIDS in East Asia and the Pacific*, World Bank, 2004.
nb PNG should now be classified as: Generalised, increasing; high risk.

Executive summary

HIV/AIDS is not simply a health threat; it is a development challenge. This global epidemic threatens to undermine development achievements as it increasingly impacts on a broad range of social and economic issues particularly in developing countries where health, education and other basic government systems are inadequate to fight the battle. Combating this development challenge requires comprehensive action which recognises that HIV/AIDS often emerges from the same societal and economic conditions that confound poverty alleviation.

The Asia Pacific region is experiencing escalating HIV/AIDS epidemics that are diverse and require multiple responses. These epidemics have unique features and are different from those in Africa. Countries in East and South-East Asia are experiencing epidemics driven largely by injecting drug use and sex work. In the Pacific, the situation varies, with the arc of Melanesian countries sharing socio-cultural factors that contribute to HIV vulnerability—such as high levels of sexual partnering, gender inequalities, high rates of sexual assault, and low literacy levels. Papua New Guinea (PNG) has an escalating generalised HIV/AIDS epidemic. Other Pacific Island countries are experiencing as yet low level, nascent epidemics driven by sexual transmission. Each of these epidemics has specific social, cultural and economic determinants and impacts. Throughout Asia Pacific, the stigma associated with HIV/AIDS is a major constraint, impeding work with vulnerable populations and reducing the availability and quality of health care.

It is highly unlikely that an effective preventive vaccine for HIV or cure for AIDS will become available in the next decade. It is probable, however, that in the medium term new biomedical approaches to prevention such as microbicides, advances in the use of antiretroviral drugs (ARVs) for prevention and treatment, and development of new monitoring and diagnostics tools designed for resource poor settings, will provide new tools for fighting the epidemic. Even with existing approaches, successes in prevention and in providing treatment and care on a large scale are possible in the region. A central guiding principle for successful responses is an evidence-based approach.

There has been a tendency to define HIV/AIDS as a disease of poverty. Poverty contributes greatly to HIV/AIDS vulnerability and the epidemic impacts heavily on populations that are socially and economically marginalised. However in Asia Pacific there is also a close association between HIV/AIDS, market growth and economic activity.

A greater focus on the gender aspects of the epidemic is required including improved understanding of how male and female social roles affect vulnerability. Feminisation has emerged as a major feature of the epidemic in sub-Saharan Africa where the majority of new infections are in women. A similar pattern is likely to emerge in PNG and other countries in the region that experience generalised HIV epidemics.

As the Asian and Pacific HIV/AIDS epidemics expand and affect a higher percentage of the general population, new family and community impacts will emerge. Orphan care and support issues, paediatric treatment and care, and mother-to-child transmission issues are likely to assume greater importance in highly affected Asian countries and PNG. Critical sectors of the workforce such as teaching, health care and policing may experience labour shortages.

Australia has positioned itself to play an ongoing and leading role in generating political commitment to HIV/AIDS in Asia Pacific. This has been a joint effort of government and civil society, with Australian NGOs and community groups playing an increasingly important role in contributing to HIV responses in the region.

Priorities for action for the next decade will need to focus on:

- Building leadership momentum, recognising that HIV/AIDS is a political challenge. Parliamentarians, community leaders and the business sector will need to be harnessed more effectively as part of this leadership work with an emphasis on HIV/AIDS as a core development issue. Governance initiatives will need to be explored to underpin sustainable responses.
- Implementing comprehensive and sustained prevention approaches. This will require expanded community mobilisation, the adoption of comprehensive harm minimisation frameworks, the strengthening of enabling law and policy environments, and the development of an evidence base. The role of antiretroviral therapy (ART) as part of the prevention approach needs to be expanded, whilst also scaling up community based prevention programs for vulnerable groups. Blood safety and infection control remains a continuing need in prevention.
- Expanding Australia's contribution to the delivery of ART effectively in resource poor settings. This will involve strengthening workforce capacity, improving testing and monitoring and supporting access to affordable treatments through trade policy.
- Addressing gender aspects including male roles and feminisation of HIV epidemics.
- Expanding and continuously improving the evidence base.
- Strengthening whole-of-government coherence in the aid program's response to HIV/AIDS in Asia Pacific.
- Looking for new ways of working, including rapid response capabilities, harmonisation and collaborative approaches, policy engagement, regional capacity strengthening, and collaborative technical assistance approaches with development partners.

1   The challenge

1.1   The nexus between HIV/AIDS and development

HIV/AIDS is a development challenge. Meeting this challenge demands a long-term vision. It is an evolving and exponentially destructive disease that strikes at the centre of a society's most productive and essential groups—its workers and its parents.

As the global numbers of those infected and affected continue to rise, it is clear that HIV/AIDS predominantly impacts on the world's most vulnerable—the most vulnerable individuals, most vulnerable groups and most vulnerable countries. Nine out of every ten people living with HIV/AIDS live in the developing world. Combating this development challenge requires comprehensive action that recognises that HIV/AIDS very often emerges from the same societal and economic conditions that confound poverty alleviation.

Diverse Asia Pacific epidemics

HIV/AIDS epidemics are classified in three types:

- **Nascent**: low-level epidemics where HIV prevalence remains below five per cent in any sub-population (for example, East Timor and Vanuatu).

- **Concentrated**: prevalence exceeds five per cent in sub-populations— such as injecting drug users, sex workers, or men who have sex with men—but remains less than one per cent in pregnant women in urban areas (for example, Indonesia, China and Vietnam)

- **Generalised**: prevalence exceeds one per cent of the adult population, as indicated for example by antenatal testing (for example, PNG, Myanmar, Cambodia, and Thailand).

1.2   Escalating epidemics in Asia Pacific

The Asia Pacific region is experiencing escalating HIV/AIDS epidemics that are diverse in nature and require multiple responses. These epidemics have unique features and are different from those in Africa.

Countries in East and South-East Asia are experiencing epidemics driven largely by injecting drug use and sex work. HIV prevalence is also high amongst men who have sex with men, and male populations who buy sex, such as transport workers. High HIV prevalence in these subpopulations accelerates the further spread of HIV. There is an emerging pattern of HIV spread into the general population of some Asian countries, with rising HIV infection rates in women who report being monogamous. The majority of new HIV infections in most

Asian countries occur through heterosexual transmission.[1] However injecting drug users usually have the highest HIV infection rates of any subpopulation in Asia, meaning that injecting continues to play a critical role in kick starting new local epidemics by introducing HIV into sexual networks.[2] Prison populations in Asia often have high HIV prevalence rates, largely associated with injecting.

Cambodia, Myanmar and Thailand have experienced the highest HIV prevalence in Asia over the last decade. More recently, provinces of southern, western and central China and states in southern and north-eastern India are emerging as new regional epicentres of the HIV epidemic. India is predicted to overtake South Africa soon as the country with the highest number of people living with HIV/AIDS globally. The large populations of China and India mean that even with low national HIV prevalence, the numbers of people living with HIV are significant. In Myanmar and Cambodia there has been significant spread into the general population and increasingly the epidemic is taking hold in rural areas. This is likely to be the longer term trend in these countries and, over time, elsewhere in the region.

Indonesia is facing the challenge of responding to rapidly expanding epidemics driven by injecting, particularly in Java, Bali and Riau as well as a major heterosexually driven epidemic in Papua Province.

Table 1

HIV and AIDS in Asia, end of 2002 and 2004

	Adults and children living with HIV	Number of women living with HIV	Adults and children newly infected with HIV	Adult prevalence (%)	Adult and child deaths due to AIDS
2004	8.2 million [5.4–11.8 million]	2.3 million [1.5–3.3 million]	1.2 million [720 000–2.4 million]	0.4 [0.3–0.6]	540 000 [350 000–810 000]
2002	7.2 million [4.6–10.5 million]	1.9 million [1.2–2.8 million]	1.1 million [540 000–2.5 million]	0.4 [0.2–0.5]	470 000 [300- ,000–690 000]

Source: *AIDS Epidemic Update*, UNAIDS, December 2004.

In the Pacific, the situation varies. The arc of Melanesian countries share socio-cultural factors that contribute to HIV vulnerability such as high levels of sexual partnering, gender inequalities, high rates of sexual assault, and low literacy levels.[3] HIV prevalence in PNG is approaching two per cent of the adult

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[1] *MAP Report 2005: Drug injection and HIV/AIDS in Asia*, Map Network, 2005.

[2] *ibid*

[3] Biological factors also play a role—for example; the absence of male circumcision has been suggested as a possible factor contributing to HIV spread in Melanesia, given that studies conducted in Africa demonstrate a correlation between male circumcision and lower rates of HIV transmission.

population[4] and Indonesia's Papua Province is experiencing similar levels. In PNG and Papua Province there are high rates of HIV among sex workers, but in the context of an expanding generalised epidemic, women and youth in the general population are also vulnerable. The epidemics in PNG and Papua Province are at a critical stage requiring urgent and focused interventions to prevent further expansion to generalised epidemics affecting a significant proportion of the population.

HIV is not evenly spread across Melanesia. Fiji is experiencing a low level but rapidly growing epidemic. Little is known about the HIV/AIDS epidemics in East Timor, Solomon Islands and Vanuatu. Although as yet relatively few diagnoses have been reported in these countries, without immediate action to address prevention and the underlying social and economic factors that drive the epidemics, there is a risk that HIV/AIDS will take a similar path in these countries as that of the more advanced epidemics in PNG and Papua Province.

Other Pacific Island countries are experiencing as yet low level, nascent epidemics driven largely by sexual transmission. Demographic factors, including the large proportion of the population aged under 25 years, combined with poor sexual health (as indicated by high rates of Sexually Transmitted Infections—STIs), labour mobility and changes to sexual behaviours, are combining to increase the vulnerability of Pacific Island states to expanding HIV/AIDS epidemics. Seafarers and their partners (including sex workers) are populations at risk of HIV in these countries. Considerable travel occurs between Polynesian countries and Australia and New Zealand, through tourism and the Polynesian diaspora, which may also provide opportunities for HIV spread. In New Caledonia and French Polynesia, men with a history of homosexual contact represent a significant proportion of infections and throughout the Pacific there are concerns that the stigmatisation of men who have sex with men means that this mode of transmission is under reported.

There are divergent views on the likely medium-term trajectory of Asian epidemics and the rate at which they could potentially progress to mature generalised epidemics. Although it is thought unlikely that HIV/AIDS in Asia or the Pacific will follow the same epidemiological path as the hardest hit sub-Saharan African countries, it is clear that an opportunity exists to prevent further escalation. If action is not taken and epidemics affecting our neighbours spread across the general population this will have social and economic consequences that will be felt for generations.

The epidemics in PNG and parts of Indonesia are already at a level that means it is necessary to consider the implications of the future path of the epidemic for Australia's strategic, security and economic interests.

1.3   No 'silver bullet' solution on the horizon

It is highly unlikely that an effective preventive vaccine for HIV or cure for AIDS will become available in the next decade. It is probable however that in the medium term new biomedical approaches to prevention such as microbicides,

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[4] A 2004 PNG Consensus meeting that reviewed surveillance data estimated prevalence at 1.7 per cent of the adult population: *Report of the 2004 National Consensus Workshop of PNG*, NAC, NDoH, WHO, NHASP, 2004.

advances in the use of ARVs for prevention and treatment, and the development of new monitoring and diagnostics tools designed for resource poor settings, will provide new tools for fighting the epidemic. It will be strategically important to ensure that such tools are made available to developing countries in Asia Pacific at an early stage, and are deployed so as to be cost effective and to maximise preventive and therapeutic benefits for the populations most affected in the poorest countries. This implies the need to invest in training the health sector workforce to support the rapid transfer and uptake of new technologies.

Even with existing approaches, successes in prevention and providing treatment and care on a large scale are possible in the region. Over the last decade, strong leadership and significant domestic investment in prevention through national responses resulted in substantial reductions in the rates of expansion of HIV epidemics in Thailand and Cambodia, although maintaining these reductions may prove difficult.

In the prevention field, achieving and sustaining behaviour change remains a daunting challenge. However certain approaches, such as well targeted community based peer education and harm reduction, can be highly effective in preventing HIV. In addition to interventions aimed at individual behaviour change, a greater focus on addressing the social determinants of vulnerability— such as stigma, gender inequalities and the social exclusion of marginalised populations—will support more effective prevention.

A key current constraint on effectiveness of prevention is the low level of national coverage of programs for the most vulnerable populations, particularly injecting drug users, sex workers, men who have sex with men, and mobile populations. Only 1 per cent of men who have sex with men, 5.4 per cent of injecting drug users and 19 per cent of sex workers were covered by HIV prevention services in 16 Asia Pacific countries surveyed in 2003.[5]

In the treatment field, advances in the scaling up of delivery of ART in middle income countries such as Thailand have been achieved within a relatively short period. Thailand's national treatment program has benefited from vigorous community sector activism and from the involvement of people living with HIV/AIDS groups in expanding the reach of clinical services and securing widespread access to locally produced generic combination ARVs through public hospitals. In 2004, 44 per cent of people with advanced HIV infection were receiving ART in Thailand compared with only one per cent in Vietnam, four per cent in India and seven per cent in China. Cambodia (23 per cent) and Indonesia (24 per cent) have also achieved significant ART scale up progress.[6] However in poorer and isolated settings delivery at scale is proving highly challenging or not occurring at all. In PNG there are as yet only a few hundred people receiving ART, yet there may be over 10 000 people who clinically require treatment.

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[5] *A Scaled up Response to AIDS in Asia and the Pacific*,.UNAIDS, 2005, p. 20.
[6] Ibid, p. 22.

Figure 1   Prevention works:
Two scenarios for the number of new HIV infections in Asia Pacific to 2010
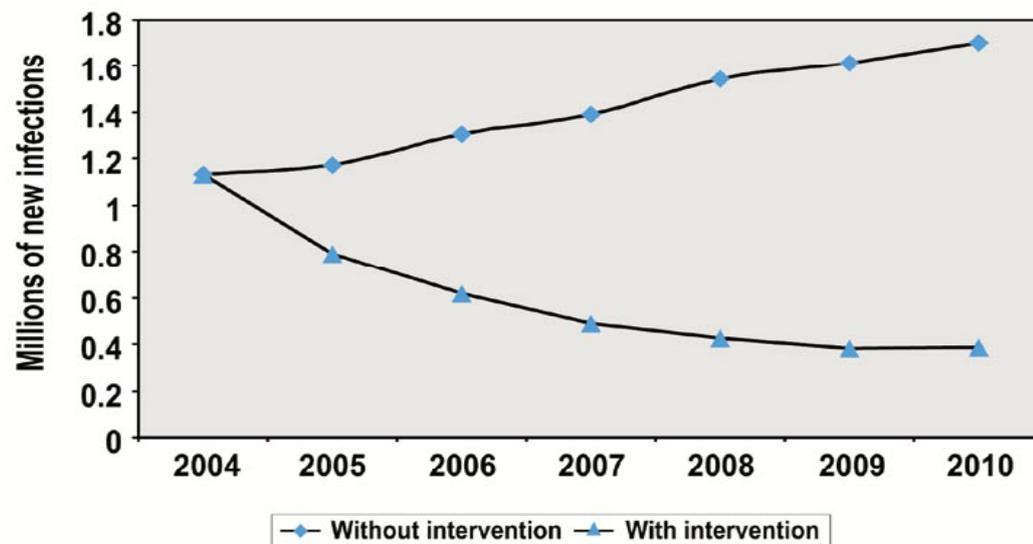
Source: *Asia Pacific's Opportunity: Investing to Avert an HIV/AIDS Crisis*, ADB/UNAIDS, 2004.

One of the key challenges to be addressed over the next decade will be securing affordable supplies of second-line ARV medicines, as viral resistance to the drugs currently used in first-line HIV/AIDS treatment strategies grows and treatment failure becomes more common. Simplified and standardised treatment approaches, and treatment education and support to help people to adhere to drug regimens, will be important to combat the emergence of drug resistance. This is important to sustain good clinical outcomes and contain drug costs. Although treatment scale up has been assisted by dramatic reduction in prices of first-line ARV drugs over the last five years and increased availability of fixed dose combinations, the prices offered by pharmaceutical companies for second-line regimens remain prohibitively high, exceeding $1000 per person per year even in low-income countries.

Stigma remains a major impediment to provision of effective prevention, treatment and care responses across the region. HIV-related stigma generally arises due to the association between HIV/AIDS and taboos regarding blood, sex, death and social deviance. The people who are most vulnerable to HIV often experience multiple levels of stigma due to their status as a sex worker, drug user, or man who has sex with other men, as well as a perception that these groups are a vector for diseases such as HIV, sexually transmitted infections (STIs) and hepatitis. HIV-related stigma is a major disincentive to people presenting for testing and treatment and drives people away from prevention and care services. Strong political and community leadership including from people living with HIV/AIDS can play a critically important role in tackling stigma and discrimination (see discussion below at 3.1.1 and 3.1.5)

A study of AIDS discrimination in Asia found that the most common area of discrimination reported by people living with HIV/AIDS is in the health sector.[7] This underscores the need to educate health workers so as to challenge stigma and to address fears and misconceptions about transmission risks, as well as providing non-discriminatory occupational health and safety measures such as universal infection control precautions.

1.4   Emerging socio-economic impacts

HIV/AIDS is a development issue with its biggest impact on the world's most economically vulnerable countries. Globally, 95 per cent of people with HIV/AIDS live in developing or transition countries. The corollary of this is that no developed country has a prevalence rate above 0.5 per cent of the adult population. While the connection between HIV/AIDS and poverty is complex, with cause and effect in a macro-economic sense still unclear, HIV/AIDS is contributing to major development setbacks in many African countries.

Although the world has yet to see a country's economy collapse solely due to HIV/AIDS, the epidemic is compounding crisis situations such as food shortages associated with drought in southern Africa. Fragile economies in our immediate region such as PNG, East Timor and Solomon Islands are vulnerable to the economic impacts of an HIV/AIDS epidemic. The PNG workforce could be reduced by 34 per cent due to HIV by 2020 (Table 2).[8]

In Asia, the macro-economic impact remains unclear and there is uncertainty on the question of the virus increasing national poverty rates.[9] Evidence suggests that HIV/AIDS has immediate micro-economic, household effects. Most HIV/AIDS related costs are borne by poor households. Individual and community vulnerability to the disease among the poorer sections of Asian societies is likely to be confounding their efforts to emerge from poverty. Macro-economic effects solely attributable to HIV/AIDS are more difficult to determine even in high prevalence African settings. In large Asian nations with prevalence rates that vary dramatically in different parts of the country, it is more likely that economic impacts will be identified at the provincial rather than the national level. However modelling has predicted a slowing in the rate of poverty reduction due to HIV/AIDS in countries such as Cambodia and India over the period 2005–2015, delaying national achievement of Millennium Development Goals (MDGs).[10]

HIV/AIDS affects an economy in several ways. It strikes at people of working age; at an individual level, people living with HIV/AIDS and their families face reductions in savings and disposable incomes, and reduced household incomes

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[7] In 2002, 54 per cent of a sample of 764 people living with HIV/AIDS drawn from India, Thailand, Philippines and Indonesia reported experiencing some form of discrimination within the health sector: *AIDS Discrimination in Asia* Asia Pacific Network of People Living with HIV/AIDS 2004.

[8] Per cent reduction as compared to the workforce size estimate but for HIV: Centre for International Economics' *Potential Economic Impact of HIV/AIDS in Papua New Guinea*, AusAID, Canberra, 2002.

[9] *Asia's Economies and the Challenge of AIDS,* ADB, April 2004.

[10] *Asia Pacific's Opportunity: Investing to Avert an HIV/AIDS Crisis*, ADB and UNAIDS, July 2004; *The Impact of HIV/AIDS on Poverty in Cambodia, India, Thailand and Viet Nam,* ADB and UNAIDS, 2004.

are absorbed by health care and funeral costs; and AIDS-related deaths act to reduce the stock of human capital.

The economic impacts of HIV/AIDS are felt first in the health sector where care needs can overwhelm under-resourced health systems. In 2004 AIDS patients occupied more than 50 per cent of medical ward beds at Port Moresby General Hospital.[11] Diversion of household income to healthcare often leads to increased debt and a downward spiral into poverty. As the epidemic progresses it strains education systems, weakens demand, widens the gender gap, and potentially leads to increases in costs across all sectors of the economy.

Large-scale epidemics, such as those unfolding in PNG, Cambodia, Myanmar, and in parts of India, slow the growth of human capital. Modelling suggests that the intergenerational impacts of HIV/AIDS on human capital formation could be dramatic.[12] As HIV/AIDS strikes at the most productive segment of a society it constrains labour supply in key sectors, taking out society's most important economy sustaining cohorts. Absence of parental care weakens knowledge transfer and productive capacity. Early parental death reduces resources available to the family with the result that children spend less, if any, time in school building their human capital and productive potential. As the transmission of capacities and potential from one generation to the next is progressively weakened, economies may slow with effects felt only over the longer term.

Table 2: PNG—impact of HIV/AIDS on the main economic indicators Deviation from baseline in 2020

	Low scenario	Medium scenario	High scenario
	%	%	%
Labour force	-13.2	-34.0	-37.5
Real GDP	-2.6	-6.8	-7.5
Real GDP per worker	12.0	41.0	47.9
Economic welfare	-5.8	-15.0	-16.6
Real consumption	-2.3	-6.0	-6.6
Real investment	3.9	9.9	11.0
Exports	-0.1	-0.2	-0.2
Imports	0.7	1.7	1.9
Current account (% of GDP)	-0.5	-1.3	-1.5
Tax revenue (nominal Kina)	2.5	6.5	7.2
Budget surplus (% of GDP)	-8.8	-19.4	-20.8
Real exchange rate	-0.6	-1.5	-1.6
Urban crime	-7.2	-16.6	-18.0

Centre for International Economics *Potential Economic Impact of HIV/AIDS in Papua New Guinea*, AusAID, Canberra, 2002.

1.5 Economic activity as a driver of Asian and Pacific epidemics

There has been a tendency to define HIV/AIDS as a disease of poverty. Poverty contributes greatly to HIV/AIDS vulnerability and the epidemic impacts heavily

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[11] *Report of the 2004 National Consensus Workshop of PNG*, NAC, NDoH, WHO, NHASP, 2004.
[12] *The Long-run Economic Costs of AIDS: Theory and an Application to South Africa*, World Bank, 2003.

on populations that are socially and economically marginalised. However it should also be recognised that in Asia Pacific there is a close association between HIV/AIDS, market growth and economic activity.

HIV epidemics in Asia Pacific are often fuelled by patterns of development. Economic development in the region has brought with it labour migration and long-distance trading. Development activity such as infrastructure projects that involve the displacement of communities, the encouragement of migrant labour, or the development of long-distance transportation routes, can contribute to the spread of HIV.

Mining and logging sites, shipping hubs, highways, and other transport routes are settings in which risk taking occurs and in which both local and mobile populations are vulnerable to HIV/AIDS. Factors include the presence of men who are working away from their families, with disposable incomes and the coexistence of formal or informal sex industries attracted by the income generating potential of a male workforce. Of particular significance to HIV spread in Asia are patterns of black market activity that open up opportunities for movement of populations between low HIV prevalence areas and high prevalence areas. HIV spread is associated with drug routes in Central Asia, Myanmar and the Mekong, and movements of sex workers between Nepal and India.

In the Pacific, seafarers who visit sex workers in ports in higher HIV prevalence countries before returning home are at risk, as are their partners. White collar workers and their partners are also directly affected by the epidemic. The Asian economic boom has led to an increase in travel by businessmen and public servants across the region, which creates opportunities to purchase sex while away from families and for HIV to spread.

The shift from agricultural to industrial economies in Asian countries is associated with urbanisation, labour mobility and changes in land use. Increasing poverty in rural areas due to a shrinking agricultural land base forces many to migrate to the cities for work. In some Asian countries village families sell their daughters to brokers for urban commercial sex establishments, or women leave the countryside voluntarily to join the sex industry in order to send money back to their families. In China, a growing pool of tens of millions of single men on the move in search of work has been identified as a risk factor for rapid HIV spread.

1.6   Gender aspects of the Asian and Pacific epidemics

Feminisation has emerged as a major feature of the epidemic in sub-Saharan Africa where the majority of new infections are in women. A similar pattern may emerge over time in parts of the region experiencing generalised epidemics such as PNG and Papua province. As the PNG epidemic matures and takes on characteristics of a heterosexual epidemic, women are increasingly infected and at younger ages than men. This is for a combination of biological factors that render women more likely to contract HIV during sex than men and social reasons such as violence against women and women's lower social and economic status.

In Asia, the pattern is very different from African epidemics and men are predominantly affected at the early stage of the HIV epidemics concentrated in injecting populations. In much of South-East Asia, including Indonesia, most infections to date have occurred in men. In Asia in 2003 there were an estimated 5.2 million men living with HIV as compared to two million women.[13] Women will likely make up an increasing proportion of new infections in areas where the epidemic is transitioning from a concentrated to a generalised epidemic.

The economic and social impacts of HIV such as discrimination are often greater on women than men.[14] Women may face difficulties accessing treatment, care and support services due to domestic responsibilities and fear of stigma, and usually carry a greater burden as carers than men.

Economic insecurity can lead women and girls to exchange sex for goods, services and cash. Sex workers are highly vulnerable to HIV. Clients of female and male sex workers are almost exclusively male and HIV is then transmitted onwards to their wives or partners who may be monogamous. Monogamous and married women are also increasingly at risk of HIV in countries with more generalised epidemics (such as Thailand and Cambodia), because of the extramarital sexual activities of their male partners. This population of women is seldom perceived as vulnerable to HIV and is thus rarely targeted by prevention campaigns.

In PNG and the Pacific, a high incidence of violence against women and girls places them in a highly vulnerable position. Cultural and religious norms can accentuate gender inequality, and leadership from those with moral authority in society is required to change traditional social values that disempower women. Women's vulnerability is accentuated by situations of economic crisis and conflict, where gender-based violence including rape is more pronounced. Poverty imposes pressures on women and girls to provide sex in exchange for money, food or access to shelter for themselves and their families.

These factors underscore the need to ensure that interventions are informed by gender analysis and address aspects of women's vulnerability, as well as male social roles that contribute to HIV risk taking. Dominant gender norms and expectations and concepts of masculinity can increase men's vulnerability to HIV/AIDS as well as women's. Social norms often are that men should take risks and have frequent sexual intercourse with more than one partner. Deeply rooted expectations can lead men to insist on sex when their partners do not want it and to resist using condoms.

Transgender people are particularly vulnerable to HIV, violence and discrimination. Men who adopt transgender roles within society, such as warias in Indonesia and fa'afafine in Samoa, have specific HIV prevention and sexual health promotion needs that are rarely addressed.

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[13] *AIDS in Asia: Face the Facts*, MAP Report, 2004, p. 16.
[14] Asia Pacific Network of People Living with HIV/AIDS 2004, op cit fn. 7.

Figure 2: *In 2003 more PNG HIV infections were detected in women than in men*
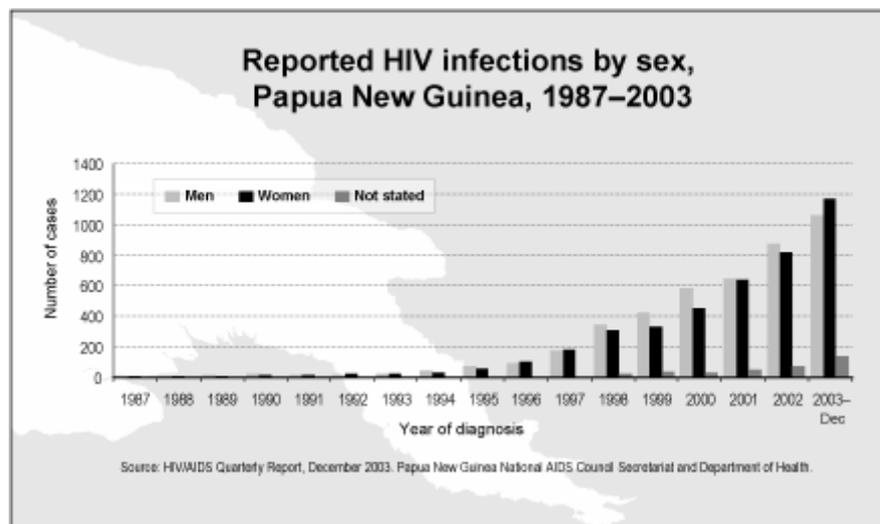
1.7 Responding to generalised epidemics

As the Asian and Pacific HIV/AIDS epidemics expand and affect a higher percentage of the general population (in particular women), new family and community impacts will emerge. Orphan care and support issues, paediatric treatment and care, and mother-to-child transmission issues are likely to assume greater importance in highly affected Asian countries and PNG. Some critical sectors of the workforce such as teaching, health care, and policing may experience labour shortages.

Of most significance to Australia in the next five to ten years is the escalating impact of a generalised epidemic in PNG and Papua Province, which could have highly disruptive effects on the workforce across sectors as varied as agriculture, transport, education, mining, health care, education, security, and defence. Already PNG is losing at least one teacher a week from the workforce due to HIV/AIDS related illness and deaths.[15] A generalised epidemic could also generate new population movements such as a return to villages for communal support and cross-border movements to seek care and treatment or to escape economic deprivation, creating pressure, for example, on Torres Strait health resources.

1.8 Fragile states and security dimensions of HIV/AIDS

HIV/AIDS presents an additional destabilising force that can compound existing social and economic inequalities and tensions, particularly in fragile and conflict affected states.

The cumulative effects of HIV/AIDS threaten stability but the impact on state functioning is gradual rather than catastrophic. Even in the countries of sub-Saharan Africa that have the highest HIV prevalence, state institutions have

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[15] National Tisa Insurance Limited estimates there will be 106 deaths among teachers in 2005, about half HIV/AIDS related: 'Teachers Dying Fast', *The Nation*, 31 May 2005.

withstood the impacts of the epidemic. HIV/AIDS tends to have a destabilising and corrosive effect on societies and state institutions that accumulates over time. In Africa, the epidemic is creating a new phenomenon of the undeveloping or fading state, as effective state functioning is gradually undermined and weakened.

The security consequences of HIV/AIDS in Asia Pacific are likely to be highly varied, with the social and political institutions of small countries with high HIV prevalence such as PNG likely to be the most vulnerable. In PNG and Indonesia's Papua Province, HIV/AIDS has the potential to exacerbate existing fractures in these already fragile societies.

As an additional compounding factor, these states are also highly vulnerable to sudden shocks from new communicable diseases such as SARS and avian influenza that can rapidly overwhelm health systems. Investment in health systems through workforce training and building surveillance, clinical and laboratory capacities can strengthen the preparedness of countries to respond to HIV/AIDS as well as other existing prevalent diseases and new health threats.

State fragility can accelerate the harmful impacts of an HIV epidemic. The epidemic will likely thrive where community and government responses are impeded due to weak governance systems and poorly developed health, education and social support systems. Improvements in overall governance help underpin HIV/AIDS strategies. Confidence in law enforcement, justice and the protection of individual rights are essential in providing a framework for an effective multi-sectoral response to HIV/AIDS.

In countries such as Myanmar where HIV already has a foothold, conflict can accelerate HIV spread through sexual violence, refugee flows and poor access to health and education services. The relationship between HIV and conflict is complex. Reduced social interactions during some conflict situations may result in reduced opportunities for HIV spread. However, increased HIV risks may be associated with the immediate post-conflict environment when new trade and transport systems open up but health and education systems remain weak. This points to increased vulnerability of populations in post-conflict contexts such as Bougainville, East Timor and Solomon Islands.

2   Factors shaping Australia's medium-term response

2.1   Australia's existing International HIV/AIDS Strategy

Australia's strategic priorities in addressing HIV/AIDS were established by *Australia's International HIV/AIDS Strategy.*[16] This strategy provides a firm foundation for planning Australia's medium-term response and sets five priority areas for action: leadership and advocacy; changing attitudes and behaviours; capacity building; treatment and care; and addressing transmission through injecting. The Strategy also commits to the principle of the greater involvement of people living with HIV/AIDS in policies and programs, and to mainstreaming HIV into all aspects of development. This Report highlights issues that require further exploration and emphasis in implementing the Strategy.

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[16] *Australia's International HIV/AIDS Strategy: Meeting the Challenge*, AusAID, July 2004.

2.2   The geographic focus of the overall aid program

The focus for Australia's efforts in addressing HIV/AIDS needs to be consistent with the overall geographic priorities of the aid program. Australia is set to remain the major donor in PNG and the South Pacific for the foreseeable future, and is a significant contributor to aid in Indonesia. In Asia, Australia is one of many donors and its aid is likely to be directed towards East and South-East Asia. In South Asia and China, where Australia's presence is dwarfed by major donors, HIV/AIDS interventions will have to be highly strategic to make a lasting impact. In these countries AusAID should offer targeted technical assistance and work with other donors and through multilateral systems such as partnership arrangements with UN agencies.

Australia's HIV/AIDS programs should reflect an assessment of how Australia's contribution can have maximum impact by focusing on areas of comparative advantage. Geographic and strategic factors suggest the primary medium-term focus of the Australian Government's HIV/AIDS programs will be Indonesia and the Pacific, with PNG accorded top priority.

Australia's engagement in HIV/AIDS to date has included sub-regional activities (the Asia Regional HIV/AIDS Project that focuses on harm reduction in East and South-East Asia, and the Pacific Regional HIV/AIDS Project working in Pacific Island countries) and significant bilateral projects in PNG, Indonesia and China. Australia has had a lower level of engagement on HIV/AIDS in South Asia, Thailand, Cambodia, Laos, East Timor and the Philippines, and assistance to HIV/AIDS in Africa has been largely limited to Australian NGO projects. Australia has also helped finance the regional response of UNAIDS, and has committed $75 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

2.3   Unique strengths of Australia's HIV/AIDS responses in the region

Australia has played a significant role in the development of harm reduction policies and programs in Asia largely through the work of key individual experts, the Burnet Institute's Centre for Harm Reduction and AusAID-supported projects. The pragmatic approach adapted to HIV and drug use by Australian-led interventions has proved highly effective. Australia has pioneered the integration of harm reduction into the work of the health, police and law enforcement sectors in many Asian countries. Australia has also developed expertise in:
   o   community based prevention interventions with sex workers and mobile populations
   o   working with men who have sex with men groups, in relation to HIV prevention, community mobilisation and advocacy, particularly in East and South-East Asia
   o   serological and behavioural surveillance in resource-poor settings in the region, particularly through the work of the national HIV research centres
   o   ambulatory care models
   o   strategic planning for HIV responses at national, provincial and sectoral levels.

2.4   Australia's history of success domestically in HIV/AIDS

Australia has a highly effective domestic HIV/AIDS response. Harm reduction approaches, particularly early introduction of needle exchanges and peer education, helped prevent an injecting driven epidemic from emerging in Australia. Mobilisation of the gay community to lead prevention efforts and targeted HIV and sexual health programs for sex workers and Indigenous communities have succeeded in slowing the spread of HIV and containing the epidemic. Australia's epidemic has primarily affected gay men and Australia has developed a high level of expertise in gay men's health promotion issues. Strong political leadership on AIDS, particularly in the early years of the epidemic when stigma was high, facilitated a pragmatic approach to the issue, supported by timely allocation of resources and establishment of a national structure for leading and managing the response.

A strength of the Australian domestic response has been the capacity to monitor and respond to trends in an epidemic that constantly throws up new prevention and treatment challenges. Australia has learnt the need for constant vigilance, to respond to new needs such as those of culturally and linguistically diverse communities, and the importance of sustained action to protect past investments.

Australia should capitalise on its significant reservoir of technical and policy development skills and expertise, and export its successes and lessons learnt (3.6.5). It would be a paradox and failure of leadership if Australia sustains a successful domestic response to HIV/AIDS whilst failing to use its expertise to mount an effective response to the epidemic in countries at our doorstep.

2.5   Australia's regional leadership role in HIV/AIDS

Australia has positioned itself to play an ongoing and leading role in generating political commitment to HIV/AIDS in Asia Pacific. This has been a joint effort of government and civil society, with Australian NGOs and community groups playing an increasingly important role in contributing to HIV responses.

AusAID is the only donor that has positioned the Asia Pacific HIV/AIDS epidemic as a central priority. Efforts to date at the ministerial level have included:

- co-founding the Asia Pacific Leadership Forum on HIV/AIDS and Development
- convening the Asia Pacific HIV/AIDS and Development Ministerial meetings in 2001 and 2004
- championing HIV/AIDS at APEC and UNESCAP
- supporting the development of a Regional Strategy on HIV/AIDS for the Pacific through the Secretariat of the Pacific Community (SPC)
- a capacity building partnership initiative linking Australian national professional and community sector peak organisations with similar groups in the region (Australian HIV/AIDS Partnership Initiative—AHAPI)
- support to regional networks working in HIV/AIDS in Asia Pacific through the '7 Sisters' initiative

- a sub-regional initiative to provide research evidence to support stronger political action on HIV/AIDS involving Indonesia, East Timor and PNG flowing from the South-West Pacific Dialogue
- laying the foundations for a business leaders initiative on HIV/AIDS in Asia Pacific.

The Australian Government actively promotes the unique needs of the region through multilateral processes such as monitoring the achievement of targets established in the UNGASS Declaration of Commitment on HIV/AIDS (2001).[17] The Australian Government should continue to advocate the needs of the region through its position on the UNAIDS Programme Coordinating Board, membership of the GFATM Board, attendance at World Health Assembly and World Bank meetings, and through input to the Commission on Narcotic Drugs, Commission on Status of Women, Commission on Human Rights, and at other multilateral high level meetings.

Australian support for, and involvement in, the biannual Asia Pacific AIDS Congresses (ICAAP) recognises the importance of the event as a vehicle for raising the profile of the issue, encouraging leadership and sharing policy, program and research learning.

2.6   A crowded environment of bilateral and multilateral players

Over the last five years HIV/AIDS has become a high priority for most of the major donors active in Asia Pacific. With the establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the United States Government's President's Emergency Plan for AIDS Relief (PEPFAR - in Vietnam), expansion of DfID's HIV/AIDS programs (particularly in South Asia), and increased investments by the World Bank and Asian Development Bank in HIV/AIDS there are significant resources available for fighting HIV/AIDS in the region. There is also a multitude of NGOs now active in HIV/AIDS in Asia and the Pacific.

Major issues currently include:

- the lack of absorptive capacity to use available funds effectively
- lack of coordination of investment by donors and multilateral agencies, leading to duplication and overburdening of staff in complying with the requirements for funds management set by multiple donors
- accountability burdens experienced by countries as a result of multiple monitoring and evaluation requirements set by donors that result in multiple processes with different timelines.
- NGO coordination—between diverse NGO programs and with other donor and domestic activities
- NGO competition for funds, hampering cooperation and capacity to provide national advocacy and influence national policy

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[17] Progress in achieving targets established by the UNGASS Declaration of Commitment is to be reviewed by the UN General Assembly in June 2006.

The multiplicity of players involved in HIV/AIDS contributes to fragmentation of the international effort. Coordination and alignment are desirable but may be difficult to achieve because of entrenched historical roles or irreconcilable priorities and approaches dictated by domestic political considerations such as willingness to engage with legally marginalised populations.

Australia is a strong supporter of closer coordination on the basis of the Three Ones principles[18] that were agreed by donors and UNAIDS in 2004. Australia is working with UNAIDS to support harmonisation of efforts and is working within the framework of the recommendations of the *Global Task Team Report on Improving AIDS Coordination among Multilateral Institutions and International Donors* (UNAIDS 2005). It is recognised that institutional capacities, needs and progress in implementing the Three Ones differ between countries and that fragile states pose additional challenges. In PNG and Pacific Island countries where Australia is the major donor, Australia should play a lead role in harmonisation efforts.

2.7   Whole-of-government aspects of the Australian response

Because of the epidemic's profound implications for core social and economic factors for Australia and the region, there is a need to ensure a significantly greater understanding within Australian government agencies of the potential impact and threats of HIV/AIDS. That understanding should be translated into a coherent approach, similar to other whole-of-government approaches which maximise Australia's comprehensive response through exploiting the strengths of individual agencies. Given the current involvement of a number of agencies in significant regional diplomatic initiatives (for example, the Enhanced Co-operation Program in PNG and RAMSI in Solomon Islands), there is a framework which can be used to develop or strengthen a comprehensive government approach through and complementary to Australia's aid program. Underscoring the importance of this approach is the direct role some of these agencies can play in helping to stem the spread of HIV/AIDS in the region.

This role can take the form of an enhanced focus on prevention work with high risk groups. For example, through the Australian Defence Force's co-operation activities, increased awareness raising and behaviour change can be incorporated into their capacity building work with other defence forces in the region, a number of which are recognised as high-risk groups within their own communities. Similarly, the work of Australian Federal Police (AFP) in the region should include a comparable prevention-focused approach—again because of the high-risk nature of some of the region's counterpart police forces.

The transboundary nature of HIV/AIDS requires the involvement of the Department of Health and Ageing not least because of responsibility in its resourcing of national organisations that play a role in regional as well as domestic responses—such as Australasian Society for HIV Medicine (ASHM), Australian Federation of AIDS Organisation (AFAO), and National Association of People Living With Aids (NAPWA)— and the Department's role in providing Torres Strait health services and Medicare arrangements, participating

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[18] One agreed HIV and AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based multi-sector mandate; one agreed country-level monitoring and evaluation system.

in the APEC Health Taskforce, participating in bilateral partnerships with health ministries, and liaising with WHO. State health departments also need to be considered as part of a broader response framework, particularly where there are actual or potential links between state health agencies and developing countries (such as Queensland Health's role in providing services to PNG citizens in Torres Strait).

Overarching specific responses are broader development issues related to HIV/AIDS. As the Australian Government's agency of development aid expertise, AusAID remains central in providing policy co-ordination, and providing expertise in building capacity and monitoring and evaluating the impact of HIV/AIDS interventions.

3 Priorities for action 2005–2015

3.1 Building leadership momentum

3.1.1 *HIV/AIDS as a political challenge*

The success of HIV/AIDS responses in the region will be determined by action in the political sphere. This is more critical to reversing the spread of HIV/AIDS than action within any single sector. Leadership requires convincing prominent people in political life and civil society, including faith based groups and the business sector, to respond seriously and scientifically to HIV/AIDS. This is particularly challenging in communities where HIV/AIDS is thought not to affect the mainstream of society and indeed may as yet be largely restricted to populations that may be perceived as undesirable such as sex workers, drug users and men who have sex with men.

A common characteristic of these marginalised groups is that their behaviour is criminalised in most Asia Pacific countries, which adds a further dimension to the stigma of these populations and makes them difficult to reach with prevention and care programs (see 1.3 above). Leadership requires action to lead communities through difficult debates regarding controversial issues—to reshape community norms regarding sexuality, the legal status of vulnerable populations and the status of women in society. This is inherently difficult and requires skills and determination to navigate politically risky terrain.

National leadership on these issues needs to be driven at a high level, with the prime minister's office or equivalent taking direct responsibility for multi-sectoral coordination mechanisms for HIV/AIDS policies and programs. Leadership on HIV/AIDS needs to occur at local, district and provincial as well as the national level. National governments in some large Asian countries do not have the influence to drive agendas at provincial and district levels. Implementation of programs is often the responsibility of provincial and district administrations that may be insufficiently informed about HIV/AIDS. AusAID's country strategies need to therefore consider how action on HIV/AIDS by all levels of government can be supported.

Civil society, organisations of people living with HIV and AIDS, community based groups, NGOs, the medical and scientific community, faith-based

organisations, businesses, and the media all have important roles to play in creating a demand for better leadership and in holding governments accountable. These groups require support to raise awareness, advocate needs, disseminate information, and stimulate debate.

Australia has positioned itself as having a central role in promoting leadership on HIV/AIDS in the region through the combined efforts of Australian Government and civil society. The capacity of key players in the Australian HIV and development sectors to support leadership from within Australia on the regional epidemic will be enhanced if a mechanism is established whereby civil society can provide ongoing advice to the Australian Government on policy and strategy issues. Consideration should be given by AusAID to establishing such an advisory mechanism.

3.1.2   Building on the Asia Pacific Leadership Forum on HIV/AIDS and Development

Leadership initiatives taken to date such as the Asia Pacific Leadership Forum on HIV/AIDS and Development (APLF) have so far only been partially effective in mobilising the political will and resources required to mount an effective response. Building on the APLF's achievements, new models and approaches are required to support sustained national and regional leadership on HIV/AIDS and to develop a more systematic, high-level approach to leadership that encompasses civil society as well as government roles. Australia should continue to work in partnership with UNAIDS to build leadership in the region, and this should be supported by stronger direct working relationships between APLF and the Australian Government through AusAID, the Department of Foreign Affairs and Trade (DFAT) and relevant ministerial staff.

A priority should be accorded to building high-level commitment from political, business and religious leaders to comprehensive HIV/AIDS responses, especially in PNG and other Asia Pacific countries in which leadership on the issue is at best mixed but often invisible. Efforts need to focus at the country level and target countries where leadership on HIV/AIDS is weakest.

The Australian Government can also engage regional fora and sub-regional agencies such as the Association of Southeast Asian Nations (ASEAN), Pacific Forum meetings and the Secretariat of the Pacific Community (SPC) to support leadership on HIV/AIDS. On the global stage and through multilateral processes, Australia will need to continue to promote the distinctive nature of the Asian, PNG and Pacific HIV/AIDS epidemics. This includes needs that arise from the social, political and geographic characteristics of these subregions.

3.1.3   Evidence to support leadership

Leadership initiatives need to be based on sound political analysis, drawing on academic expertise in political sciences that supports a deeper understanding of political cultures in the region. Pathways of political influence on HIV/AIDS and development need to be understood. Within Government, the most appropriate ministers, advisers and senior bureaucrats need to be identified and supported in advocating the issue. This needs to encompass not only key personnel in the health portfolio but also other ministries including, critically, finance and the prime minister's office or equivalent.

Leadership also needs to be informed by experience of what works in persuading people to give higher priority to HIV/AIDS, in reducing stigma and in improving the social environment for people living with HIV/AIDS and affected communities. It may be important to define a metric of success against which progress in preventing escalation of the epidemic can be measured, for example by using a standardised prediction for each country in the region of the level that new HIV infections will rise to if no action is taken in a given period (Figure 1).

Effective leadership can be supported by establishing an incentive structure in which leaders are persuaded that the long-term benefits of engaging in the fight against the epidemic outweigh the short-term costs and political liabilities associated with championing what may be perceived as an unpopular cause. Leaders need to be persuaded of the necessity of acting on the basis of accurate medical, economic and social research evidence. Consideration of evidence of effectiveness can rapidly shift opinions by appealing to pragmatic political interests, such as the poverty and stability impacts of HIV/AIDS. Experience of harm reduction programs in Asia is that attitudes can, over time, be changed when evidence of effectiveness in reducing infections and the social and economic costs associated with HIV/AIDS is demonstrated.

Especially in the early stages of an epidemic, leaders will be more readily convinced to invest resources and attention to HIV/AIDS if they understand the epidemiological characteristics of HIV. This includes the long period of latency, the way it can spread explosively in vulnerable populations and then more broadly throughout the whole population, its incurability, the complexity of treatment, and the way HIV/AIDS interacts with and compounds the impact of other prevalent diseases.

The Australian Government should work with other donors and UNAIDS to ensure that political and civil society leaders in the region who are committed and effective in championing HIV/AIDS are supported. People or organisations that stand in the way of effective leadership on HIV/AIDS (due to religious or customary constraints, for example) need to be identified and their opposition negotiated so as to shift opinions.

To support its programs on leadership, AusAID should adopt a more systematic approach to drawing on political science expertise relevant to the region from Australia and internationally, including the expertise that exists outside of the HIV sector.

3.1.4   Parliamentarians

Parliamentarians are a key target group for leadership programs. Levels of basic knowledge about HIV/AIDS amongst parliamentarians are often low. Ministers working across diverse portfolios need to be educated on the nature and multisectoral impacts of HIV/AIDS and supported in advocating improved responses. Ministers responsible for issues such as rural development, crime and justice, trade, transport, and migration need to appreciate the potential effects of the epidemic on their areas.

Parliamentary groups provide a process for improving understanding amongst political elites and for identifying potential champions. Australia should support the development of regional parliamentary groups to support education of and by parliamentarians on HIV/AIDS and related issues such as sexual and reproductive health. Australia's own Parliamentary Group on HIV/AIDS should be supported in taking a more active role in raising the profile of issues surrounding the regional epidemic and in engaging with regional parliamentarians.

Action at the foreign ministerial level has been key to Australia positioning itself as a regional leader in HIV/AIDS responses. The ongoing engagement of the Minister and Parliamentary Secretary of DFAT in HIV/AIDS issues needs to be supported by the actions of leading diplomats, including ambassadors and high commissioners in the region and diplomatic staff engaged in multilateral discussions and debates. Australia needs to ensure that diplomatic staff are well briefed on HIV/AIDS and development, and equipped to play leadership roles for improved HIV/AIDS responses.

3.1.5 Community sector leadership

Building community sector leadership involves supporting advocacy groups representing vulnerable populations such as injecting drug users, sex workers and men who have sex with men. Identifying and supporting representatives of these communities to contribute to national HIV/AIDS responses is a vital part of leadership. Community based organisations contribute to leadership through advocacy, innovation and a watchdog role. Supporting links between community based advocacy groups throughout the region, including Australian organisations, can help build leadership capacity.

Australia's *International HIV/AIDS Strategy* commits to the principle known as GIPA—the Greater Involvement of People Living with HIV/AIDS—in all levels of decision making regarding policies and programs. This is important because of the knowledge and experience about the epidemic people living with HIV/AIDS bring, and also because their involvement helps ensure that people living with HIV/AIDS have confidence in and cooperate with decisions on policy and program options. Public involvement of people living with HIV/AIDS also helps break down stigma. Enabling people living with HIV/AIDS to adopt leadership roles, including through funding regional and national organisations and networks of people living with HIV/AIDS, is crucial to support peer based mobilisation. Governments need to provide a supportive environment in which people living with HIV/AIDS can participate in shaping national responses.

3.1.6 Employers and business sector leadership initiatives

The resources of the business sector should be harnessed to meet the epidemic's escalating demands. The capacity of this sector to influence the course of the regional epidemic through its own activities and influence on other players has been largely overlooked to date.

Business is already playing a significant role in responding to HIV/AIDS in Sub-Saharan Africa. In Asia Pacific, the spread of HIV/AIDS is associated with

economic activity and it is crucial to engage employers to support responses that address employee needs and to contribute to addressing the prevention and care needs of the broader community. In much of Asia the ready supply of labour means employers may not consider that HIV/AIDS poses a direct threat to workforce productivity. However business leaders need to understand the potential medium- and long-term impact HIV/AIDS will have on their businesses as a result of depletion of markets and increasing costs such as health care payments, insurance premia and training expenditures for skilled labour. Employer and labour organisations should be targeted, and greater use should be made of the regional International Labour Organisation (ILO) office in supporting business responses to HIV/AIDS.

Business leaders in key sectors such as media and mining also influence national political priorities and it can be effective to target business leaders to ensure HIV/AIDS is placed higher on political agendas. Lessons can be learnt from the work of national business initiatives on HIV/AIDS that have been established in Asian countries such as China and Thailand and the Asian Business Coalition on AIDS, which supports workplace programs in several countries in the region. A greater level of engagement is required, and the Australian Government should support a coordinated response to the regional epidemic from the Australian business sector. Australian businesses active in the region should be encouraged to adopt HIV/AIDS policies drawing on resources and experiences from the region.

3.1.7   HIV/AIDS as a core development issue

Australia's *International HIV/AIDS Strategy* commits AusAID to mainstreaming HIV/AIDS across its development cooperation activities. Beyond this, at the policy level, Australia needs to encourage counterpart governments of aid recipient countries to mainstream HIV/AIDS within their own policies and programs. This implies a conscious political choice to recognise HIV/AIDS as a key issue to be addressed in all development strategies aiming at economic growth and poverty alleviation. Mainstreaming HIV/AIDS across governments can only be achieved through political action. For mainstreaming to work, the finance and planning ministries controlling budgets and negotiating terms of foreign assistance must be encouraged to make HIV/AIDS a priority.

Mainstreaming efforts should adapt core business of sectors to the realities of HIV/AIDS, drawing on the comparative advantage of each sector in addressing different aspects of the epidemic and its social drivers such as poverty, gender inequalities, and violence. Mainstreaming should not necessarily involve all ministries or sectors, but should first focus on priority ministries and sectors relative to the transmission dynamics in each country. For example, in countries where drug use and sex work are major drivers of the epidemic, engaging justice, prisons, police, and social welfare sectors should be a priority.

To ensure that Australia's aid program incorporates HIV/AIDS-related development issues into the breadth of its bilateral work, the linkages between development and HIV/AIDS need to be woven into respective country strategies and approaches regardless of the presence or not of a specific HIV/AIDS activity. As a major development challenge, this recognition needs to be a core

element of each country strategy and preferably in the form of an individually crafted approach that accounts for local priorities and the mainstreaming activities of other donors.

3.1.8   Governance initiatives to underpin HIV/AIDS responses

Improvements to governance structures and training and support on implementing good governance principles are important for providing the foundation for effective national HIV responses. Good governance is important for creating an 'enabling environment' for effective programs. Australia should support the building of transparent, accountable and participatory health and community services in developing countries as essential elements of an effective HIV/AIDS response. Institutional capacity building in the health and education sectors and improved accountability for HIV related investments to minimise corruption in procurement activities are essential for effectively delivering HIV/AIDS programs.

Investment in governance programs enhances the capacity of governments to respond to HIV/AIDS through sound functioning institutions that support leadership and transparent decision making. Robust HIV/AIDS responses require processes by which society can discuss the health aspects of sex and drug use openly, and talk about condoms, injecting and sexual transmission of infections. Governance needs to include creating accountable HIV-specific mechanisms such as national AIDS councils. More generally, HIV responses will be supported by healthy democratic institutions and a free press to facilitate open dialogue, a strong and pluralistic civil society, freedom of expression and association, and an impartial and effective legal system. If HIV-affected communities cannot organise freely, register their associations, and deliver education to peers without fear of persecution, they will be driven underground and the chances of mounting an effective public health response to HIV/AIDS will be reduced.

Good governance means competent management of a country's public health and education resources in an open, transparent, accountable, and equitable manner which responds to peoples' needs. Good governance is critical to supporting community mobilisation and to meeting the political challenge of prioritising HIV/AIDS in government policies and programs. Fostering the development of civil society includes supporting community organisations such as women and youth groups and community media.

The architecture of HIV/AIDS policy and program development, such as national and provincial AIDS committees and planning mechanisms, will not function effectively without good governance principles. Community based responses to HIV/AIDS rely on effective mechanisms and institutions through which HIV affected groups can articulate their needs and legitimately influence allocation of resources, such as functioning national coordinating authorities and other consultative and advisory bodies. The HIV/AIDS response will also be strengthened by developing approaches in related policy areas such as drug control and law enforcement that encourage the involvement of affected communities in debates and decisions, allowing assessment of the potential HIV/AIDS impacts of policy choices.

Populations such as sex workers, illicit drug users and men who have sex with men may be held back from participating in planning and policy development because of fear of discrimination and legal repercussions. In some Asian countries these groups are unable to form associations or express their needs openly. The character of the epidemic is such that individual behaviour change and the transformation of social norms regarding sexual and injecting behaviours lie at the core of prevention. It is difficult, if not impossible, to secure these through coercion. Protection of the human rights of marginalised populations is essential to ensure these populations have trust and confidence in health authorities, come forward for testing, and access prevention, treatment and care services without fear of discrimination, police harassment or arrest. Anti-corruption and governance programs that make police more accountable may lead to more women reporting incidents of violence and more effective police responses to gender based violence.

Stigma is a major impediment to greater involvement of people living with HIV/AIDS. Very few people living with HIV/AIDS from Pacific or Asian countries are in a position to play a public role in the fight against the disease. In the few cases where marginalised populations have organised representative groups and become effective in influencing national policy (as in Thailand) this has tended to be through effective advocacy and use of media rather than a government facilitated process. Governments do not always accept or appreciate the important role people living with HIV/AIDS can play in contributing to policy development and planning.

The Three Ones principles provide a framework for strengthening country-led responses, but progress towards implementation is patchy in the region. In PNG, the National AIDS Council and Provincial AIDS Committees have been under-resourced and unable to operate effectively—central Government leadership has been mixed on HIV/AIDS and there is planning confusion. Indonesia needs to build a more robust central national coordinating mechanism for policy development relating to, and planning of, a country-wide response. In the Pacific, national coordinating authorities often struggle to maintain profile, political support and clarity of purpose.

The advent of GFATM has been welcomed but has added an extra level of complexity to governance arrangements. New GFATM structures such as Country Coordinating Mechanisms (CCMs) have not worked well in some Asian countries, although they generally provide scope for more participatory approaches. In PNG and the Pacific concerns have been raised that CCMs could duplicate national AIDS council functions. CCMs should be better harmonised with other structures.

The danger is that one-size-fits-all, inflexible models are unlikely to work in all national contexts. In some countries, national multisectoral councils or commissions and CCM processes may diffuse central government focus on HIV and marginalise the health sector at a stage in the epidemic when a robust health sector response may be critical for establishing surveillance and health workforce capacity. The role of the health sector should be enhanced, while simultaneously

strengthening other sectors to play a role in the national HIV/AIDS response such as police and education, as well as civil society and private sector responses.

3.2 Prevention

3.2.1 Prevention is for life: Comprehensive and sustained approaches

The global consensus is that, to be effective, country responses to the prevention of HIV must include a comprehensive range of policies and programs.[19] The response should include expanded access to condoms, education including by peers to address sustained behaviour change and combat stigma, harm reduction measures such as needle exchanges and drug substitution programs to address transmission through injecting drug use, programs addressing gender issues, STI treatment services, primary prevention for pregnant women, parent-to-child prevention programs, blood safety measures, and infection control in health care settings. Concentrated epidemics like those in much of Asia among sex workers, injecting drug users and men who have sex with men are eminently preventable at relatively low cost through well targeted interventions.

In the context of predominantly sexually driven epidemics such as those in PNG and the Pacific, aspects of HIV prevention should be integrated with sexual and reproductive health services and programs to address gender violence and sexual coercion. High STI rates significantly accelerate HIV epidemics. The presence of an STI can significantly increase the likelihood that a person will acquire and transmit HIV. STI testing and treatment services, and related education and sexual health promotion, are extremely important and often highly cost effective interventions for HIV prevention.

To respond to rapidly expanding epidemics, HIV prevention must be given a consistent, high-level focus. HIV prevention will not succeed on the basis of one-off awareness campaigns. Sustained prevention strategies must be multi-pronged and well targeted, involving and engaging communities at higher risk and people living with HIV/AIDS to review and renew educational messages to ensure that these messages work for vulnerable populations. Where HIV epidemics are nascent but likely to develop quickly unless immediate action is taken—as in Solomon Islands, Vanuatu and East Timor—there is a strong case to intervene with highly targeted prevention interventions. These need to be supplemented by interventions that address structural and contextual causes of vulnerability, such as income disparities and social exclusion of marginalised populations. To build a sustainable response, communities need help to identify the problems, skills and resources required to respond to the causes and impacts of HIV/AIDS.

Stigma and discrimination constitute a major barrier to effective prevention across the region and AusAID should identify opportunities for reducing these through its programs. For example, training for health care workers, teachers, prison staff, and drug rehabilitation personnel should include education to reduce stigma.

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[19] *UNAIDS Policy Position Paper: Intensifying HIV Prevention,* June 2005.

Integrating HIV, drug use and sexual health education into the curriculum of formal education systems (through life skills and healthy lifestyles) is a cost-effective way to reach young people in school. Education sector programs should be required to mainstream HIV/AIDS, to ensure that the education workforce is HIV/AIDS literate, that teachers are trained in HIV and sexual health education methodologies, that there is a non-discriminatory educational environment for teachers and students living with or affected by HIV/AIDS, and that there is access to accurate and appropriate teaching resources. Strategies for working with out-of-school youth in other settings, including culturally and faith-based youth groups, are also required.

3.2.2   Community mobilisation to underpin prevention

Priority should be given to expanding HIV programs for populations at increased risk in Asia Pacific. Governments often have little expertise and minimal credibility in changing community values in areas of intimate personal behaviour, including sex and drug use in socially and legally marginalised populations. Therefore community mobilisation for prevention is necessary through NGOs and community groups representing affected populations. HIV affected communities such as sex workers, drug users and men who have sex with men can play an important role as peer educators and advocates for prevention. Visibility and participation of people living with HIV/AIDS in prevention is also crucially important. Efforts to combat stigma and discrimination affecting these groups will support their involvement in prevention. Community activism can ensure high levels of support for, and uptake of services by, affected communities. The energy of these groups needs to be harnessed to greater effect. However, across the region the capacity of civil society groups to participate in debates and decisions regarding national and provincial HIV/AIDS responses is often limited by resource constraints, and lack of a well defined role.

In many countries in the region, community mobilisation is impeded by legal and political constraints or lack of a strong indigenous community based sector within which HIV programs can be located. Some countries in Asia have single party systems and civil society is restricted in its influence on government policy. In many Pacific countries and PNG there are few community based groups able to play a role in prevention outside of the Church sector, which is likely to remain central to the community response. Investment in capacity building for community based groups and promotion of policy reform to support growth of a vibrant community sector are important to underpin effective prevention with poor and marginalised populations.

Developing effective HIV responses requires engagement of government and civil society with complex, controversial and sensitive issues. In Australia and other countries that have mounted successful HIV responses, policy development and program implementation has been supported by vigorous political and community debate. Community organisations in Thailand and Indonesia are already important players in shaping the national response in their countries and more recently in China and Vietnam new civil society groups have emerged that are advocating needs to government and mobilising communities to expand the response.

Greater use needs to be made of new communication tools and technologies. The media, for example, can develop novel communication approaches for HIV prevention such as narrowcasting of targeted messages to specific populations. Prevention strategies need to be informed by an understanding of the political environment that dictates what is culturally acceptable. Political decisions regarding HIV prevention and vulnerable populations are sometimes not made on a rational basis. To address this, new media can be used to educate about the realities of HIV/AIDS and to promote an evidence-based approach whilst working within contextual constraints and political realities.

3.2.3 Harm reduction

Australia should support comprehensive harm minimisation frameworks that address illicit drug use through a range of measures that encompass demand and supply reduction, as well as harm reduction for HIV prevention.[20]

Harm reduction measures such as needle exchanges, peer education and outreach to injecting drug users have been highly effective in HIV prevention. Harm reduction approaches should be part of a broader set of approaches appropriate for health promotion and illicit drug use prevention (which includes the full range of treatment programs—including drug substitution treatment and abstinence based programs, and equitable access for drug users to education, testing and treatment services for STIs and HIV, preferably in a context of accessible primary health care). Drug substitution programs—such as methadone or buprenorphine maintenance—can be highly effective for HIV prevention in resource poor settings, due to the reduction in HIV transmission that results from reducing injecting, and the opportunities for counselling and education. Programs addressing HIV and illicit drug use should recognise that people who use drugs have complex prevention, care and support needs that should be addressed to reduce drug related harms to individuals, their families and communities.

Australia has a strong track record in harm reduction programs in South-East Asia and China and plays a leading role internationally in drug control and harm minimisation policy and programs. Australia has also been highly successful in engaging the police and justice sectors to work with the health sector to deliver harm reduction programs in countries such as Myanmar, Vietnam, China, and Indonesia. This approach should continue. Neglected areas requiring greater priority include preventing HIV in prisons and addressing the role non-injectable drugs such as amphetamines, cannabis and alcohol play in HIV transmission. Alcohol plays a major role in the incidence of sexual violence in many Pacific Island communities.

In the harm reduction field Australia risks becoming a minor player if it concentrates only on program funding. Program funding and promoting good practice are important, but it may be more strategically significant to concentrate on expanding Australia's role to providing technical assistance on harm reduction and other aspects of illicit drugs policy and programming. Australia has high

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[20] Australia's *National Drugs Strategy: Australia's Integrated Framework 2004–2009* defines a conceptual model that positions harm reduction alongside supply and demand reduction efforts as three components of a broader 'harm minimisation' framework.

levels of technical expertise in training and capacity building for drug policy development, education and information, demand reduction, and drug treatment. Work with national authorities on HIV prevention among people who use illicit drugs can also result in strengthened partnerships with those responsible for narcotics control and other related transnational issues such as terrorist networks, people trafficking and arms trafficking.

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Australia is also in a key position to assist in the development of policies that reduce the impact of the HIV and drug epidemics in Asia by integrating responses to HIV and drug use with broader development goals and processes. Consideration needs to be given to the impact of broader strategies for social and economic development on the prevention or amelioration of vulnerabilities to illicit drug use. Awareness of the role that social and economic development processes can play in creating or worsening vulnerabilities should inform development thinking. Through its involvement in harm reduction and law enforcement capacity building in the region, Australia is well placed strategically to advocate the need to link these agendas, provide forums for their development and model them in action.

3.2.4   Enabling law and policy environment for prevention

An essential component of successful prevention is an enabling and supportive policy and legislative framework. A common issue faced in the region is the lack of a regulatory environment to support ready access to prevention technologies, including condoms, lubricant and needles and syringes, especially in high-risk settings where sexual activity and injecting are commonplace. Laws that criminalise behaviours of sex workers, drug users and men who have sex with men may need to be amended to ensure HIV prevention and health promotion services are provided without risk of prosecution or police harassment. Law and policy reform are also important to ensure a non-discriminatory environment for people living with HIV/AIDS and for vulnerable populations that experience stigma.

Australia has developed internationally recognised expertise in regulatory approaches and reform to criminal and public health laws in areas such as testing and notification, contact tracing, confidentiality, discrimination, occupational health and safety, sex industry regulation, quality control of condoms, and regulation of the distribution of needles and syringes. Australia has experience in drugs policy frameworks that encompass HIV prevention through pragmatic and humane approaches. Australia should capitalise on its capacity to offer technical assistance in legislative and regulatory frameworks for HIV/AIDS. Australian expertise enabled PNG to enact model HIV/AIDS legislation.[21]

3.2.5   Prevention in the age of Antiretroviral Therapy

Australia should continue to support a balanced approach to allocating resources to treatment and prevention. These are closely interrelated and should be positioned as elements of a continuum of interventions.

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[21] *HIV/AIDS Management and Prevention Act 2003,* PNG.

In low prevalence countries such as Pacific Island states, prevention should be an overall priority. However, with low patient caseloads universal ARV treatment is affordable and should also be available. The availability of ART has been shown to strengthen the prevention response in some settings such as Haiti and South Africa. The availability of ART and care and support services can help break down stigma and provide a strong incentive for people to seek HIV testing and to access behavioural counselling and advice. People diagnosed with HIV are an important target population for prevention education. Information and peer education about safe sex and drug use for people living with HIV/AIDS form an important part of a comprehensive prevention approach. Care and support provided to people living with HIV/AIDS helps provide a supportive environment for prevention work.

Scaling up treatment, care and prevention—as opposed to focusing on only one aspect—will lead to greater benefits in reducing new infections and averting deaths. Epidemiological modelling shows that expanding care activities with prevention in a comprehensive manner can dramatically reduce the resource needs for treatment over the long term. Treatment makes prevention more effective, while prevention makes treatment more affordable.[22]

For populations experiencing high HIV infection rates treatment access provides new opportunities for HIV prevention as a result of the increased accessibility of affected groups to health promotion services. When ARV treatment is taken up broadly in an affected population there are also preventive benefits due to the lowering of the level of virus circulating in the community (community viral load).

However, the availability of treatment may also have a negative impact on prevention, particularly if resources are diverted from community based prevention programs to fund testing and treatment. Improved access to treatment is sometimes associated with an increase in risk taking behaviour since some people at risk may assess unsafe sex as carrying less personal risk. This underscores the need to maintain vigorous prevention programs to forestall an increase in risk taking. Another risk associated with treatment scale up is that prevention services are increasingly located in clinical settings. Although there are benefits associated with integrating some prevention services with testing and treatment services (for example, to reach newly diagnosed people), this should not detract from the need to expand prevention services such as peer education and access to condoms and clean needles in a variety of accessible, non-clinical community settings.

ARV availability is also essential for effective mother-to-child transmission prevention (PMTCT) programs and for providing post exposure prophylaxis (PEP). Australia has technical expertise in administering ARVs for PMTCT and PEP. This expertise should be used to implement PMTCT programs targeted to the most vulnerable groups, and PEP for those who may have been exposed to HIV (such as survivors of sexual assault and health care workers in resource poor settings).

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[22] Salomon, J et al 'Integrating HIV prevention: from slogans to impact', *PLoS Medicine*, Vol 1, Issue 2, January 2005.

3.2.6   *Developing an evidence base for effective prevention*

Prevention resources must focus primarily on populations where infections are occurring. HIV surveillance is critical to ensure that prevention investments are appropriately targeted. Lack of capacity to track the path of the epidemic through timely serological and behavioural surveillance is a common issue for all Asia Pacific countries. Prevention needs to be informed by improved surveillance and social research, including behavioural, sociological, ethnographic and political research.

Evidence of effective behaviour change interventions in specific cultural settings is a priority. Australian expertise in epidemiology and behavioural sciences should be better used to respond to regional epidemics. Socio-cultural research gaps (such as addressing gender, tackling prevention within the context of traditional cultures and taboos, transferring learning where appropriate from Africa, Brazil and elsewhere) and surveillance challenges need to be identified and addressed.

Biomedical prevention approaches such as the development of microbicides, increased use of antiretroviral treatments in prevention and the possibility of a low efficacy first generation HIV vaccine may emerge as important issues in the medium term. Australia has expertise in clinical, social and behavioural research that can support the implementation of these new prevention technologies. Researchers should be encouraged to integrate or link biological and behavioural research so the implications of new developments are better understood.

3.2.7   *Blood safety and infection control*

There is a continuing need to prevent HIV transmission through blood products and Australia could play a greater role in providing technical assistance and capacity building to ensure that blood safety screening processes and blood bank services are implemented. Through the National Serology Reference Laboratory, Australia has developed expertise in quality assurance systems for screening procedures for HIV and other blood borne viruses. Australia already plays a role in quality assurance for laboratories and in improving occupational health and infection control standards in health care workplaces and should build on this expertise.

3.3   Treatment and care

3.3.1   *Towards universal treatment access 2010–2015*

The past five years has seen significant advances in effective ART delivery in resource poor settings. There is increasing demand for sophisticated treatment regimes in resource and capacity poor settings. Several donors may be supporting parallel efforts to scale up treatment and care, often through vertical programs that stand outside government health systems. This can result in diverse approaches to treatment delivery that may not be sustainable.

AusAID should work through partnerships to facilitate access to HIV/AIDS treatment by all people who need them in the Asia Pacific countries that receive Australian aid. Improved access to existing drugs for ART and prophylaxis and treatment of opportunistic infections, as well as access to new drugs and

diagnostic and therapeutic technologies, is vital in dealing with the complex and changing nature of HIV/AIDS. More effective use of fixed dose ARV drug combinations and developing and implementing simplified and standardised approaches to treatment, including patient monitoring, is an immediate priority which needs to be supported by standardised training in ART delivery for health care workers.

In addition to ART, treatment and care needs that are poorly met in the region include prevention and management of tuberculosis, addressing reproductive needs, home and community based care, palliative care and funeral support, psycho-social support and management of paediatric HIV infection.

Treatment and care scale up strategies should be led by communities. Community preparedness measures such as treatment education are a necessary prerequisite to successful scale up. The experiences of people living with HIV/AIDS can help to improve the quality and acceptability of treatment and care by giving insight into how the uptake of services and adherence to drug regimens can be supported at the local community levels. Clinical centres need to explore options for fostering community involvement such as peer support groups, participation of community members on advisory boards or centre management, and involvement of people living with HIV/AIDS in counseling, support and treatment education. Community members working in partnership with health care workers should help to plan and implement treatment and care scale up strategies.

Australia needs to work at the country and sub-regional level in Asia, PNG and the Pacific to support nationally led treatment, care and support responses that:

- involve people living with HIV/AIDS and affected communities in decision making
- coordinate public sector, NGO, faith based, and private sector service provision
- address gender equity and equitable access for marginalised populations such as drug users, sex workers and men who have sex with men
- help strengthen the systems that deliver health services
- strengthen procurement and supply management systems for drugs and diagnostics
- provide treatment education and peer support services particularly addressing adherence issues, for people living with HIV/AIDS
- address stigma and discrimination in the health sector by educating care and support workers and addressing occupational health and safety concerns
- link HIV clinical services to treatment, care and support services addressing other needs commonly confronted by people living with HIV such as mental health services, STI services and reproductive health services
- encourage governments to build treatment costs into their national budgets
- promote alignment at the country level and harmonisation at the international level.

A first step is to work with governments and other stakeholders to support informed policy choices about treatment through assessing opportunity costs, cost effectiveness and the long-term financial implications of investments. Governments need to factor some HIV treatment costs into their own health budgets and not rely entirely on donor resources and GFATM grants.

Public-private partnerships should be encouraged where they have the potential to expand access to treatment and care and improve service coordination.

Treatment delivery in poor countries that have only rudimentary primary care services such as PNG will only be achieved through an intensive and long-term program of capacity building and health sector workforce development. In the short term, models of treatment delivery can be implemented that are simple and incorporate a basic care package including standardised ART, and prophylaxis and treatment for the most common opportunistic infections. These models can then be built upon as capacity improves in the medium- to long-term.

Capacity building is challenging and requires significant investment in training, adapting and reviewing treatment protocols, and upgrading laboratory capacities. Building ART delivery capacity will in many cases be an important entry point for developing primary care capacities for treating and preventing other prevalent diseases such as hepatitis, TB and malaria, and for improved maternal and child health care services. New models that integrate HIV and TB services should be developed, and the service delivery implications of the relationship between HIV, TB and reproductive health services needs to be better understood. There is likely to be pressure to justify the allocation of funds to HIV/AIDS at the apparent expense of TB and malaria, which in many countries in the region may represent greater current causes of morbidity and mortality than HIV/AIDS.

Injecting drug users in Asia have very high rates of co-infection with hepatitis C and/or hepatitis B, which complicates treatment options and can lead to higher rates of illness and deaths. The prospects of affordable treatment for hepatitis C remain remote. Investment in improving clinical management approaches for co-infected patients will be important in the Asian context.

3.3.2 Treatment scale up in PNG and the Pacific

GFATM funding to PNG and the Pacific provides opportunities to begin widespread testing and treatment programs, however this will only be feasible with parallel efforts to strengthen health systems including at the primary care level.

Since the Pacific has a relatively small but highly dispersed population of people living with HIV/AIDS, universal access to ART and prophylaxis and treatment for opportunistic infections in the sub-region is achievable in the short- to medium-term. Consistent with G8 commitments to support efforts to reach universal access to HIV/AIDS treatments by 2010 in Africa, Australia should work with other donors—particularly the Asian Development Bank (ADB), New Zealand and France—to achieve a target of universal HIV/AIDS treatment access by 2010 for all Pacific Island states.

One option to consider is establishing a Pacific Trust Fund that supplements the GFATM to support drug procurement, delivery systems, surveillance and Voluntary Counselling and Testing (VCT). Australia could explore this option if supported by other key donors and the SPC. In so far as this may mean that Australia contributes to financing ARV procurement directly rather than through GFATM contributions, this would be a diversion from the position established by Australia's existing *International HIV/AIDS Strategy*, which is that ARV procurement is best financed through global mechanisms and government negotiations with pharmaceutical companies. One possibility would be to fund the establishment of a regional procurement mechanism using GFATM funds to purchase ARVs.

For PNG, ART roll out is challenging particularly in rural and remote areas. ART delivery is only feasible in the medium term provided there is sustained and significant investment in building the capacity of health delivery systems and the health care workforce. Not only is there a lack of clinical facilities and lack of trained medical personnel, but immense difficulties are presented by geographic isolation, poor transport links, lack of basic storage facilities for drugs, and poor management of the supply chain for medical goods with a risk of essential drugs being diverted. Investment in ensuring secure supplies of essential medicines for HIV/AIDS and Opportunistic Infections (OIs) and diagnostics is a priority.

Advancing ART roll out in PNG will require Australia to provide substantial ongoing support to ensure that GFATM investments are well managed, that health system capacities are built, that essential medicines are regularly supplied, and that health sector workforce gaps are filled. Models for primary care provision, in which integrated services offer HIV testing, reproductive health services (including STI testing and treatment), ART, and TB testing and treatment, are required.

Australia may need to consider placing medical personnel in the field in PNG for lengthy periods before local systems reach sustainable levels of operation. To support this, Australia should consider establishing long-term partnerships between state and territory clinical centres in Australia and PNG hospitals and clinics. The role of the Church in supporting treatment and care sustainability needs to be factored into a treatment scale up strategy for PNG.

3.3.3   Treatment and care of children

Paediatric care needs are a neglected area that will require greater investment. Responses to children's treatment and care needs should include:

- Measures to promote greater availability of low cost tests that allow early diagnosis in infants, child-friendly ARV drugs, and training of health care workers in paediatric care
- Ensuring that women and couples who know they have HIV have access to advice and interventions to reduce the risk of transmission of HIV to babies
- Integrated interventions to protect women from infection during pregnancy and the post-partum period when they are more susceptible to infection, and have a higher risk that HIV will pass to the baby

- Careful planning of voluntary antenatal testing and PMTCT programs that include treatment, care and support interventions for those who test positive and their families
- Population based strategies that take into account that most women do not know their HIV status, including promoting the nutrition and health of pregnant women, and supporting all women in developing countries to exclusively breastfeed for six months.

3.3.4 Human capacity development for treatment and care scale up

Focus is required on strengthening the capacity of health systems, especially to ensure there are enough trained health workers to deliver treatment and care in urban and rural areas. Health workers in the region are concentrated in key urban areas that constrain efforts to increase national ART coverage. Workforce training requires the development of simplified and easily deliverable training on HIV medicine and care issues. HIV care does not have to be doctor driven in every setting. In poor rural areas, for example, nurses can be trained as clinical officers so they can test and monitor ART.

Labour mobility and the impact of the brain drain from the region to Australia, New Zealand and other OECD countries needs to be included when assessing the capacity of the medical workforce to tackle expanding epidemics. Australia's recruitment practices in the health care sector should not exacerbate developing countries' human resource constraints.

Investment in training is required to support simplified testing strategies and the implementation of simplified treatment protocols. Strengthening the relationships between medical and scientific societies in the region can support capacity building, and Australian professional organisations (such as ASHM and medical colleges) are well placed to play a role in professional education and disseminating best practice. Train-the-trainer programs are required for nurses, pharmacists and doctors. Training is also needed at a managerial level for laboratory and clinic managers who may have little previous experience in how to employ, keep, mentor, and manage staff. Other training needs include data management, networking of services and training of engineers to maintain medical equipment.

Australia should continue to support regional approaches to investing in capacity building in public health and HIV/AIDS in the Pacific. This requires selecting focal points for investment and building on the work of the Pacific Regional HIV/AIDS Project and the SPC. Centres of expertise need to be developed in such fields as disease surveillance, testing and laboratory technologies, HIV medicine and clinical service standards, and culturally appropriate treatment education approaches.

In Indonesia and PNG, workforce capacity building needs to be tailored to national contexts. In PNG capacity building will need to be conducted largely by Australia and with the expectation that the Australian Government and professional and NGO agencies will play a significant role.

In some Asia Pacific countries, Australia may not be active in the health sector but may be able to influence other donors and multilateral agencies to place a greater priority on health sector workforce development that supports treatment scale up.

In addition to technical skills, investment is required in building managerial skills in the region. The high turnover of managers of national and provincial AIDS control programs impedes scaling up prevention and care programs. Many countries do not have an adequate number of public health managers to implement large-scale programs. Creating capacities in institutions of excellence for training of public health professionals will support sustainability of program implementation.

3.3.5   Testing and monitoring

Improving treatment access is linked to expanding HIV testing and clinical monitoring services, and opportunities for secondary prevention with people newly diagnosed. Different testing and monitoring models are needed according to local capacity and constraints on accessing laboratory services operating at the appropriate standard. Investment in laboratory upgrading is important for effective prevention and treatment. Laboratory delays can significantly impede the prevention of mother-to-child transmission through ARV prophylaxis. Investment is required in transfer of appropriate technology to allow effective and affordable laboratory services.

Australia should continue to support confidential Voluntary Counselling and Testing (VCT) as the preferred approach for testing in the region (as is the standard in Australia). VCT will generate community confidence in HIV services and attract populations most at risk into testing, as compared to models of mandatory testing without full consent. If routine testing models are introduced—such as the 'opt out' approach for testing all pregnant women— great care is needed to ensure that such models are not used as a back door mechanism to enable mandatory testing. Principles of confidentiality and fully informed consent should not be compromised, and protections from the adverse social consequences of an HIV diagnosis such as discrimination should be in place. Australia should also support expanded access to rapid testing technologies and improvement of laboratory capacities to enable more accurate and speedy HIV diagnostic services. The availability of point-of-care, rapid HIV testing, and low cost and low technology CD4 tests is important to support treatment roll out.

3.3.6   Access to affordable treatments and trade policy

Australia needs to maintain a policy agenda that supports expanded access to affordable HIV medicines in developing countries (for example, in its position on WTO trade rules such as the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and in trade and investment agreements that affect access to medicines in poor countries). Australia should support ongoing efforts through multilateral systems to reduce HIV drug costs, particularly for new ARVs. This will increase in significance as new HIV drugs enter the market that are not available from generic suppliers. Competition from generic medicines has helped reduce the price of existing ARTs. New HIV drugs are essential for

effective 'second-line' combination treatments that are required where more affordable first-line combinations fail due to emergence of drug resistant strains of HIV.

3.4   Gender and feminisation

Responding to the feminisation of the HIV epidemic in Asia Pacific is a key medium-term challenge for the aid program. This involves considering the social roles played by men and women that influence HIV risk behaviour, the role of women as carers, and the factors that contribute to the vulnerability of women and girls to poor sexual and reproductive health outcomes.

Approaches to HIV prevention based on the ABC model ('Abstain, be faithful, use condoms') are likely to be limited in protecting women from HIV/AIDS unless broader contextual issues are also addressed. Prevention programs need to focus on individual risk taking and on the social and cultural factors that determine vulnerability to HIV/AIDS, such as the power men have over women and girls due to economic factors and traditional social roles. Prevention programs must recognise that the capacity of women and girls to negotiate safe sex is constrained by power relationships—their economic wellbeing and personal safety may be threatened if sex is refused or an attempt made to insist on using condoms. Addressing gender comprehensively requires investing in interventions that target men and boys and address aspects of masculinity that determine social roles and behaviours, as well as programs targeting women and girls.

Increasing women's access to condoms, education, health care, support, safety, and justice all contribute to reducing HIV vulnerability. However, to achieve a lasting turnaround for women, a gender-sensitive approach to HIV/AIDS requires a better understanding of how male social roles, patterns of male mobility, and concepts of masculinity in different cultures contribute to HIV transmission and gender-based violence. This understanding then needs to inform the engagement of men and boys in HIV prevention.

AusAID should assess how development interventions can challenge and change social norms to promote gender equality. Changing attitudes and behaviours towards women and girls needs to begin during school education. It also needs to be addressed more broadly in the community through incorporating gender issues in leadership initiatives and by supporting advocacy by women on sexual and reproductive rights, including by women living with HIV/AIDS.

Promoting gender equality through reforms to laws and social policies can provide an environment that supports improvement in sexual health for women and girls. Reforms to property laws, inheritance laws and changes to traditional norms governing the status of women enable women to contribute to economic life outside the domestic sphere. Promoting economic independence places women in a stronger position to negotiate safety in sexual and interpersonal relationships and thereby reduces vulnerability to gender based violence, sexually transmitted infections and HIV/AIDS.

Australia should support research into the links between gender-based violence, HIV vulnerability and sexual and reproductive health outcomes. Australia should also play a greater role in promoting female controlled methods of HIV and STI prevention for resource-poor settings (for example, female condoms, other barrier protection methods, and microbicides). Programs are required to respond to the needs of women and girls living with HIV/AIDS, including equity in access to treatment and care services and consideration of protection from discrimination, social ostracism, homelessness, and violence as a result of known HIV/AIDS status.

Service delivery models that support greater equity for women in access to HIV/AIDS prevention, care and support services are needed. Integrating HIV services with sexual and reproductive health services should aim to achieve higher levels of uptake of prevention and testing services by women and girls.

Investing in girls' education helps address key factors contributing to the feminisation of HIV—early marriage, economic dependency and limited knowledge of HIV/AIDS. Educated girls tend to marry later and are less likely to be economically dependent.

A gender-sensitive approach to HIV prevention and care is also critically important for addressing the needs of transgender populations. HIV vulnerability of transgender populations is exacerbated by discrimination, social ostracism and violence, as well as lack of prevention messages and HIV services tailored to their needs. Social constructs of masculinity often exacerbate the vulnerability of transgender populations to a range of health and personal safety threats including sexual violence. HIV and sexual health services need to explicitly consider the needs of transgender populations. Social research and behavioural surveillance should address issues confronting transgender populations.

3.5 Whole-of-government coherence

Improved coherence of the Australian approach to HIV/AIDS in the region can be achieved through a whole-of-government framework that coordinates efforts of relevant government agencies (Section 2.7). Diplomatic posts should be encouraged to engage with counterparts in raising HIV/AIDS as a high-level political issue, not just a health issue.

As the government's agency of development aid expertise, AusAID remains central in providing policy co-ordination, expertise in building capacity and monitoring and evaluating the impact and durability of HIV/AIDS interventions. AusAID should adopt a more proactive and pivotal role in coordinating and leading a whole-of-government policy response to HIV/AIDS globally and through program delivery in the region.

3.6 New ways of working

3.6.1 Rapid response capabilities

AusAID's HIV/AIDS assistance has traditionally been delivered through time-limited projects managed by Australian Management Contractors. Projects have

been tied to outputs and outcomes, which in some cases has constrained projects, preventing them from responding to changing circumstances. It also means projects have tended to take a short-term view or have been at odds with long-term, local program directions. Since responsibility for project implementation has rested with the Australian Management Contractors, it has sometimes been difficult to generate ongoing local ownership in a project and achieve sustainable outcomes.

In AusAID there has been a shift away from traditional project delivery mechanisms to program responses such as Sector-Wide Approaches (SWAPs) in the health and education sectors. This is desirable for achieving long-term developmental goals. However, in the context of rapidly expanding HIV epidemics Australia needs to develop the capacity to implement more interventionist responses for areas with acute needs. Vertical, stand-alone interventions can weaken national systems and responses. Therefore emergency responses need to be accompanied by efforts that focus on strengthening health systems and build a strong supportive environment.

A twin-track approach of responding to immediate needs and building capacity for long-term responses is required. If local governments lack the will or capacity to respond to HIV in an effective and timely manner then, at least in the short-term, aid interventions may need to work through NGOs or establish new service delivery models parallel to public sector health services.

The aid program needs to have a more diverse menu of effective and responsive aid delivery options at its disposal. Direct project-style interventions and long-term, programmatic approaches each have benefits and problems. For HIV/AIDS, it is increasingly evident that Australia needs the capacity to intervene with rapid responses directed at critical focal points of emerging epidemics.

Radical approaches are required when existing systems are failing or are clearly inadequate. In settings such as PNG, emergency action against HIV/AIDS is called for, but the nature of this emergency is long-term. It is necessary therefore to consider how to institutionalise an emergency response. This may require placing technical experts in line agencies in recipient countries for substantial periods of time to ensure that effective delivery occurs without delay, as well as to build longer-term local capacity. Such interventions are costly in the short term but may prove highly cost effective in the long term if the result is to forestall a major epidemic.

3.6.2 *Harmonisation and collaborative approaches*

Fragmentation of HIV responses due to increasingly diverse sources of aid for HIV/AIDS is a major issue for many countries. To reverse this trend, Australia will need to:
- actively explore opportunities for strategic collaboration with other donors

- build on the Three Ones commitments and translate them into action, within the framework proposed by the *Report of the Global Task Team on Improving AIDS Coordination*[23]
- channel more support through multilateral partners in line with commitments to harmonisation
- work more closely with multilateral institutions, in particular GFATM, ADB, SPC, and UNAIDS and its co-sponsors the World Bank, UNDP, UNFPA, UNODC, UNICEF, ILO, UNHCR, UNESCO, WFP and WHO
- strengthen the ability of multilateral organisations to support effective national action by increasing harmonisation and donor coordination, and providing high-level technical assistance.

Through its harmonisation work, AusAID should argue for increased international emphasis on HIV/AIDS in Asia Pacific, especially in Melanesia. Support for developing quality operational plans for implementing national HIV/AIDS strategies is an important prerequisite for harmonisation since it provides the common reference point for harmonisation efforts. Working more collaboratively will also involve:

- private-sector partnerships
- technical support through research partnerships and workforce development programs
- pooling of resources with other donors where this will support harmonisation and more effective programming.

Consideration should be given to harmonising donor efforts through pooled funding mechanisms that channel bilateral and multilateral support on HIV/AIDS, thereby reducing the aid transaction burden on recipient governments. It will be difficult to harmonise aid programs and priorities fully when donor funding is conditional, given that such conditions may relate to other donors' domestic political considerations rather than to evidence of what works.

Australia should continue to support the GFATM and advocate for improvement of its operations so its systems promote national ownership and are characterised by simplified, rapid and transparent processes. Developing the absorptive capacity of public and community sectors is the greatest current challenge in ensuring that new funds provided by the GFATM flow through to programs in Asia Pacific. GFATM is not proving effective in some Asia Pacific countries because of the lack of country capacity to manage and spend new funds effectively and under complex GFATM requirements. Australia can help to address this through supporting countries to prepare applications and comply with monitoring and reporting requirements. Through representation on GFATM's governing Board Australia can support the adoption of a more calibrated approach that responds to different country needs and encourages cost-effective use of funds.

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[23] *Global Task Team Report on Improving AIDS Coordination Among Multilateral Institutions and International Donors*, UNAIDS, 2005.

Australia should also explore the potential benefits of developing responsive and flexible funding mechanisms for specific HIV-related needs that might be more appropriately addressed through donor coordination outside the GFATM process.

3.6.3 Policy engagement

Well targeted policy interventions can achieve significant change as a result of relatively small investments. Lessons learnt from frontline delivery need to be systematically fed back into policy interventions. Priority should be accorded to supporting policy development at the national level, and this should encompass HIV issues across diverse portfolios such as justice, welfare, transport, migration, and health. Policy support at the regional level can be provided through assisting regional bodies such as ASEAN and the SPC. Particularly in Indonesia and other large Asian countries, provincial governments should be offered technical assistance in HIV/AIDS strategy development and related policy issues. Australia is well placed to play a leading policy role in the HIV aspects of illicit drugs policy, bridging health, corrections, and justice policy issues.

3.6.4 Research and practice partnerships

An expanded and continuously improved evidence base is essential to the success of the Australian aid program's HIV/AIDS response. Delivery requires investment in long-term partnerships with research institutes, development practitioners and HIV/AIDS agencies in the region. The Australian Government should promote stronger links between national HIV/AIDS responses and domestic HIV/AIDS expertise.

Greater focus should be given to long-term research and practice partnerships. Generating an evidence base for planning, policies and programs requires stronger links between Australian research institutions and regional and international centres. The aim should be to develop centres of regional research excellence in HIV/AIDS and development that directly informs policy and practice. To ensure long-term sustainability in responding to HIV/AIDS and other health threats, a research strategy should build research capacities in PNG, the Pacific and South-East Asia, in the clinical, epidemiological, behavioural, and socio-cultural research fields.

Priorities for research include:
- epidemiological and behavioural surveillance
- the cultural, economic and political dynamics that are driving the epidemic
- the nexus between HIV/AIDS, poverty, economic activity, and development
- Asian and Pacific experiences of feminisation and gender impacts.

In the prevention sphere a key emerging issue is the impact of biomedical prevention methods on behavioural prevention approaches. In the treatment sphere areas of research that support ART scale up include operational research on ART protocols suitable for resource poor settings, the impact of integrating prevention and treatment services, constraints on ART and VCT uptake, viral resistance, and adherence and treatment education needs and services. Population-based ARV resistance studies can provide evidence of the success of

training of health care workers in ART delivery, adherence by people taking ART, and the effectiveness of monitoring.

Research into quality of life issues affecting people living with HIV/AIDS is essential to ensure that there is an understanding of the complexity and diversity of psychosocial needs, including such issues as wellbeing, mental health, experiences of discrimination and social connectedness.

Models of research that actively engage communities in developing and participating in research should be supported. Communities in which research occurs should be supported in participating not just as research subjects but as partners who can inform the definition of research questions and the design, management and practice of research. Greater attention need to be given to the ethics of HIV research in resource poor settings and the necessity of community participation in research decision-making. This is particularly important given the history of criticism of the ethics of HIV clinical trials in developing countries and concerns regarding consent issues that arise in HIV surveillance.

In addition to maintaining its role in the social and behavioural sciences relating to HIV, drug use and sexual health, Australia is likely to continue to play an important global role in basic science and clinical research relating to HIV/AIDS. The Australian Government can fund this research through National Health and Medical Research Council grants, ARC grants and the work of the National HIV Research Centres.

It may be important for Australia's medium-term response for the Government to consider how new support or incentives (for example, through the tax system) can be provided to Australian researchers in developing new prevention technologies for use in developing countries, particularly microbicides. A female-controlled method of STI and HIV prevention could be highly beneficial in the PNG and Pacific contexts where women's low social status is a critical factor in vulnerability. Australian biotechnology companies are already involved in microbicide research. The potential for Australia to contribute to public-private partnerships to support clinical testing of products in developing countries in our region, with the support of agencies such as the International Partnership for Microbicides, should be investigated.

3.6.5 Regional capacity development strategy

AusAID should develop an Asia Pacific HIV/AIDS Capacity Development Strategy to enable Australia to build on its skills and expertise to strengthen technical and workforce capacity issues in the region. The goal of the strategy would be to assist communities, health systems and governments to rapidly develop the capacity to build a workforce to implement HIV responses in priority areas. The strategy would make expertise in Australia available in a strategic and systematic way, and should aim to build capacities through five-to-ten-year frameworks. The Government should invest in a business development model to mobilise Australian technical and training expertise for workforce development. This may require developing a mechanism for seed funding of programs in specific areas.

Australia should focus on areas in which it has a comparative advantage, including:

- clinical, epidemiological, social, behavioural. and economic research capacities
- HIV medicine, laboratory technical skills and transfer of medical technologies
- STI control including testing, treatment and education strategies
- infection control
- harm reduction for injecting drug users
- HIV prevention and sexual health promotion needs of sex workers and men who have sex with men
- working with people living with HIV/AIDS groups on advocacy, care, support, and prevention
- law and justice sector responses to HIV/AIDS that provide an enabling environment for health promotion
- developing leadership and policy development skills for bureaucrats and the community sector.

A program should be developed that allows for:

- the design and development of program modules for key activities and/or priority populations (Table 3)
- liaison with partner training providers in Asian and Pacific countries
- liaison and marketing with the major international donors active in the region
- contract development advice, including on advice on export incentives.

Alternative models for implementing the strategy need to be considered such as the creation of an Asia Pacific Centre on HIV/AIDS, a network of centres, or a consortium of agencies in Australia and across the region working to an agreed program. The program would aim to maximise a collegiate and collaborative approach to employing the skills and strengths of Australia's HIV/AIDS expertise in enhancing capacity in the region.

AusAID may fund some implementation in-country, but in most cases the cost of implementing these training programs and modules would be met by international donors—for example, the ADB, USAID, the Ford Foundation, and the UK Department for International Development (DfID)—and regional governments.

Australia is relatively inexperienced in responding to needs that arise in major generalised epidemics, such as orphan care and support. Some Australian NGOs have experience in these areas as a result of work in Africa and an assessment should be made of how best to transfer lessons learned to Asia and PNG.

3.6.6   Development partners and cooperative technical assistance

In its approach to development assistance, AusAID should value contestability of ideas including acknowledging the entitlement of countries to consider a menu of options for HIV interventions. Partner countries will expect that they will be

afforded an opportunity to consider the relative merits of different approaches to key challenges such as stigma, leadership, and addressing the needs of vulnerable populations. AusAID's approach to technical assistance can support partner countries in managing their responses through providing evidence of effectiveness of interventions and by facilitating access to technical assistance from a range of sources. This will support countries to actively shape their HIV responses.

AusAID should explore opportunities for cooperating with other countries in the region to provide technical assistance to developing countries. For example, opportunities may exist for cooperating with China and Hong Kong in providing technical assistance to third countries on issues such as responding to HIV transmission through injecting drug use or working with media agencies to address stigma and raise awareness. There may also be opportunities for delivering HIV/AIDS programs in the region in partnership with Japan, Thailand and India. Opportunities for providing technical assistance through multilateral mechanisms should also be investigated. For example, the UNAIDS Technical Support Facility for South-East Asia and the Pacific will be established in 2006.

4. Key recommendations

HIV/AIDS integrated as a core development issue

1. HIV/AIDS needs to be woven into AusAID country strategies regardless of the presence or not of a specific HIV/AIDS project. This needs to be a core element of each country strategy as an individually crafted approach.

Social and political mobilisation to support scaled up responses

2. AusAID should support more focused action to influence the socio-political contexts in which the HIV/AIDS epidemic emerges by moving beyond stand-alone projects to a more comprehensive strategy that engages political, faith and business leaders and mobilises communities for comprehensive national action.

3. Australia's parliamentary group on HIV/AIDS and regional parliamentary groups should be supported in taking a more active leadership role.

4. All diplomatic staff should be briefed on HIV/AIDS so they have the knowledge to play a leadership role and advocate for improved HIV/AIDS responses.

5. An advisory mechanism comprising representatives of the HIV and development sectors, researchers, and people living with HIV/AIDS should be established to provide advice to AusAID on policy and strategy relating to the epidemic, with a focus on leadership issues.

6. The Australian Government should remain committed to the Asia Pacific Leadership Forum on HIV/AIDS and encourage it to focus on progress at country level and mobilisation of civil society leadership. The Australian Government should develop a Business Sector Leadership Initiative on HIV in Asia Pacific, to encourage Australian businesses to adopt best practice workplace

HIV/AIDS policies and to play a stronger leadership role on HIV/AIDS in countries where they operate.

7. The aid program should support people living with HIV/AIDS and community based groups to adopt national leadership roles, including through capacity building of regional and national organisations and networks.

Geographic focus of Australia's regional response

8. AusAID should give priority to addressing the emerging epicentres of the epidemic in Indonesia, PNG and the Pacific. Top priority should be effort to elevate the breadth and depth of the response to HIV/AIDS in PNG. Australia should also make a significant contribution to fighting HIV/AIDS in East and South-East Asian countries. Where Australia has comparative advantage, it should work bilaterally (for example, in PNG and Indonesia). Where other donors and multilateral agencies have stronger comparative advantage, Australia should work though these agencies (for example, South Asia and Africa).

9. The Australian Government should promote the unique needs of the region through multilateral processes such as monitoring the UNGASS Declaration of Commitment on HIV/AIDS, and participating on the Boards of UNAIDS and GFATM.

Flexibility and responsiveness to urgent needs

10. In PNG and other countries where an emergency HIV response is warranted Australia should develop capacity to rapidly deliver focused interventions where it will make a difference in stemming escalating epidemics and relieving personal and community impacts of HIV/AIDS, in parallel with longer term capacity building efforts. AusAID should invest in ensuring that GFATM funds in PNG are well managed.

Treatment scale up

11. Australia should work with other donors to secure universal treatment access in the Pacific by 2010 and in PNG as soon as practicable. Consideration should be given to establishing a Pacific Trust Fund for HIV/AIDS that supplements GFATM by resourcing improved regional procurement mechanisms. The Australian Government should work through multilateral processes to ensure that essential HIV medicines are affordable to developing countries.

Gender and feminisation

12. Country strategies should consider the need to address feminisation of the epidemic as an emerging trend. Systems should be introduced to promote gender equity in access to HIV services. Interventions should address male and female social roles affecting vulnerability. Health, education and justice sector policies should challenge and change social norms to promote gender equality.

Research and practice partnerships

13. Australia should support the development of long-term research and practice partnerships in the region to build capacity and expertise in responding to the HIV/AIDS needs of PNG, the Pacific and South-East Asia. Centres of research excellence in HIV/AIDS and development should be established that generate an evidence base for planning, policy development and program delivery.

Harmonisation and alignment

14. Australia should implement the recommendations of the *Global Task Team Report on Improving AIDS Coordination among Multilateral Institutions and International Donors* and work increasingly through partnerships with other donors' bilateral programs and regional and global multilateral institutions. In particular, Australia should work more closely with UNAIDS, its UN system co-sponsors, GFATM, SPC, and the Asian Development Bank in coordinating and targeting regional responses.

Whole-of-government response

15. Improved coherence of the Australian approach to HIV/AIDS in the region can be achieved through a whole-of-government framework that coordinates efforts of relevant government agencies. AusAID should adopt a pivotal role in coordinating a government-wide policy and program response to HIV/AIDS.

Capacity development strategy

16. AusAID should develop an Asia Pacific HIV/AIDS Capacity Development Strategy that more effectively uses Australian expertise in addressing workforce and broader capacity issues. A key feature will be the potential to attract funds from other donors to support in-country implementation. Australia should invest in capacity building in such fields as community based prevention, surveillance, testing and laboratory technologies, HIV medicine and clinical service standards, treatment education approaches, and building community and public sector managerial and leadership skills.

Table 3:   Asia Pacific HIV/AIDS Capacity Development Strategy
            Resource Matrix: Australian skills and expertise

This Matrix is not exhaustive. It does, however, exemplify the analysis required to establish a regional HIV/AIDS capacity development program.

Priorities/ target populations	Program planning and project design	Project management and reporting	HIV prevention curriculum	Peer outreach work	Treatments education
Injectors	Yes	Yes	Yes	Yes	No
Sex workers	Yes	Yes	Yes	Yes	No
Gay-MSM	Yes	Yes	Yes	Yes	Yes
People living with HIV/AIDS	Yes	Yes	Yes	Yes	Yes
Leaders and potential advocates	Yes	-	-	-	-
Policy analysts and legal skills	Yes	-	Yes	Yes	Yes
Clinical services delivery personnel	Yes	Yes	-	-	Yes
Clinical researchers	Yes	Yes	-	-	-
Social, behavioural and epidemiological researchers	Yes	Yes	-	-	-
Community organisation leaders / managers	Yes	Yes	-	-	-

Glossary

ADB	Asian Development Bank
AFAO	Australian Federation of AIDS Organisations
AFP	Australian Federal Police
AHAPI	AusAID Australian HIV/AIDS Partnership Initiative
APEC	Australian Pacific-Economic Cooperation
APLF	Asia Pacific Leadership Forum on HIV/AIDS and Development
APN+	Asia Pacific Network of People Living with HIV/AIDS
ART	Antiretroviral therapy
ARVs	Antiretroviral drugs
ASEAN	Association of South East Asian Nations
ASHM	Australasian Society for HIV Medicine
CCMs	Country Coordinating Mechanisms
CD4	T cells, CD4 tests provide an indication of immune system status
DFAT	Department of Foreign Affairs and Trade
DfID	UK Department for International Development
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS
ICAAP	International Congress on AIDS in Asia Pacific
ILO	International Labour Organisation
MDG	Millennium Development Goals
NAPWA	National Association of People Living with HIV/AIDS
NHRMC	National Health and Medical Research Council
OI	Opportunistic Infections
PEP	Post exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS relief
PMTCT	Prevention of mother to child transmission
PNG	Papua New Guinea
RAMSI	Regional Assistance Mission to Solomon Islands
SPC	Secretariat of the Pacific Community
STI	Sexually Transmitted Infections
SWAPs	'Sector wide approaches' to development assistance eg through donor pooling for government led health sector programs
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization

UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	US Agency for International Development
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
WHO	World Health Organization

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