

HIV/AIDS: The Looming Asia Pacific Pandemic

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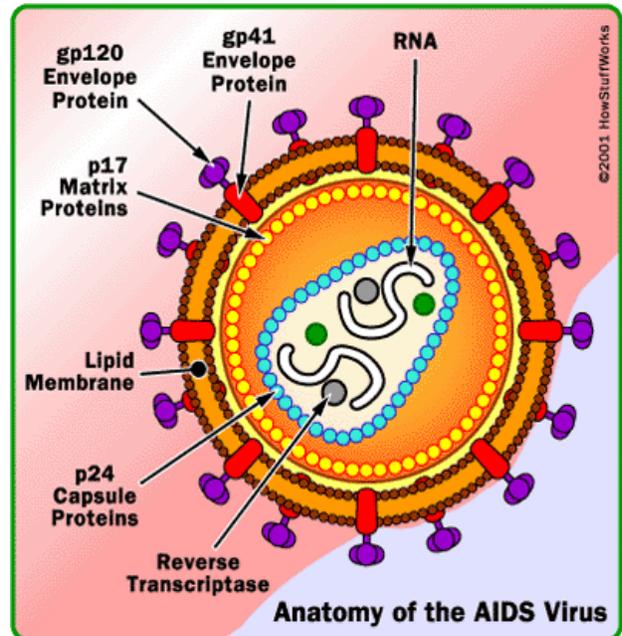
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Contemplating the appalling mismanagement of the global political response to the emergence and early years of the HIV/AIDS pandemic, it is hard not to come to the conclusion that the greatest enemy of rational public policy making is not, as might have been expected in the case of AIDS, nihilism and paralyzing despair.

Rather, the staggering inability of the global community to prevent the long, relentless march of AIDS from its African origins to the shores of the Asia Pacific owes a great deal to the limitless capacity of human beings for invincible optimism. Time and again, evidence that the HIV virus was a dangerous threat requiring decisive pre-emptive containment action was ignored or discounted.

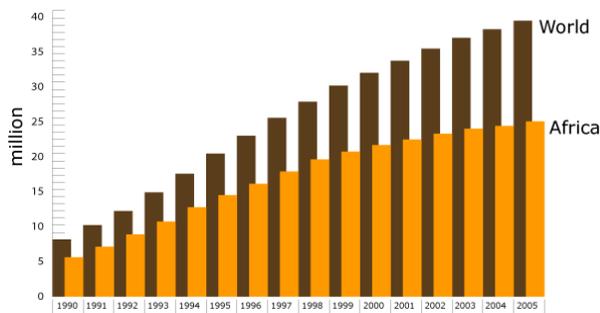
Cultural Taboos and the AIDS Pandemic

For fear of offending cultural taboos, confronting uncomfortable truths about sexuality, or just in the blind hope that something would turn up, the world simply did nothing much at all to stop AIDS before it became the greatest public health crisis of our times. In creating AIDS policy, faith, hope, groundless optimism and simple stupidity time and again trumped evidence, science and reason.



The greater the accumulation of evidence that simple, cheap and easily engineered changes in risky behaviors could largely prevent transmission, the greater the attachment to pursuing expensive and fanciful policies that directly contributed to the rapid expansion of the global HIV caseload.

In the 25 years of the AIDS pandemic, some 65 million people have been infected with the HIV virus. Twenty-five million have died from AIDS caused by HIV infection. Forty million people are presently living with HIV/AIDS. In 2006, 4.3 million people were newly infected with HIV and 3 million people died from AIDS. In 2006, half of all new HIV infections occurred in people under the age of 25.



World and Africa HIV/AIDS Statistics

While the preponderant caseload remains in sub-Saharan Africa, the HIV virus is now present in every region of the planet, and in almost every country and territory. The global HIV caseload is growing at about 10% per annum, which means that the present global HIV caseload may double in about a decade or less.

The HIV virus is an orthodox product of evolutionary biology. But the AIDS pandemic is a creation of politics. In some quarters, it was once fashionable to describe the advent of HIV and its relentless spread around the world in terms of a divinely-ordained act of God. This pernicious nonsense implied that AIDS was therefore something about which nothing much could be done. But this was never the case. HIV is not Ebola, or even influenza.

Preventing Aids

The HIV virus is a blood-borne virus that is relatively hard to transmit. It is very susceptible to simple measures and technologies that easily prevent its transmission between humans. At almost any time in the decade or so following the first identification of the HIV virus in 1981, the use of simple prevention measures by at-risk populations could have greatly impeded the spread of the HIV virus and contained the problem.

In 2007, the global AIDS pandemic is so large

because the wrong policy decisions were taken in the early years of the emergence of the problem. Rather than squarely face up to the fact that the transmission of HIV was closely linked to sexual and drug-taking behaviors among young people in particular, many governments denied that the problem was ever likely to become a serious threat to their populations. They hoped instead that medical science would shortly fashion a vaccine, treatment or a cure that would relieve them of the need to acknowledge the great variety of risky behaviors indulged in by humankind.

In the 1980s and 1990s, only a few countries dealt openly and honestly with the policy consequences of HIV/AIDS and its transmission vectors. These countries generally fashioned a suite of prevention policies that involved distribution and promotion of condoms to all sexually active people, widespread availability of information about HIV/AIDS, universal access to testing and treatments and, most significantly of all, distribution of clean needles and syringes to the users of illicit drugs.

The countries that adopted these policies were generally rewarded with sustained low and therefore manageable rates of HIV and AIDS infections. Over two decades, an immense volume of evidence accumulated that these simple policies were effective in containing HIV/AIDS. These simple harm reduction measures were everywhere much more successful in preventing the spread of HIV/AIDS than containment policies that required young people to abandon sex and drug use.

AIDS and Prohibition

The idea that HIV/AIDS could be beaten by the prohibition of these pleasures proved to be as counter-productive as the prohibition of alcohol was in the United States in the 1920s. As was the case with Prohibition, the laws and policies that were introduced ostensibly to control the

problem ended up contributing to its spread. Heterosexual and homosexual sex, the consumption of illicit drugs through injection, ritual scarification and tattooing practices, and prostitution are, for better or worse, ineradicable elements of the human condition.

It is neither possible nor desirable to base effective HIV containment policies on the assumption that people will abandon them. They will not. The incontrovertible evidence of the last 25 years of the global response to AIDS is that the best that can be done is to inform people of the risks involved in such practices and to persuade them to make the minimal changes in behavior that reduce the risk of HIV transmission while indulging their propensity for pleasure. This approach is mature and sensible. Above all, where it has been tried it has broadly worked while the other approaches based on pious moralizing; faith-based optimism and stern proscription have been unmitigated disasters.

In the early years of the pandemic, especially in the United States, rational policy-making was overwhelmed by the explanation of AIDS as a form of divine punishment for the sinful trinity of homosexuality, prostitution and drug use. For political reasons, attempts to mitigate the spread of HIV by introducing needle and syringe exchanges, promotion and distribution of condoms and safer sex information and generally approaching the problem in a mature and considered way, were deeply opposed by the forces of religious reaction. In the United States, these forces compelled the federal government to abandon its attempts to introduce a coordinated national HIV response based on prevention principles. However, the irrational vilification of AIDS in these quarters began to moderate somewhat after new therapies and treatments became available in the mid-1990s.

While opposition remained high to workable prevention policies, the pressing and urgent

need to deal with the rising numbers of HIV infected people led the United States Congress and others to greatly increase funding for these expensive new therapies. Over time, this has led to a more nuanced view of AIDS within the United States Congress that might best be summarized as "hate the sin, love the sinner". So while the obstacles to provision of care and treatment have, in principle, begun to crumble, the greatest obstacle to the provision of sensible prevention policies remains the conflation of the HIV virus and "sin".

It is extraordinary that the public health response to a single disease, HIV/AIDS, has been entangled in an endless, spurious and mendacious debate about how to suppress vice and promote virtue. The fight against AIDS has been gravely hampered by its politicization by those engaged in the great religious revival that has swept the world in the last several decades. There is no meaning to be found in the coming of the AIDS virus nor can it be suppressed by any measures other than those based on sound science, empirical observations and the accumulation of evidence about what does and does not work to persuade people to make small changes in risky behaviours.

After two decades, the evidence is completely clear that the promotion and use of condoms, and the use of sterile needles and syringes are key factors in reducing HIV transmission in those at greatest risk of infection - that is, young people. Of course, these technologies have to be made widely available, disincentives to their use have to be removed or reduced, and information about HIV/AIDS has to be made widely available if the maximum preventive effect is to be obtained. Providing these technologies also assumes that the public health authorities accept the realities of sexual behavior and diversity, and of the consumption of often illicit drugs.

These assumptions will, by their nature, conflict with those who wish to restrict and

contain sexual expression and activity, and suppress the trade in illicit drugs.

In most jurisdictions, however, there is no evidence to suggest that the availability and use of condoms or clean needles and syringes has increased the rates of sexual or drug-taking activity. Unfortunately, the HIV pandemic is not able to be legislated away. The resort to "tough measures" that "send signals" in relation to sexuality and drug use has been a failure in terms of containing the spread of HIV/AIDS. It is beyond time to actually take tough decisions to implement effective HIV prevention policies rather than simply talk tough.

Looming AIDS Pandemic in the Asia Pacific

The chequered history of the political response to the AIDS pandemic should be borne in mind as we survey the sobering outlook for the potential spread of the pandemic into the Asia Pacific region, the world's most populous and economically vibrant and dynamic region. Asia Pacific policy makers would do well to regard the present situation with none of the misplaced optimism that has failed so spectacularly to contain AIDS in the other regions of the world. Rather, they should learn from the litany of errors that has brought about the present catastrophe, and resolve not to repeat them.

UNAIDS reports the overall rate of HIV infection in the region for 2006 at less than 0.1%. However, this overall figure marks wide intra-regional disparities, very significant disparities in infection rates and histories within individual countries, and very different risk profiles for different states and territories within the region.

The numbers of HIV/AIDS cases in China and India have been notoriously difficult to report, and both have been the subject of intense attention and study. It seems clear that earlier assumptions that large numbers of HIV infections were unreported in both countries

were wrong. India now reports an adult HIV prevalence rate of 0.36%. China reports that something less than a million of its citizens are HIV positive. However, when the population of both countries is in excess of one billion people, the consequences of even small increases in the prevalence of HIV infections could be significant. Other countries in the region, such as Thailand and Cambodia, have large and long-standing HIV epidemics, although both have been diligent in applying harm-reduction policies.

In a globalized world, with large numbers of people travelling for leisure and business, there is an increasingly greater risk of HIV transmission between countries.

As we move in to 2008, it is clear that the global HIV pandemic has not been brought under control. Strategies to contain the HIV virus have so far failed to curb its spread into new countries and regions of the globe, notably the Asia Pacific. Without major changes in strategy and significant increases in funding for behavioral prevention programs, the HIV outlook for 2008 and beyond is very grim. There is little prospect that an HIV vaccine, much less a cure for AIDS, will be developed or become broadly available within the foreseeable future.

Antiretroviral therapies for HIV infection (ART) have generated greatly improved outcomes for HIV-positive people by delaying the onset of AIDS and suppressing many debilitating consequences of earlier HIV treatments. While of undeniable benefit to individuals, the advent of ART has created a large, increasing pool of HIV positive people requiring indefinite access to costly treatments that are complex to deliver. The size of this caseload will have increasingly severe economic and systemic consequences. There is little prospect that sufficient funds can be found to ensure universal treatment access for the present global HIV caseload, let alone one that is likely

to double within the next decade or so. There are also clear indications that in the wake of the HIV pandemic new strains of virulent tuberculosis are emerging. Tuberculosis is more contagious than HIV. It poses severe health risks to HIV-positive people, as well as to otherwise healthy individuals.

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

The preponderant HIV caseload remains in sub-Saharan Africa but the disease is expanding rapidly into Russia, east and central Asia and eastern Europe. Between 2004 and 2006, in eastern Europe and central Asia there was a 70% rise in new HIV infections. China has an estimated HIV caseload of about 600,000, which is probably still incompletely reported. However, in 2006, the overall prevalence of HIV infection in east and south-east Asia remains at less than 0.1%, indicating there is still a window of opportunity for effective preventive action to be taken in the region as a whole.

The impact of the HIV pandemic in the Asia Pacific region varies widely between and within countries. Of particular concern is the rapid spread of HIV infection in Papua New Guinea. Some 1.8% of the adult population of Papua New Guinea is infected with HIV and prevalence in urban areas may be as high as 3.5% which is comparable to the situation in sub-Saharan Africa. Rates of new HIV diagnoses in Papua New Guinea have increased at about 30% per year since 1997. The very high level of HIV infection in Papua New Guinea raises concerns about the potential for the rapid onset of HIV infection of neighboring Melanesian societies, including West Papua,

East Timor, Solomon Islands and other Pacific Island states. Recent, anecdotal and other reports suggest that HIV prevalence in some parts of West Papua and Irian Jaya may be approaching those in Papua New Guinea.



AIDS in Papua New Guinea

The provision of universal access to HIV/AIDS care and treatment remains one of the major, sensible and relevant goals of the United Nations HIV/AIDS grand strategy. The realization of this goal is life-saving and transforming for people with HIV/AIDS. Under PEPFAR and United Nations and other programs, the pharmaceutical industry is being subsidized to produce ever-increasing quantities of new and improved ART treatments. The short-term benefits are obvious. But in the rush to do the right thing, no thought has been given to the fundamental question “Who pays?”

Size Matters

It is increasingly clear that the world cannot afford, or will not meet, the real costs of treating even the present HIV/AIDS caseload. This caseload exists because of the failure to prevent the spread of HIV/AIDS infection through harm reduction and behavioral prevention measures. The sheer size of this caseload is transforming the threat posed by the HIV/AIDS pandemic. The present and

projected global caseload threatens to impose immense new financial costs on national economies and the international system. The costs of providing ART therapies to even a significant proportion of a global caseload that may number 80 million people within a decade are staggering. The costs of providing genuine universal access to necessary HIV treatments for the entire global HIV caseload do not seem to have been fully assessed even in the most recent actuarial calculations.

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

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

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

The Paradoxical Spiral

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

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

Two HIV/AIDS Pandemics: The Actual and

the Potential

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

The actual HIV/AIDS pandemic is the one that emerged in the last 25 years, predominantly in sub-Saharan Africa. This pandemic is an “after the event” pandemic, largely concerned with the care and treatment of those infected with the disease. It is more about AIDS than HIV. Its needs have led to the development of effective but expensive treatments and political consensus around devoting the resources necessary to deal with a large, but inherently manageable, caseload. As devastating as its impact has been on the 65 million people so far infected with HIV/AIDS, for the past quarter-century the impact of HIV/AIDS has fallen mostly on individuals in small and impoverished countries without the resources and structural depth to contain the pandemic. Until now, this has meant that the pandemic has not had global, systemic effects. The response to the pandemic has been characterized by humanitarian concern and charitable intentions. The toll of dead, dying and infected from HIV/AIDS has been great, but clearly insufficient to precipitate effective action.

The second HIV/AIDS pandemic is the one that looms in the Asia Pacific region. This pandemic is potential rather than actual. It is, in 2007, more about HIV than AIDS. It is being driven by a massively large pool of present infections that is spawning new and virulent co-infections. Because those who are infected will not die from AIDS provided treatments are made available, the potential epidemic will have great financial implications that will strain the budgets of even the most prosperous and largest regional economies. The looming pandemic will appear first in the most vulnerable social groups and countries. In the

Asia Pacific region, these first affected societies are scattered throughout the region. They are connected to adjacent societies by links of trade and tourism and by large legal and illegal migration and refugee flows. It is only a matter of chance and time before HIV spreads across the region from the areas that were first affected by it.

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

The HIV/AIDS strategy promoted by the United Nations and accepted as orthodoxy by the international community is an unwieldy and unsatisfactory compromise. Despite heroic efforts by UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria, there is as yet insufficient political support and funding to both treat the present and projected HIV caseload, and to implement effective behavioral change programs. It is time for a more sophisticated, flexible and appropriate set of strategies to meet the challenges of containing HIV/AIDS in the Asia Pacific region.

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

In recent decades, Asia Pacific policy makers have clearly demonstrated their preference for

sound, pragmatic and non-ideological economic policy-making. As they now contemplate the looming threat of HIV/AIDS and its associated miseries, they would do very well to apply these principles to in the fields of public health and social policy as well. They reject the failed HIV containment policies of the past two decades and embrace only those that can be demonstrated by evidence and experience to

have worked to contain HIV/AIDS.

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