



Development Bulletin

No. 52 June 2000

HIV/AIDS: Implications for development

◆ Features

Should HIV be on the development agenda? Australia's international response; HIV, development and unhealthy institutions; HIV/AIDS, human rights and development; HIV vulnerability and mobile populations; HIV/AIDS in the former Soviet Union; HIV and development the PNG way; safe sex or healthy sex? young people and HIV/AIDS; HIV and technology; HIV/AIDS in Thailand, Indonesia, PNG and Zimbabwe

This electronic version of Development Bulletin No. 52 has been sponsored by UNAIDS Asia Pacific Intercountry Team (APICT).

*Development Studies Network Research School of Social Sciences
Australian National University Canberra ACT 0200 Australia
E-mail: devnetwork@anu.edu.au <http://devnet.anu.edu.au>*

Contents

Features

Introduction: HIV and development <i>John Ballard</i>	4
Should HIV be on the development agenda? <i>Rob Moodie</i>	6
Linking HIV/AIDS to development <i>Stephen McNally</i>	9
HIV, development and unhealthy institutions <i>Carol Jenkins</i>	12
HIV/AIDS, human rights and development <i>David Patterson</i>	14
Migrants and HIV/AIDS <i>Margaret Duckett</i>	18
Incorporating social capital into development practice: The HIV epidemic <i>Elizabeth Reid</i>	21
HIV and technology: The issue of prophylactic vaccines <i>Susan Kippax</i>	24
Australia's international response to HIV/AIDS <i>Jacinta Cubis</i>	26
The HIV/AIDS epidemic in India: Are we doing enough? <i>Indrani Gupta</i>	30
Hope, paradox and the politics of suspicion: Confronting latter-day AIDS in Thailand <i>Chris Lyttleton</i>	32
Reproductive health rights and women with HIV in Thailand <i>Andrea Whittaker</i>	35
HIV vulnerability and mobile populations: Thailand and its borders <i>Allan Beeseey</i>	38
The challenge of HIV spread among injecting drug users in Asia <i>Alex Wodak</i>	42
Harm reduction, HIV and development <i>Paul Deany and Nick Crofts</i>	45
Strategies for dealing with HIV/AIDS in the former Soviet Union <i>Dave Burrows</i>	49
AIDS: A nightmare ingredient in the Indonesian development broth <i>Chris Green</i>	52
Sex talk, Indonesian youth and HIV/AIDS <i>Linda Rae Bennett</i>	54
HIV and development the Papua New Guinea way <i>Clement Malau and Sue Crockett</i>	58
The sociocultural and economic context of HIV/AIDS in Papua New Guinea <i>Gina Koczberski</i>	61
Safe sex or healthy sex? <i>Bernard Broughton</i>	64
Young people, HIV/AIDS, and intervention: Barriers and gateways to behaviour change <i>Christine A. Varga</i>	67

Contents

A national disaster: A social analysis of AIDS in Zimbabwe <i>Diana Patel</i>	71
The socioeconomic implications of HIV/AIDS in sub-Saharan Africa <i>J.R.S. Malungo</i>	75

Introduction: HIV and development

John Ballard, Graduate School, The Australian National University

The timing of a special issue of the *Development Bulletin* on HIV and development is opportune. Within the past few months the World Bank and other international financial institutions have placed AIDS at the top of their aid agenda, the UN Security Council has held an unprecedented special session on AIDS in Africa, and President Clinton, following a CIA report on the threat of global infectious disease,¹ has declared AIDS a major security issue for the United States.

Why this belated focus of attention on an epidemic that has been recognised for over 15 years? The rates of infection in Africa and parts of Asia have increased steadily, but only in South Africa have they made a notable jump in the past year or so.² What appears to have changed is recognition by the United States and the World Bank that the limited amounts of assistance provided so far have had little impact and that the spread of HIV is undermining the economy and security of many states.

The impact of HIV on development, at least in African economies, has been on the World Bank's agenda for a decade and has been widely written about, primarily in economic terms. During the same period the United Nations Development Programme has had an HIV and Development Programme, established by Elizabeth Reid after her engagement in Australia's first National HIV/AIDS Strategy, and this has focused on the social impact of HIV and social responses. In Australia the need to place HIV on the agenda of aid-NGOs led AusAID and Commonwealth health authorities to fund an HIV and Development Network (HIDNA), which brought together the skills of the Australian Federation of AIDS Organisations (AFAO) and the capacities of member organisations of the Australian Council for Overseas Aid (ACFOA).³

Five years ago the Academy of Social Sciences in Australia sponsored a symposium on HIV and development, leading to the publication of *No place for borders: The HIV/AIDS epidemic and development in Asia and the Pacific* (Linge and Porter 1997). Chris Beyrer (1998) then published the only book-length treatment of the epidemic in the region, *War in the blood: Sex, politics and AIDS in Southeast Asia*. The present *Bulletin* displays the breadth of research and programmes undertaken since these were written, as well as some significant shifts in the epidemic and in thinking about it. A contemporary essay by Dennis Altman (1999) on 'Globalisation, political economy and HIV/AIDS', also captures and enhances much recent thinking about HIV and development.

Lessons of the Australian response to HIV

Australia is frequently cited as exemplary for its response to HIV. Early political recognition of a need to respond was hastened by Commonwealth responsibility for the blood supply and production of Factor VIII. A strong tradition of health promotion helped produce support for programmes of harm minimisation and funding for community-based education and care programmes, initially among gay men, then among sex workers, injecting drug users and people living with HIV and AIDS. The engagement of social researchers with gay-organised AIDS Councils produced a world-renowned model for interdisciplinary social research. In 1988–89 the consultative production of a national strategy on HIV/AIDS codified policies which had been developed and provided an exceptional three-year funding commitment; the current fourth national strategy maintains the thrust of Australia's successful programmes.

But can these programmes survive as export models? There has been limited success in applying them in indigenous communities within Australia itself, and it is difficult to conceive of their survival in many parts of the United States, let alone South Africa and Papua New Guinea. They raise not only problems of cultural sensitivity, but wider issues concerning the social, political and economic context within which the programmes evolved. A few elements of this context are worth rehearsing.

Community mobilisation with government support has a legitimacy in industrial societies since the 1960s which it did not previously hold. Much of the success of community responses to HIV derived from the specific nature of the gay community, which provided a model for others. Without its urban focus, its education and substantial resources, including its own media, and its previous decade of political mobilisation around issues of legalisation and discrimination, there would have been no community with a capacity for response. In fact, it is difficult to conceive of any other community with such well developed bases for an appropriate response to HIV.

The sexual and gender revolution of the 1960s and 1970s, following on the availability of the Pill and leading to the articulation of demand for gender equality and gay and lesbian rights, made possible the public discussion of sexual issues. In industrial societies this cultural revolution was taken for granted by the 1990s, yet elsewhere – in Eastern Europe as much as in

Africa and Asia – the changes implicit in this revolution are taking place only in the context of AIDS and cannot be assumed.

The ideology of health promotion set forth in the Ottawa Charter of 1986 was already espoused by a strong contingent within Australia's health establishment, which had practical success in early tobacco cessation and other health education programmes. In non-industrial societies, as well as in some such as France, ideologies of public health have been dominated by medical or quarantine models that leave no legitimate scope for community-based health education.

The legitimacy of community mobilisation, open discussion of sexual issues and health promotion are specific preconditions for much of the Australian response to HIV, but there is a broader context within which Australians function: an established value of open and critical debate, including reasonably lively and independent media; the availability of resources for a public health system which ensures treatment and care; and a high degree of public security. None of these can be assumed elsewhere and yet it is difficult to imagine the success of the Australian response to HIV without them.

All of this may suggest that Australian programmes for HIV and development abroad need to be conceived more broadly so as to encourage a political and social climate for harm reduction. Human rights and law reform are already very much on the HIV and development agenda, as David Patterson indicates in his paper here. What Carol Jenkins describes as 'unhealthy institutions' require much more explicit attention. She notes the deleterious effects of 'health sector reform' on HIV prevention and care, while it is clear that the public security sector can serve as a primary vector for the spread of HIV infection, not only through sexual transmission by military and police forces but also in prisons and 'rehabilitation centres' as focal points for drug use.

Features

This brings us to the papers in this issue of the *Development Bulletin*. The order in which they are presented has a certain rationale. Rob Moodie addresses the broad issue of HIV on the development agenda, while Stephen McNally questions conventional interpretations of development in the context of HIV and Carol Jenkins examines critically the impact of development programmes. David Patterson charts the relationship of human rights to HIV and development and Margaret Duckett examines this in the context of migrants. Elizabeth Reid then argues the advantages of a selective approach to social capital in responding to HIV and development and Susan Kippax deals with the issue of HIV and technology in the case of vaccines.

Following a review of Australia's international response by Jacinta Cubis, a set of country-focused papers raises both general and specific aspects of the relationship between HIV and development. Indrani Gupta takes a broad and critical approach to the epidemic in India, while Chris Lyttleton surveys recent issues arising in Thailand and Andrea Whittaker examines the specific problems of reproductive health rights in Thailand.

Allan Beesey's discussion of migration across Thai borders provides a bridge to a set of papers focused on HIV transmission through drug use. Alex Wodak, Paul Deany and Nick Crofts set out the relationship between drug use and development and the need for responding through strategies of harm reduction, and Dave Burrows applies this to the former states of the Soviet Union. Chris Green, in describing the threat of an Indonesian epidemic through drug use, leads back to a further series of country studies in which the focus is primarily on sexual transmission.

Linda Rae Bennett provides an analysis of youth and HIV in one region of Indonesia, and Sue Crockett and Clement Malau review Papua New Guinea's response to HIV, while Gina Koczberski analyses the context within which that response has developed. Bernard Broughton introduces a final set of African papers with his argument for broadening the strategies for coping with sexual transmission. Christine Varga examines the difficulties of intervention in South Africa and Diana Patel the equally catastrophic situation in Zimbabwe, while Jacob Malungo winds up with a review of the development implications of HIV in Africa.

Notes

1. See www.cia.gov/cia/publications/nie/report/nie99-17d.html.
2. Current statistics reported to UNAIDS are available at www.unaids.org. The fact that reporting is a political matter for many states and that epidemiology is non-existent in some is most obvious in the absence of statistics from Congo.
3. HIDNA was wound up in 1999, but the network remains as an e-mail discussion group, which can be joined by sending the message 'Suscribe hiv-and-development-1 <your e-mail address>' to majordomo@coombs.anu.edu.au.

References

- Altman, D. 1999, 'Globalisation, political economy and HIV/AIDS', *Theory and Society*, 28, 559–84.
- Beyrer, C. 1998, *War in the blood: Sex, politics and AIDS in Southeast Asia*, Zed, London.
- Linge, G. and D. Porter (eds) 1997, *No place for borders: The HIV/AIDS epidemic and development in Asia and the Pacific*, Allen & Unwin, St Leonards.

Should HIV be on the development agenda?

Rob Moodie, Victorian Health Promotion Foundation, Melbourne

Introduction

In 1992 the World Health Organization (WHO) predicted that by the year 2000 there would be 40 million people infected with HIV. Unfortunately, this prediction has been surpassed. It is now estimated that there are 33.6 million people living with HIV and a further 16.3 million who have died since the early 1980s (UNAIDS/WHO 1999). Around 16,000 people are being infected each day, 90 per cent of them in sub-Saharan Africa and in the developing countries of Asia. More than 1 in 100 sexually active adults across the world are infected with HIV, yet only a small fraction of these people have access to counselling and testing, and actually know they are infected.

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

Why is HIV continuing to spread?

HIV is difficult, much more so than we had ever imagined. One might call it a master virus. It taunts us from all perspectives: technical, behavioural, social, cultural, economic and political.

From a technical and virological point of view, the virus is elusive and evasive. It is a unique human pathogen which has learnt to kill off the immune system. Notwithstanding recent advances in therapy, an effective vaccine lies many years in the future. It is just as complex behaviourally and culturally, because it is spread by deeply ingrained human behaviours, again elusive and evasive issues to deal with. In eastern Africa, for example, sexual intercourse is intimately associated with many rites of passage and with the symbolic union of families, let alone its associations with procreation, pleasure, power and survival. An example of its symbolic nature is the practice of 'widow cleansing'. In this case, a widow has sex with the brother of her deceased husband to symbolise the fact that she will be looked after by the extended family.

A story from India also illustrates this point. There is an HIV prevention programme for commercial sex workers in Sangli which works with a group of generous, insightful women who, by no fault of their own, have been 'born into' prostitution. In discussions one day, they commented that business had recently been slack because of end-of-year high school exams:

one of their major client groups, many of whom as they said could barely grow a moustache, was not around. In this town, as in countless others in India and in other parts of the world, young men and boys have their sexual initiation with sex workers. Commercial sex is deeply entrenched in the cultural life of India, yet it is virtually ignored and most often denied by the leaders of government and society.

Culture has proven to be a complicated, and at times convenient, barrier to the efficient implementation of measures to prevent and control HIV/AIDS, as well as in other areas such as reproductive health and girls' and women's health. Thailand's leaders realised that they would have to 'clash with culture' to get effective programmes up and running.

From the socioeconomic point of view, HIV thrives where social and economic vulnerability is greatest. In sub-Saharan Africa, the single most important risk factor for women is simply being married. For young women in rural Thailand or Laos or Myanmar who end up in the sex industry, the main risk factor is being poor.

Social and economic factors are not only determinants of HIV, they are also associated with the spread of the virus. The ever-increasing impact of the epidemic is evident in the effects on family cohesion and survival, on community cohesion and survival. The UN Security Council and the US Government are now explicit in their recognition of AIDS as a security threat to the survival of nations. How much of the current civil unrest in Zimbabwe is caused by an economy weakened by very high levels of sickness and death as a result of AIDS?

HIV is as challenging from the political perspective as from any other. Effective national programmes often require dramatic cultural shifts and a challenging of longstanding taboos. They require open and honest government to acknowledge the spread of HIV, and political foresight and leadership to deal with issues of sex, drugs and discrimination. As Meechai Viravaidya said in the early days of AIDS in Thailand, you have to clash with culture to be effective. Leaders like President Chissano in Mozambique are needed, leaders who are prepared to go to the rural areas most affected, to talk with and listen to children with HIV.

And there is hope. We do know that HIV can be prevented and radically curbed, not only from the experience in the wealthier countries of northern Europe, North America, Australia and New Zealand but also in countries such as Uganda, Thailand and Senegal. In Uganda, the national programme,

encouraged and led by President Museveni, has resulted in declining levels of new infections, particularly in younger urban women, as a result of delayed sexual debut, fewer sexual partners and more frequent condom use. A 15-year-old girl in urban Uganda now has a 40 per cent less chance of becoming HIV infected than she did five or six years ago.

In Thailand, declining HIV levels in sex workers and their clients have occurred as a result of a society being willing to openly discuss and deal with the determinants and the consequences of unsafe sexual behaviour. A good example of this openness was the 100 per cent condom programme in which, with government support, sex workers and brothel owners enforced maximum condom use in brothels. This was further reinforced by media campaigns to encourage respect for women and to discourage men from commercial sex, and by literacy and vocational programmes to prevent young women from having to join the sex industry.

But these two countries still remain the exception, not the rule. South African President Mbeki's recent dalliance with the Duisberg conspiracy theorists (who claim that HIV does not cause AIDS) seems incredible – yet it is a political reality, and one that may retard progress against HIV in all of southern Africa. The fact that he has called into question the origin of AIDS will probably give other national leaders new 'political space' to continue to ignore the issue.

What is the role of political leaders?

The determinants of, and response to, HIV/AIDS are heavily influenced by social and economic forces, by huge global inequalities in resource availability and utilisation, and by forces that lead to massive movements of people. There is no doubt that major advances in lowering levels could occur through increases in per capita income and in literacy rates and through the reduction of inequalities in wealth distribution, both within and between countries. However, the world economic order, or disorder, is unlikely to change for the better in terms of the prevention and care of HIV/AIDS in the next ten years or so. So, what can we do now, given the economic hand we have been dealt? And what can and must be done to act in the political arena?

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

Let us take two examples from sub-Saharan Africa. In Kenya, the government and President Daniel Arap Moi have not only been silent about the seriousness of the epidemic but they have also often denied its existence, for fear of affecting their tourist trade. With over 11 per cent of the adult population already

infected with HIV, silence and denial will only lead to further misery. In Zimbabwe, nearly 26 per cent of the adult population have HIV and over 350 people a day are being infected. Many Zimbabweans, particularly those in community based groups, are making heroic efforts in the face of declining resources. Yet President Mugabe rarely speaks of AIDS other than to blame gays or foreigners. This is clearly negligent and contravenes the human right to information. How much does it cost for a president to speak about HIV, to openly and honestly discuss it as a national problem? It costs nothing.

What is the role of the United Nations?

In countries such as Kenya and Zimbabwe, it is clearly the role of the international community to advocate political and organisational behaviour change, persuading governments to invest now to prevent huge financial and human losses in the future. Even so, it can be very difficult to move some governments down the right path; no single organisation or aid agency can do it. Strong, synergistic and consistent efforts by the international community are required.

The presence of an effective United Nations is absolutely vital in tackling the epidemic. It is needed as convenor, coordinator and umpire for the many external agencies working on AIDS and related issues. It is needed to marshal and encourage political advocacy in countries where only concerted, collaborative and coordinated efforts will result in needed changes at the political level.

One of the early, and quite radical, reforms that predates Kofi Annan's leadership, but which has been strongly supported by him, was the establishment of UNAIDS in 1996. But, wisely, instead of it being a new agency to further complicate the UN menu (this would have been number 50), UNAIDS was created to work through seven existing major agencies, using their administrative structures and 'leveraging' their capacity to commit human and financial resources: United Nations Development Programme (UNDP), UN Drug Control Programme (UNDCP), UNESCO, UN Fund for Population Activities (UNFPA), UNICEF, WHO, and the World Bank. Its collaborative nature was taken a step further by having, for the first time in the UN, non government organisations (NGOs) and people living with AIDS represented on the board.

But reform is not easy. And it wasn't easy in the beginning, during the preparatory year in 1995, and after official commencement of the programme in January 1996. Donor governments, having publicly 'rapped WHO over the knuckles' by moving their money to the new programme, insisted that UNAIDS work with WHO and the other agencies with which WHO had been fighting. The establishment of UNAIDS has been much more difficult than first imagined. It has had to overcome 50 years of institutional separatism and organisational rivalry. It has to work with a coalition of partners who differ greatly in size, mandate, operational capacity, and organisational culture. The most glaring example is the difference between

UNESCO, which is small and poorly funded and has little credibility, and the World Bank, which is well funded, institutionally arrogant and politically powerful and has a much greater capacity.

There have also been unrealistic and differing expectations of the new programme. Donor governments demanded dramatic change within two years, despite providing less funding, while recipient governments and NGOs saw UNAIDS as a new magical source of significantly increased funding. Some donor governments, the paymasters, want the programme to coordinate the national response, while others have diametrically opposed views. Sometimes it is forgotten that, although UNAIDS has the responsibility to lead the global response, it is not the global response.

Although AIDS requires a complex, multifaceted and long-term response, as in other aspects of human development, governments and their international aid agencies seem to take a paradoxically short-term view of its control. Patience is not a virtue in international aid agencies. UNAIDS is a form of 'community development' within the United Nations – and, to work, it requires foresight, patience and persistence.

What is the role of development agencies?

Can development agencies afford to deny the importance of HIV, especially if they are working in sub-Saharan Africa or in Southeast or South Asia?

The reasons they usually give for not considering it an issue include that there are other equally important health problems, such as malaria and TB, that local counterparts do not believe it is a priority, or that it is a health issue and thus not of concern to agencies with broader agendas. But can they continue to

ignore HIV/AIDS in endemic areas, when up to 25 per cent of their workers might be infected? Or when virtually every public and private sector organisation will suffer an increasing skill drain as premature death from HIV 'guts' the skilled, let alone the unskilled, workforce? In Kenya, commercial farms are now losing employees through illness and death related to AIDS rather than through retirement because of old age (UNAIDS/WHO 1999).

HIV/AIDS is not simply a health issue; it affects virtually all aspects of human development. And the risk of becoming infected with HIV is greatly influenced by social, cultural and political factors. So, development agencies are involved whether they like it or not – because their staff may be infected with HIV or sick with AIDS, and because by virtue of the work they do, such as in the areas of education, labour, employment, credit schemes, agriculture, and community development, agencies help to diminish individual and collective vulnerability to HIV/AIDS.

Development agencies working in areas where HIV is prevalent must ensure that they protect and care for their staff. And they can easily incorporate work to diminish general vulnerability to HIV, and at the same time use their influence to get HIV much higher up on the political agenda, be that at a local, provincial or national level.

HIV/AIDS remains a silent and invisible disease in so many parts of the world. Anyone interested in development cannot continue to be silent.

Reference

UNAIDS/WHO 1999, *AIDS epidemic update: December 1999*, www.unaids.org.

Linking HIV/AIDS to development

*Stephen McNally, PhD candidate, Department of Anthropology and Archaeology,
The Australian National University*

Introduction

This paper explores how development creates, through its paradigms, institutions and its diverse cast of experts, understandings of HIV/AIDS. Discourses of development have been subjected to critical analysis during the 1990s, forcing us to recognise hidden assumptions in its concepts and tools. In a similar fashion, the work of Paula Treichler (1989), Cindy Patton (1990) and Simon Watney (1994) has explored HIV/AIDS as a complex social and cultural narrative. How has development as a way of thinking and as a practice helped to create what we have come to know about HIV/AIDS in the developing world? The aim here is to question that which has been taken for granted over the past decade of work on HIV in non-industrial societies, focusing on the hidden assumptions in the use of statistics and the concepts of need and poverty.

HIV/AIDS as a 'development problem'

Since the early 1990s the nexus between HIV/AIDS and development has been explored by a number of organisations, the most prominent being UNDP's HIV and Development Programme, the Panos Institute, and to a lesser extent WHO's Global Programme on AIDS. The most recent and most high-profile of these organisations, UNAIDS, came into existence in 1996. During this time, the gap between what could be seen as one epidemic in the First World and another in the Third World has widened. The claim has now been widely made by these and other organisations that HIV/AIDS is much more than just another health problem. It is a 'development problem', with the potential to threaten and even reverse many of the achievements that have been made over the past five development decades. However, in most instances where HIV/AIDS is promoted as a 'development problem', it tends to be reduced to a range of social and economic impacts at the family, community and national levels. An understanding of HIV/AIDS as a development issue tends to be limited by narrow economic interpretations. An example of this thinking would be as follows: higher infection levels in the adult population of a developing country reduce per capita growth rates, which in turn result in a significant loss of income. The following quote from a UN report in Vietnam identifies the impact of HIV/AIDS on development in terms of cost-benefit analysis:

As in other developing countries, one of the key concerns about HIV/AIDS in Vietnam is the effect this may have on

development. Increased spending on HIV/AIDS means fewer resources to spend on other fundamental aspects of development such as education, infrastructure and human resource development, while the fatal nature of the disease means fewer managers, producers and consumers (*UN News* 2(2), 1996).

Over the past decade significant progress has been made in moving the debate from a narrowly based health problem to one that is seen as a much broader 'development problem', although still grounded in economics. However, the relationship between HIV/AIDS and development remains for the most part unexplored and as a consequence that relationship is often misunderstood. These misunderstandings are exacerbated by the unique challenges posed by the means of virus transmission. The relationship is further clouded by the fact that, while development promises to curb the spread of HIV/AIDS, evidence suggests that the very acts of development increase the rate of HIV infection. 'HIV/AIDS is both a symptom and increasingly a cause of underdevelopment' (Panos Institute 1992:140).

Discourses of development and HIV/AIDS

In an effort to move beyond analysing HIV/AIDS in economic terms, we need to seek out what Escobar terms the system of relations between elements: technology, education, capital and the institutions.

It is this system that allows the systematic creation of objects, concepts, and strategies; it determines what can be thought and said. These relations – established between institutions, socioeconomic processes, forms of knowledge, technological factors, and so on – define the conditions under which objects, concepts, theories, and strategies can be incorporated into the discourse. In sum, the system of relations establishes a discursive practice that sets the rules of the game, who can speak, from what points of view, with what authority, and according to what criteria of expertise; it sets the rules that must be followed for this or that problem, theory, or object to emerge and be named, analysed and eventually transformed into a policy or plan (Escobar 1995:40–1).

Simply put, one needs to look at the system of relations, which determines what can be thought and said. In order to identify these systems of relations, it is necessary to ask how knowledge relating to the many discourses associated with HIV/AIDS and HIV prevention is produced, how it travels and how it is consumed by the development industry. In

particular, the many stories of HIV/AIDS are continually being produced and interpreted through the production of statistics, development reports, social research, information, education and communication (IEC) campaigns, media reports, global health reports, international conferences, UN development policy, non government organisations (NGOs), and through the experts themselves, whether it be development experts, medical doctors, or government officials. However, one should not stop there but also look towards what appears to be a never-ending list of related discourses which influence particular representations of development and HIV/AIDS, such as: the discourse of sexuality, gender, masculinity, drug use and sex work. The ways in which these discourses are created and how they attempt to construct the objects of development is critical to understanding how HIV/AIDS is understood in a Third World context.

A growing body of work labelled 'post-development' has exposed development thinking and practice as a collection of historically and culturally produced concepts. Of all the development texts of the 1990s, Sachs' edited work, *The development dictionary: A guide to knowledge as power* (1992), unsettled development thinking the most by dismantling a range of development concepts that had become the foundation to what has often been considered a single development discourse. By emphasising the multiplicity of development discourses, it helped us to question what we had taken for granted and to expose the assumptions underlying central concepts such as statistics, need and poverty.

Statistics

Statistics create subjects; they tell stories and shape cultures. Over the past five decades, development practitioners have prided themselves on successfully creating more sophisticated ways to measure and compare change. Statistics have become crucial, if not the most crucial of, development tools. They describe, measure and help to build arguments in favour of, or even against, development. Statistics, we are told, reflect economic and social characteristics; they have the power to bring awareness to a range of problems, deficiencies, challenges and improvements. Of all the development tools, it is clear that statistics play a central role in constructing power and knowledge.

However, statistics are often used unknowingly by development experts to further 'entrench the development discourse' (Escobar 1995:213). The problematic nature of the statistic in development work is given little credence. While being comforted by the statistic, we remain unaware of how central the use of statistics can be to the politics of representation. Statistics are political technologies, which create reality and are understood as facts that translate to truth.

In the story of HIV/AIDS, as is the case with most other areas of development, the statistic has become crucial in helping to understand what is happening. For example, the statistic and,

in particular, the projections for HIV/AIDS in Vietnam have played a crucial role in turning what could be seen as an impending epidemic into an epidemic. Also, the calculations that have produced projections for particular groups of people have raised the level of consciousness concerning where the threat lies.

Making statistics in Vietnam, as is the case in many other developing countries, raises many questions, obvious questions, like who is tested and who is not? The problems associated with testing, such as confidentiality and overrepresentation, are rarely reflected in the many tables that help create the threat of HIV/AIDS in most development reports. The statistic is usually the first piece of information that is looked for. And in countries such as Vietnam, where very little social research has been undertaken, the statistic is often elevated to a much higher position of authority. 'Given its historical mission, statistical analysis, not unexpectedly, is widely seen as the most powerful way to understand the latest incarnation for the "darkly unknowable" AIDS in the Third World' (Treichler 1989:49). It is the epidemiologist who often leads the developer not only in setting out the facts but also in setting the research agenda. The developer working in HIV/AIDS prevention is just as comfortable with the statistic as the epidemiologist is. In many cases, the developer has had to rely solely upon the statistic. The statistic has allowed for the epidemic to be cast in what Escobar (1984:387) calls the 'neutral realm of science'. Identities are created through numbers, which are interpreted and reinterpreted as further information becomes available. The list of indicators in the area of HIV prevention is long and continues to increase as more research is undertaken. Statistics reinforce what the expert believes to be a complex and even at times contradictory reality. As in other areas of development, the formula is a simple one: the more statistics, the better.

Need

Globalisation plays a part in creating 'needs' by exposing the developed world like never before to the developing world. The concept of need has become universally imagined since the 1950s and people have come to speak of essential needs, often reflected in aid priorities from donors. Shelter, education and health have each become universally accepted as needs to the extent that 'today it has become almost impossible to deny the existence of needs' (Illich 1992:92). The spread of HIV/AIDS throughout the developing world has, for example, created a range of needs that have only recently been articulated.

Identifying needs is an important part of creating HIV/AIDS as a development problem. The assumption is that needs exist and the challenge for the developer is to fit that need with an appropriate response. Through professional expertise, along with the use of specific development tools, such as statistics, specific needs relating to HIV prevention are identified. A crucial part of development work is to demonstrate that there is a need for intervention and that there is a deficiency that should be addressed. However, this notion of need is problematic. Needs

are not self-evident; they are political and they are created. How needs are identified and responded to is open to a variety of interpretations. It is not simply the case of encouraging participatory development which works to involve people at the local level in identifying and contextualising their own needs.

Development organisations have been instrumental in encouraging donor recipients not only to accept that they require assistance but also to articulate in internationally accepted development language what their needs are. The UNDP's recent project, 'Strengthening Capacity in Coordination, Planning and Management of HIV/AIDS in Vietnam', is only one example of a development programme not only encouraging recipient government departments to accept that a need exists but also providing help in articulating the need in internationally accepted terms. Other examples include the work of many development organisations in broadening the understanding of risk away from specific risk groups, such as sex workers and intravenous drug users, towards an understanding of risk as a set of behaviours.

Poverty

There is an assumption that, if you are poor, you have a greater chance of becoming infected with HIV. Across the growing gap between the First and Third World, poverty has become one of the foundations to help explain who is most at risk from HIV/AIDS. The concept of poverty is one of the most common discourses of development that works to organise, distort and mislead. This concept and what it has come to mean works to fix subjectivities. It has come to mean much more than simply being poor. To use the label 'poverty' implies a range of assumptions, the most glaring being that the person is probably ignorant, or at the very least lacking necessary information. It is assumed that, if you suffer from poverty, you are most likely unable to make decisions that affect your well-being. And if you are able to make decisions, there is a greater chance that your decisions will be based on what is seen by 'experts' to be incorrect or misleading information. Not only does poverty imply ignorance and lack of knowledge but it also implies that the person has few or no choices. For example, a common representation of sex work in Vietnam is that of women having no choices and being forced into prostitution due to circumstances beyond their control. Projects such as CARE's Vietnam project 'Skills Training for Incarcerated Women' have been developed to increase women's choices. Agency is often nowhere to be found in such projects. There needs to be 'alternative views on "poverty" and HIV/AIDS as a way of elaborating an alternative conception of subjectivity and identity that . . . is more consistent with the diverse ways in which local people account for their situations and actions' (Porter 1998:218).

Conclusion

To create effective HIV/AIDS prevention programmes and projects an extensive list of development concepts and their hidden assumptions need to be identified and subsequently explored. Concepts such as progress, help, participation, planning and even the term development itself need to be examined from anthropological, political, social, and historical viewpoints. However, we must not stop there if HIV/AIDS is to be understood in broader terms than development economics. There are other key concepts that have become part of the HIV/AIDS prevention landscape. These concepts include IEC, behaviour change, harm reduction and even the term HIV/AIDS epidemic. To explore the unique qualities of HIV/AIDS and development beyond the tools and concepts of development the 'experts' in HIV/AIDS prevention need to look at related discourses, those of human rights, sexuality, care and counselling, drug use and sex work, to name only a few. Just as important as the concepts of development, we need to become aware of how these other concepts shape HIV/AIDS within a specific time and place. This of course makes the task of HIV/AIDS prevention even greater, but the consequences of not doing so will result in many more deaths.

References

- Escobar, A. 1984, 'Discourse and power in development: Michel Foucault and the relevance of his work to the Third World', *Alternatives*, 10(3), 377–400.
- Escobar, A. 1995, *Encountering development: The making and unmaking of the Third World*, Princeton University Press, Princeton, NJ.
- Illich, I. 1992, 'Needs', in W. Sachs (ed.), *The development dictionary: A guide to knowledge as power*, Zed Books, London, 88–101.
- Panos Institute 1992, *The hidden cost of AIDS: The challenge of HIV to development*, Panos Institute, London and Washington, DC.
- Patton, C. 1990, *Inventing AIDS*, Routledge, New York.
- Porter, D. 1998, 'A plague on the borders: HIV, development and travelling identities in the golden triangle', in M. Manderson and M. Jolly (eds), *Sites of desire, economies of pleasure: Sexualities in Asia and the Pacific*, Chicago University Press, Chicago.
- Sachs, W. (ed.) 1992, *The development dictionary: A guide to knowledge as power*, Zed Books, London.
- Treichler, P. 1989, 'AIDS and HIV infection in the Third World: A First World chronicle', in B. Kruger and P. Mariari (eds), *Remaking history*, Bay Press, Seattle, 31–86.
- Watney, S. 1994, *Practices of freedom: Selected writings on HIV/AIDS*, Duke University Press, Durham.

HIV, development and unhealthy institutions

Carol Jenkins, Health and Population Sector Coordinator, CARE, Bangladesh

It has been clear for a long time that, wherever the HIV epidemic is seeded, unhealthy institutions provide the cracks through which it can grow. Such institutions and the policies that drive them, both written and unwritten, are found in nations at all levels of economic development, which suggests that economic success alone cannot provide an indicator of healthy institutions. Internationally accepted development indicators report the proportion of people in some health or economic related condition but provide no information on the health of the institutions that create these conditions. Appeals to the individual to alter his or her HIV-related risk behaviour reach some and produce some results, at least for a while, but it is increasingly clear that behaviour change models have missed a piece of the puzzle. Perhaps that piece is the healthy functioning of the primary institutions of government and society.

Unhealthy institutions and HIV

What do we mean by unhealthy institutions and how do they impact on overall social and economic development in this era of AIDS? We can cite a few examples:

- This year the two millionth convict entered the US prison system.
- A specially commissioned study has shown that 5–6 per cent of the gross national product in South Asian nations is lost to corruption.
- Some 52,000 women report a rape each year in South Africa. Police officials estimate that only one in every 36 victims actually reports the crime, which suggests that the real number of victims could be in excess of one million.
- Each year, unsafe transfusion and injection practices cause an estimated 8–16 million hepatitis B virus infections, 2.3–4.7 million hepatitis C virus infections, and 80,000–160,000 HIV infections.

Underlying each of these statements is a configuration of historical events, programmes and investments (or disinvestments) that have played a role in creating weak legal, educational, health, transport, environmental, commercial and other vital systems. When these systems fail, international development donors, including banks, usually attempt to address the problems with increased investment under conditions of sector reform, structural adjustment or a similar altered

formulation of government structure and function. But HIV is simply a virus that spreads through blood or sex. This virus requires unprotected sex, shared injecting equipment or pregnant women to pass itself on. It cannot tell the difference between rape and consensual sex or between illegal and legal needle use. If structural adjustment policies reduce salaries relative to the cost of basic needs, or shift increasing economic burdens to women, HIV wins. If sector reforms, particularly in health, produce years of confusion, resistance and frozen systems, HIV wins. If legal policies place millions of people in jail for drug or sex related crimes for which there are few societal remedies in place, these people circulate frequently between prison and the outside, and HIV wins again.

Barriers to change

In one unnamed country, a health sector reform package, funded by multiple donors, was put in place during a period of low HIV prevalence. The system was a corrupt one and, to ensure better accountability, the funds were overseen by a development bank. For nearly three years, both the funding and the plans for blood screening and the shift to volunteered rather than purchased blood sat unutilised. After two years, new drug procurement policies had yet to be implemented and contraceptives, among other essential drugs, were running out. Levels of immunisation dropped, health workers were not receiving salaries and the entire health system was demoralised. The HIV/AIDS programme, imbedded in this structure, was non-functional. Additional funds from a UN source were added but still little could be accomplished because the mind-set of those in charge, most of whom were political appointees, were conditioned to kickbacks and sub rosa payments or gifts of various sorts. Without these, the system was stagnant. Despite the objections of a few lonely voices, the solution was seen to be the acquisition of more money, this time from a loan. But the underlying dynamics were never addressed and no funds were reaching implementing agencies, such as non government organisations (NGOs), nearly three years later. Meanwhile, the potential for the spread of HIV was well documented and clearly showed the need for immediate action. Such reports fell on deaf ears.

Another example: disposable needles and syringes were not placed on the essential drug list, which had not been reviewed in decades. Hence, these items required a 40 per cent duty tax

when imported. Locally manufactured needles and syringes did exist, however. These were of lower quality but, more remarkably, were more expensive than imported ones with the duty included. Needless to say, government health services were obliged to purchase the local variety, but newspaper reports repeatedly pointed out that these were frequently recirculated, repackaged and resold. Evidence of contamination was seen, so government health authorities requested that only blister packs (instead of standard cellophane packs) be purchased henceforth. This decision was apparently made with the surmise that recirculation and repackaging would somehow be more difficult if the needles and syringes were in a blister pack.

In the same country, condoms were not considered an essential drug item. The government had an agreement with the local social marketing company to allow it to bring in condoms for family planning through a UN agency, thereby avoiding duty – and thereby ensuring low prices and a monopoly. In this era of AIDS, no other private sector company can offer good quality condoms at prices as low as the social marketing company, but this company has done little to reposition the condom as a disease preventive device and usage overall remains very low.

In another country, one with far greater financial and social resources than the last example, a commission was funded to undertake an examination of why drug abuse continued to rise, despite increasing investment in legal control. After two years of investigation, the commission, which was composed of persons representing a wide swathe of society, concluded that the drug control programme had lost credibility by incarcerating persons whose drug use was essentially mild and of no problem to anyone but themselves. The commission recommended decriminalisation of cannabis and similar products, but the head of the control programme rejected the commission's findings outright. He stated that it was wrong and that greater investment in stricter enforcement was right.

In yet another country, rape has only recently been redefined, with a thorough review of existing laws, although passage of the redefined laws has yet to take place. The law stated that the age of consent was 12 for girls and 7 for boys. No one seemed to know how such an age for boys was decided upon or when. As the nation has a complex colonial history, with a migrant mine worker past, this may account for it, but no one was willing to guess. Written reports do exist in neighbouring nations of boy wives taken by miners, especially during colonial times.

A fuller recounting of institutional barriers to better HIV prevention could easily rival Voltaire's Dictionary for size. What has not apparently been learned by donors and other development agencies is that, unless these policy and practice issues are directly dealt with at the appropriate level, no amount of funds given to grassroots NGOs or even to government AIDS programmes, will realise their full value. HIV continues to spread in the majority of the world's nations today, despite a great deal of standard investment. New approaches are desperately needed.

Some suggestions

Instead of donations or loans being simply given, they should be accompanied by required positions for ombudsmen with guaranteed immunity for those who dare to bring complaints to their attention, and guaranteed budgets for the ombudsmen's offices. Where there is a culture of corruption, creative and strong measures must be put in place, no matter how unpopular among government personnel. Where abusive older laws and regulations exist, a vigorous revision must be undertaken, with public exposure and debate. Altering a rape or age of consent law or, for that matter, drug use laws, will not have a chance of contributing to real social change unless the public understands the issues under debate and learns enough to make decisions. A strong free press and access to information through all forms of technology are required to bring this about. Investing in information technology for the masses may have a greater impact on HIV prevention than many standard health interventions. Through them, the people might develop a voice, as appears to be occurring today in several fairly repressive regimes. Learning to listen to the people until one thinks like them should be a requirement for any development agent.

Finally, we can be fairly certain that the HIV pandemic is not the last infectious disease epidemic the human race will witness. Increasingly, common disease organisms are shifting their hosts, their mechanisms of defence and their modes of transmission as well. Public health is not simply the 'public's health' but a public enterprise of disease prevention and health promotion. The fuller involvement of the public in this enterprise is essential. Development agencies, if they do not wish to be seen as the cynical implementers of aid programmes for their own nation's political interests, would help the world's people more by mustering the courage to ensure healthy institutions in their midst.

HIV/AIDS, human rights and development

David Patterson, independent consultant, Geneva

In many ways South Africa's past – as that of most colonial societies – remains with us today, not least in the social dimensions of the unfolding AIDS epidemic. The poor; the vulnerable; the unschooled; the socially marginalized; the women and the children; those who bear the burden of colonial legacy – these are the sectors of society which bear the burden of AIDS (Mandela 1997).

In just two decades, AIDS has risen to become the leading cause of death in Africa and now kills more people worldwide than any other infectious disease (UNAIDS 1999a). Present treatments are expensive: an affordable vaccine in the developing world is many years away. Preventing new infections today is the only way to stem the growing tide of morbidity and mortality.

Yet in almost every developing country, prevention programmes are *not* turning the tide of new infections. Information, education and communication programmes on their own are found to be relatively ineffective. National resources and donor aid budgets do not reflect the magnitude of the problem, communities are paralysed by fear and denial, and governments seem slow to respond.

HIV/AIDS programmes and activities often remain narrow in their scope, applicability and impact. In many cases, they operate within a paradigm which focuses on the individual and on individual behavioural change. Socioeconomic and political factors such as gender based inequalities, poverty, corruption and government inaction, which lie at the root of the problem, are not addressed.

Links between HIV/AIDS, development and human rights

HIV/AIDS and development

Over 95 per cent of people currently infected live in developing countries, which also account for over 95 per cent of the lives claimed by AIDS (UNAIDS 1998:16). Biological, cultural and structural cofactors have been identified to explain why some countries are severely affected (in sub-Saharan Africa) or face rapidly growing epidemics (in Asia and the Pacific, Latin America and the Caribbean, and Eastern Europe). These factors include high rates of untreated sexually transmitted diseases; gender imbalances in access to schooling, vocational training and capital; and social disruption caused by labour migration and wars (Decosas 1996).

Conversely, HIV/AIDS is having a devastating impact on development: 'In the world's nine most severely-affected countries (all of them in Africa), where at least one-tenth of the adult population has HIV, life expectancy for a child born in 2000–2005 will drop to 43 years from the pre-AIDS expectation of 60 years of life' (UNAIDS 1998:17). In response, one of these countries, South Africa, devoted an entire issue of its national *Human development report* to HIV/AIDS in 1998.

A rights based approach to development

In 1986, the UN General Assembly adopted the Declaration on the Right to Development, which notes the right and the duty of states 'to formulate appropriate national development policies that aim at the constant improvement of the well-being of the entire population and of all individuals, on the basis of their active, free and meaningful participation in development and in the fair distribution of the benefits resulting therefrom (Resolution 41/128 of 4 December 1986, www.unhchr.ch/html/menu3/b/74.htm). In 1998, the UN Secretary-General launched a broad rights based approach to development, intended to help states and development agencies to 'redirect their development thinking':

A rights-based approach to development describes situations not simply in terms of human needs, or of developmental requirements, but in terms of society's obligations to respond to the inalienable rights of individuals. It empowers people to demand justice as a right, not as charity, and gives communities a moral basis from which to claim international assistance where needed (UN 1998:paras 173–4).

Primary legal responsibility for national development rests with national governments. The international community can help with financial and technical assistance to governments and non government organisations (NGOs), while also supporting the development of civil society, which is necessary to enable communities to demand the efficient, effective and equitable use of these resources as a right. Civil and political rights (including freedom of speech and association, due process of law, independent judiciary, genuine periodic elections) are thus inseparable elements of development and development assistance.

HIV/AIDS and human rights

The cofactors of widespread HIV/AIDS related illness and death in developing countries noted above are rights issues and subject

to a rights based analysis. Given that the virus entered countries at different times in the last two decades, HIV infection levels are generally lower in countries where rights are respected, protected and fulfilled.¹ Conversely, those countries which rank poorly in terms of civil, political, economic, social and cultural rights are generally the worst affected, or are expected to face rapidly expanding epidemics in the next decade. Note that *all* human rights are implicated: the participation of affected communities in the planning and implementation of HIV/AIDS programmes is both a right, and essential to their success.²

This analysis has important implications for HIV-related development assistance. Projects which assist communities to demand and secure their human rights will address the cofactors of the HIV/AIDS epidemic and will contribute to a reduction in rates of infection, morbidity and mortality. Projects which only focus on information, education and communication will have little long-term impact on the course of the epidemic.

The theoretical tools for, and practical examples of, rights-based HIV/AIDS programming are now available. Two international consultations of experts have addressed the issue of human rights in the context of HIV/AIDS (see Centre for Human Rights 1991, UNAIDS and OHCHR 1998). The latter produced international guidelines which provide a comprehensive approach to policy and law reform. In particular, the guidelines set out steps to be taken to review and reform laws which have a differential impact on women and girls in such areas as property and marital relations; access to employment and economic opportunity; and reproductive and sexual rights.³ Further, in 1999, UNAIDS and the Inter-Parliamentary Union published a guide for legislators which gives positive examples of law and policy reform in the developed and developing world context.

Discrimination

At the 1994 Paris AIDS Summit, 42 national governments declared their obligation and resolve to act with compassion for and solidarity with those with HIV or at risk of becoming infected, both within societies and internationally; their determination to ensure that all persons living with HIV/AIDS are able to realise the full and equal enjoyment of their fundamental freedoms without distinction and under all circumstances; their determination to fight against poverty, stigmatisation and discrimination; and their determination to mobilise all of society – the public and private sectors, community based organisations and people living with HIV/AIDS – in a spirit of true partnership. The Paris Declaration (1 December 1994) thus articulated at the highest level the principle of the greater involvement of people living with HIV/AIDS: the ‘GIPA Principle’ (UNAIDS 1999b).

Discrimination against people living with HIV/AIDS is not only contrary to human rights principles, it hinders the participation of people infected and affected and hence impedes public health prevention and care efforts. Law reform to prohibit

discrimination is part of the solution, but, to be effective, law reform must be accompanied by public education, although experience has revealed the complex nature of discrimination and the lack of simple solutions to address it.

The following two case studies and other examples of rights-based projects and activities provide models for rights-based programming that can be adapted to different national contexts.

The AIDS Law Project, South Africa

The AIDS Law Project was founded in 1993 and is based at the Centre for Applied Legal Studies at the University of Witwatersrand. The project:

- carries out litigation to counter wrongs that have occurred and, where possible, to establish legal precedents that prevent them from recurring;
- offers free legal advice that will empower people living with HIV and AIDS to seek legal remedies in response to acts of unfair discrimination;
- carries out research to support policy formulation and bring about practices that prevent discrimination; and
- produces media that create an awareness of rights in government and civil society and that promote effective lobbying and advocacy.

HIV/AIDS related legal issues addressed by the AIDS Law Project have included:

- access to bonds (mortgages);
- employment benefits;
- the lawfulness of HIV testing in the workplace;
- employment practices and codes of conduct;
- rights concerning access to treatments;
- wilful transmission and HIV infection in marriage;
- rights of domestic workers;
- confidentiality of children in preschool/school and hospital settings;
- treatment for sexually abused women and rape survivors;
- protocols concerning needle-stick injuries;
- liability for infection through blood transfusions;
- adoption; and
- rights to cover for HIV infection by medical aid schemes.

The project also undertakes extensive community education and research and distributes publications free or at low cost. In 1999, it adopted a partnership agreement with the Canadian HIV/AIDS Legal Network to undertake joint projects and to promote the transfer of skills and experience between the two countries. International funders in 1998–99 included the European Union, the South African AIDS Training Programme (Canadian International Development Agency/Canadian Public Health Association) and the Ford Foundation.

The South African AIDS Training Programme (SAT)

SAT has more than eight years experience of working with community based organisations in southern Africa. Although there was general recognition that human rights abuses have an important impact on the lives of people living with HIV/AIDS, discussions with SAT partners revealed that they had little ability to respond to this issue in their work. Several partners requested assistance to build their skills and capacity in this area and, in response, SAT held a series of workshops which demonstrated the linkage between HIV, gender, human rights, and child rights issues in practical terms.

The approach is to identify the laws, both national and customary, that can be applied to enhance the lives of those with HIV/AIDS. Furthermore, SAT partners are equipped with advocacy skills to enable them to lobby for law reforms. Examples of partners undertaking training include Women AIDS Support Network, Women's Action Group, Family Health Trust, Musasa Project, Training and Research Support Centre, OATUU Health and Safety Programme (all in Zimbabwe), Young Women's Christian Association (Zambia), Tanzania Media Women's Association, Tanzania Gender Networking Programme (Tanzania), Mulher Lei e Desenvolvimento (MULEIDE) (Mozambique), AIDS Law Project (South Africa) and Botswana Federation of Trade Unions.

While evaluation of the long-term impact is difficult, a number of partners have since been involved in highly visible landmark cases and initiatives. These include the introduction of the Sexual Offences Act in Tanzania and the Child Victim Friendly Courts Initiative in Zimbabwe. SAT partners have also played a prominent role in lobbying for land rights for women in Zimbabwe, Tanzania and Zambia.⁴

Other examples

Law reform

- Nicaragua: In 1996, the UN Development Programme (UNDP) hosted a parliamentary seminar on HIV/AIDS. A law to protect rights in the context of AIDS was subsequently enacted.
- Hong Kong: The Disability Discrimination Ordinance was introduced following substantial lobbying from the Coalition of AIDS Organizations Against Discrimination and other groups.
- Uganda: The Ugandan Network on Law, Ethics & HIV/AIDS reviewed Ugandan laws through a consultative process. The report was given to the AIDS Commission, the Law Reform Commission and the Ministry of Justice (see also UNAIDS and Inter-Parliamentary Union 1999).

Legal advice and litigation

- India: The Lawyers Collective, HIV/AIDS Unit, responds specifically to the legal needs of people with HIV. It provides legal aid and advice, promotes awareness of HIV-related legal issues in the general community and among the legal profession, and advocates law reform.
- Costa Rica: As a result of legal action by the Coalition of Costa Ricans with HIV/AIDS, the Supreme Court ruled that the national health care system should provide certain medications for people with HIV infection.

Legal education

- Russia: In 1998 UNAIDS hosted a workshop on HIV/AIDS and legal issues for some 30 legal academics and professionals and government policy makers.
- Canada: The Faculty of Law at McGill University was one of the first in the world to offer an elective in HIV/AIDS and the Law.
- South Africa: The AIDS Law Project and Lawyers for Human Rights have published a resource manual in plain English for people with HIV/AIDS and the general community.

Monitoring and documentation

- Burma and Thailand: Human Rights Watch investigated the trafficking of girls and their vulnerability to HIV infection. The report moved the conceptualisation of the issue from 'social problem' to 'human rights violation'.
- Romania: The Bucharest Acceptance Group was funded by UNAIDS to report on the impact of the criminal law on HIV/AIDS prevention among men who have sex with men. The report was presented at a workshop on reproductive rights at the 1998 World Association of Medical Law Congress and submitted to the UN Human Rights Committee, which subsequently recommended that Romania reform its laws on homosexual relations between consenting adults.

Women's rights

- India: The Lawyers Collective applied a gender analysis and identified a number of laws whose impact increased the vulnerability of women to HIV and AIDS. Advocacy for appropriate law reform has resulted (see Dhaliwal 1999).
- Zimbabwe: Groups such as the Women and AIDS Support Network applied a gender analysis to a proposal to increase criminal penalties for HIV

transmission and found that, for complex social reasons, women would be differentially affected. These groups then lobbied for a different approach based on a gender and rights analysis (Kanyangarara 1999).

Children's rights

- Malawi: To address the issue of children orphaned by HIV/AIDS within the framework of the Convention on the Rights of the Child, community based organisations are using a training manual developed by the Unit for Research and Education on the Convention on the Rights of the Child (University of Victoria, Canada).

Partnerships and networks

- Regional networks on human rights and HIV/AIDS have been established in Asia, sub-Saharan Africa, and Latin America and the Caribbean.
- In 1999 the AIDS Law Project (South Africa) and the Canadian HIV/AIDS Legal Network formally adopted a partnership agreement to provide mutual support in achieving their missions and goals.
- The Interagency Coalition on AIDS and Development, in collaboration with the Centre for Education and Research on the Convention on the Rights of the Child (University of Victoria), is developing methodologies to facilitate the participation of children in the planning of HIV/AIDS projects to address their needs. Resources to educate community based organisations and other stakeholders on how to utilise the methodologies are also being developed. The Coalition also educates its members on a human rights approach to HIV/AIDS policy development and programming.

Strengthening national institutions

- In 1998 UNAIDS and the Office of the High Commissioner for Human Rights agreed on a pilot project to place two national human rights advisers with HIV/AIDS related expertise in national human rights commissions in India and Uganda.

Other useful examples can be found in Human Rights Internet (1998) and in ICASO (1999).

Acknowledgement

This article is based on work commissioned by the Interagency Coalition on AIDS and Development (ICAD), Canada.

Permission to reproduce it is gratefully acknowledged. The original text can be viewed on the ICAD website www.icad-cisd.com. For further information e-mail info@icad-cisd.com

Notes

1. Even in developed countries disadvantaged minorities, such as indigenous peoples, may have higher than average levels of HIV infection, consistent with this analysis. See generally UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, on the right to the highest attainable standard of health care.
2. See *Declaration of Alma-Ata* International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978, www.who.int/hpr/docs/almaata.html.
3. In 2001 all UN member states will be asked to report to the Commission on Human Rights on the steps they have taken to promote and implement the guidelines (Commission on Human Rights resolution 1999/49).
4. For further information, contact the Resource Centre Officer, PO Box 390, Kopje, Harare. Telephone: 263-4-781123; fax: 263-4-752-609; e-mail: info@sat.org.zw

References

- Centre for Human Rights 1991, *Report of an international consultation on AIDS and human rights*, HR/PUB/90/2, Geneva.
- Decosas, J. 1996, 'AIDS and development: What is the link?', in *Development Express No. 7*, International Development Information Centre, Ottawa. See also UNDP HDP website.
- Dhaliwal, M. 1999, 'Creation of an enabling and gender-just legal environment as a prevention strategy for HIV/AIDS among women in India', *Canadian HIV/AIDS Policy and Law Newsletter*, 4(2/3), Spring, 86–9.
- Human Rights Internet 1998, *Human rights and HIV/AIDS: Effective community responses*, Ottawa.
- ICASO (International Council of AIDS Service Organizations) 1999, *Stories from the frontline*, Ottawa.
- Kanyangarara, S. 1999, 'Proposed use of the criminal law to deal with HIV transmission in Zimbabwe', *Canadian HIV/AIDS Policy and Law Newsletter*, 4(2/3), Spring, 98–100.
- Mandela, N. 1997, speech to the World Economic Forum, Switzerland, February.
- UN 1998, *Report of the Secretary-General on the work of the organization*, A/53/1, United Nations, New York.
- UNAIDS 1998, *The UNAIDS report*, UNAIDS, Geneva.
- UNAIDS 1999a, press release, 11 May, figures based on 1999 *World health report*, World Health Organization, Geneva.
- UNAIDS 1999b, *From principle to practice. Greater involvement of people living with or affected by HIV/AIDS (GIPA)*, Geneva.
- UNAIDS and Inter-Parliamentary Union 1999, *Handbook for legislators on HIV/AIDS, law and human rights*, Geneva.
- UNAIDS and OHCHR (Office of the High Commissioner for Human Rights) 1998, *HIV/AIDS and human rights: International guidelines*, HR/PUB/98/1, Geneva.

Migrants and HIV/AIDS

Margaret Duckett, Sydney

The expansion of the rule of law in international relations has been the foundation of much of the political, social and economic progress achieved in recent years (Annan 2000).

The International Covenant on Economic, Social and Cultural Rights, which entered into force in 1976, explicitly recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Article 2(1) provides that each State Party to the Covenant undertake to take steps, individually and through international assistance and cooperation, to achieve progressively the rights in the Covenant.

A forthcoming statement by the UN Committee on Economic, Social and Cultural Rights is expected to state their interpretation that health is both a fundamental human right in itself and an indispensable precondition for the exercise of other human rights.

The recognition and acknowledgment of a universal right to health care in international human rights instruments is not in question. What is in the balance are the parameters and enforceability of such a right. This paper outlines some of the imperatives that should drive attention to the rights of migrants (both legal and illegal) to health, particularly in relation to HIV/AIDS.

The 'global village'

Increasing globalisation raises reconsideration of the concept of total State sovereignty within a country's borders. The 'global village' is much more than a global market – in a global village there is one global public health. Tuberculosis (TB) provides an example of this: in Australia, Hong Kong (China), Malaysia and Singapore, cases have not decreased for several years because of the incidence of TB among new immigrants (WHO 1999).

Unfortunately, HIV is causing an associated and increasing epidemic of TB in many of the most severely affected countries, and while active TB can easily be detected in a clinical examination, it can also easily be transmitted in a work or social situation, unlike HIV. In some parts of Africa, the incidence of tuberculosis is increasing at an alarming rate – sometimes as high as eight per cent annually.

While people undermined by HIV infection are more easily infected with the TB bacillus, many already harbour it from childhood. Worldwide, millions of people are already infected with both HIV and the TB bacillus, and the potential for further growth of co-infection in the developing countries is vast, given the prevalence of TB in the general population (some 30 per

cent) and the almost 6 million new HIV infections a year. The skyrocketing of TB incidence globally is expected to be associated with the emergence of a significant number of drug-resistant strains of TB, along with the further spread of multidrug resistant (MDR) strains of TB throughout developed countries, as well as developing countries. Delay in tackling the dual HIV/TB epidemics in developing countries may directly lead to major problems in the health care sector for all countries.

Much of past policy concern about migrants has centred on whether they are likely to become a burden on health and social services in receiving countries. There are a number of countries that require HIV-negative status at entry or on renewal of work permits (Duckett and Orkin 1989). Restrictions are reported in, or by, countries with very high, and countries with very low, numbers of reported cases. Indeed, many countries adopt a double standard: compassionate policies and practices relating to HIV/AIDS in regard to their own citizens, but an approach encompassing economic death in relation to migrants. UNAIDS noted that 'restrictions may ultimately increase migrants' vulnerability to infection by HIV by undermining trust, increasing hostility, and discouraging individuals who may be affected from coming forward for counselling and support' (UNAIDS 1999:5).

Relatively little attention has been paid to the economic (and ethical) dangers of ignoring the health needs of these workers. Since the majority of migrants are adults in the prime of their earning potential as well as their reproductive life, HIV can have devastating social and economic effects should a large number of this sizeable earning population cease contributing to society. This scenario is already the case in many African countries, and is now increasing in importance in other parts of the world with large mobile populations.

As long as any segment of a population (whether or not they are present illegally) is neglected in public health terms, the global response to AIDS is limited, with concomitant costs and suffering.

Why should migrants' health be singled out?

Despite the Constitution of the World Health Organization, which defines health as a state of 'complete physical, mental and social well-being, and not merely the absence of disease or infirmity', most countries have defined their obligations to non-citizens in terms of essential care or care in emergency situations.

Even in relation to officially accepted migrant workers, special arrangements to ensure real equity in access to health (compared with nationals) are rarely put in place.

There are a number of reports documenting the reduced access to health care and the health consequences for migrants in many parts of the world. Bollini and Siem (1995) argue that poor health outcomes are linked to the lower entitlements for migrants and ethnic groups in the receiving countries. They note:

Not only are they exposed to poor working and living conditions, which are *per se* determinants of poor health, but they also have reduced access to health care for a number of political, administrative and cultural reasons which are not necessarily present for the native population, and which vary in different societies and for different groups. Language, different concepts of health and disease, or the presence of racism are examples of such selective barriers (Bollini and Siem 1995:821).

Bollini and Siem note that the trend to poor health outcomes may vary from one group of migrants to another and for individuals within a group.

The tendency for migrants to have less access to health care and resultant poorer health status is more marked for recent arrivals or for 'groups' who are otherwise more socially disadvantaged in the host society (for example, North Africans in France, Bangladeshis in the United Kingdom, Indonesians in Malaysia). Tan (1998:2) offers the term 'ethnic distance' to illustrate the elements of cultural differences and risk inherent in moves from one country to another, even where the same sending and receiving countries are involved. Tan notes that the ethnic distance for a young Filipina from a small village going to work as a domestic helper in Hong Kong is much greater than that for a young Filipino male executive also going to Hong Kong to take up a job with a multinational corporation. In cases where the sending and receiving countries are highly disparate in cultural values, this ethnic distance can be even more substantial.

The access of migrants to health is an issue for countries of origin and transition as well as for receiving countries. Migrant workers with health problems often return to their home countries due to financial conditions, lack of proper immigration documents and ill health, increasingly related to HIV/AIDS. Many countries have now experienced substantial numbers of nationals returning to die among their relatives or original communities.

This raises questions about the delicate balance required by governments to recognise that migrants may be at risk of infection in their new environment, while avoiding any scapegoating of migrants for bringing HIV with them into the community. A good example of this balance can be found in Greece's Ministry of Health and Welfare 1999 information programme: 'Taking Care of Migrants' Health at the Same Time as Our Own.' This, however, is a rare approach.

How many people are migrants?

In 1995 the World Bank estimated that at least 125 million people lived outside their country of origin (World Bank 1995).

Every year, over one million people emigrate permanently and nearly as many seek asylum. However, if short-term visitors are included in the definition of mobile people, then there are over one billion international travellers every year. In some tourist destination countries, the annual number of short-term visitors exceeds the resident population. If we include in-country mobility, then there are probably two billion people on the move globally each year.

Why is HIV/AIDS a particular issue for migrants?

Human mobility is associated with an increased risk of HIV infection. However, as Decosas and Adrien (1997) point out, there are problems with many epidemiological surveys because they often lead to a focus on migrants rather than on the factors increasing vulnerability in mobile populations. Being a migrant, in and of itself, is not a risk factor, it is the activities undertaken during the migration process that are the risk factors.

Movement may not involve the crossing of any borders: in China, for example, about 100 million people are considered mobile between rural and urban areas, and from one urban area to another. Increasingly, compared with earlier generations, many individuals in a number of countries have become bilocal or even multilocal, within a country or in a different country than the country of origin. Particularly for students but increasingly for many others, a pattern of circular mobility is part of life. As Singhanetra-Renard notes in regard to Thailand 'daily commuting, seasonal migration, periodic, short- and long-term circulation are undertaken by both the rural and urban population for employment, education, entertainment, as well as for other sociocultural reasons' (Singhanetra-Renard 1994:14).

While moving may increase vulnerability and lead to people engaging in higher risk behaviour, this is by no means axiomatic. For example, as Tan (1998:2) writes:

Rural women may not be able to break out of their low social status if they stay in their village. Their future is limited to an early marriage, often with little bargaining power and little support for reproductive and sexual health. Migrating to cities is still an option for social mobility and could actually mean a better quality of life and health. A shift to an urban environment, where sexuality-related issues can be more openly discussed, may also be beneficial.

Sometimes people are able to move with their entire families. However, for much labour migration, this is not the case. In Asia, there is a large regional movement of female workers who provide domestic services; in many other parts of the world, single sex migration is predominantly male to sustain industries such as mining, construction and agriculture. The changed circumstances may lead to increased personal risk: perhaps separated from family, from a regular sex partner, in single-sex

housing, and with the stresses and vulnerabilities associated with the migration process. For some, there is a strong need for money to buy necessities or on which to subsist while waiting for employment. For others, the anonymity of being a foreigner, especially in transit areas, can increase sexual activities. Similarly, loneliness, frustration and peer pressure combined with easier access to drugs can make it hard for some to resist injecting drugs. And, of course, there may be drug dealers exploiting this vulnerability.

In some cases, moving may be undertaken so that the individual may engage in what might be shameful or illegal in their own neighbourhood. For example, CARAM-Asia has noted that 'thousands of poor Vietnamese women come to Cambodia to earn [money] by engaging in sex work . . . one third of the commercial sex workers reported being born in Vietnam' (CARAM-Asia 1998:20).

Conclusion

Migrants can be especially vulnerable to HIV/AIDS/STD, but are often excluded or simply missed in many prevention and care programmes. The effects of globalisation would seem to require governments, if only for self-interest, to ensure that this state of affairs does not continue. There is evidence of human rights and other ethical violations occurring that need to be urgently addressed at local, national and international levels.

Successful HIV/AIDS/STD prevention and care programmes for migrant populations tend to be those developed with and guided by migrant communities, and involving substantial community mobilisation. Programmes must ensure access to care and be integrated with other local and national AIDS-related programmes. Peer educators often may play a key role, but flexibility and committed staff are essential.

It may be particularly difficult for government agencies to deal with illegal migrants. However, non government organisations in a number of countries and settings have shown that they can readily access and work effectively with these sub-populations. Beyond the formal legal system, as noted in *Our Global Neighbourhood*

The technical, organisational, and lobbying skills of some NGOs are an efficient means of achieving enhanced compliance. We encourage these groups to continue lobbying and pressuring governments, multilateral institutions, transnational corporations, and other subjects of international law to comply with their international legal obligations (Commission on Global Governance 1995:327).

Some progress in preventing the spread of HIV to and from migrants, and ameliorating the impact of HIV upon HIV-infected migrants has been made. Projects addressing other sexually transmitted infections and reproductive health for migrants and mobile populations are available in a number of countries and settings. The challenge now is to address more comprehensively the complex issues involved, in all countries and at all levels through compliance with the letter and spirit of international covenants.

Acknowledgement

This article is a shortened version of a long policy paper prepared for UNAIDS and the International Organisation for Migration.

References

- Annan, K. 2000, 12 May correspondence with heads of government in relation to the Millennium Summit, 6–8 September 2000.
- Bollini, P. and H. Siem 1995, 'No real progress towards equity: Health of migrants and ethnic minorities on the eve of the Year 2000', *Social Science and Medicine*, 41(6), 819–28.
- CARAM-Asia (Coordination of Action Research on AIDS and Migration) 1998, *The vulnerability of migrants to HIV/AIDS*, CARAM-Asia, June.
- Commission on Global Governance 1995, *Our global neighbourhood: The report of the Commission on Global Governance*, Oxford University Press, Oxford.
- Decosas, J. and A. Adrien 1997, 'Migration and HIV', *AIDS*, 11(Supplement A), 577–84.
- Duckett, M. and A.J. Orkin 1989, 'HIV/AIDS-related migration and travel policies and restrictions: A global study', *AIDS*, 3(Supplement 1), S231–252.
- Singhanetra-Renard, A. 1994 'Population movement and the AIDS epidemic in Thailand', paper presented at IUSSP Seminar on Sexual Subcultures and Migration in the Era of AIDS/STDs, Bangkok, March.
- Tan, M. 1998, 'Migration and risk', *AIDS action*, Issue 40, July–September.
- UNAIDS 1999, *Technical update on migration and HIV/AIDS*, UNAIDS, Geneva.
- WHO (World Health Organization) 1999, *Tuberculosis in the Western Pacific*, WHO Regional Office for the Western Pacific.
- World Bank 1995, *World development report 1995: Workers in an integrating world*, Oxford University Press, Oxford.

Incorporating social capital into development practice: The HIV epidemic

Elizabeth Reid, former head of the HIV and Development Division, UN Development Programme

Do the quality of the relations that people have with others, their density and their extension affect the way that a community develops? This question is at the heart of the increasingly rich discussions of concepts such as social capital, social cohesion and social integrity, and of attempts to incorporate the strengthening of social capital in development practice.

The question is also being explored in the struggle to find more effective strategies with which to address the HIV epidemic in developing countries. In particular, it is being asked whether communities with stronger social capital have lower rates of HIV infection and whether they have a more humane and supportive response to those infected. Intuitively, it would seem possible that such linkages exist, although they may be complex and in need of unravelling.

Research and practice relating to the epidemic have focused on associations between HIV and individual-level factors (knowledge, attitudes and beliefs, information, education and communication), interpersonal factors such as peer support and sanctioning, and macro-level determinants such as poverty, wealth, gender and mobility. Much remains to be learnt about the influence of communities and of social norms and values on both HIV and development outcomes.

However, the evidence continues to grow that social and interpersonal relations matter in determining developmental outcomes. Putnam (1993) and others have argued that social capital influences economic development, strengthens a society's moral resources, renders democratic processes more effective, lowers crime rates and increases the societal value given to education and health.

The benefits of strong social capital

Research undertaken in communities and neighbourhoods indicates that social capital influences positive outcomes at this level also. The degree of social capital in a neighbourhood, measured by trust and willingness to intervene for the public good, is a significant predictor of aberrant behaviour in youth, crime victimisation and homicide rates.

Recent explorations of social capital and its influence on health have shown that the concept of social capital explains variations among communities in mortality rates, including infant mortality and violent deaths, which remain after accounting for differences in income and poverty rates. Social capital is also positively associated with self-rated health, that

is, whether people think that they are in good or poor health, and with longevity and quality of life.

The literature on social capital contains a diversity of definitions of the concept (Rosling Feldman and Assaf 1999). In my judgement, the key elements of a definition for development *practice* are:

- the extent of norms of mutual respect, interpersonal trust, and mutual support;
- the extent of social and civic engagement and collective activism, which is often reflected in the density and extension of membership in networks, groups or associations; and
- the extent to which there is a sense of striving for the common good.

In this understanding of the concept, social capital is not an attribute of an individual, an organisation or a collective, but inheres in the nature of relationships between and among people. It is found in communities, organisations or societies in which certain human relationships hold. It manifests its presence through mechanisms such as community discussion of issues, mutual aid, collective action, and civic and political participation.

So what is the relevance of this concept to the HIV epidemic? What does our knowledge of the epidemic contribute to a better understanding of social capital?

It has been argued that communities with strong social capital are better able to respond effectively to the epidemic. Social capital manifests itself in stronger patterns of mutual support, in greater capacity for collective problem solving and action, in more inclusive patterns of connectedness, in traditions of volunteerism and a stronger sense of the common good. All of these qualities are required in an effective response to the epidemic.

However, it has also been argued that social capital can exacerbate inequalities across gender, ethnicity, class and other social cleavages, and can also be a force for social exclusion and domination. Some cohesive communities can be characterised by distrust, fear, racism and the exclusion of outsiders. They may not be supportive of those who are not a part of them, or to insiders who disagree with or are different from the majority.

The HIV epidemic has shown that access to mutual support and reciprocal exchange enhances the coping strategies of affected households. The existence of social capital in these communities manifests itself through the ability of affected households to borrow cash, to call on help at critical times in

the agricultural cycle when household labour is short, or to arrange assistance in the care of the sick.

However, this manifestation of social capital also has its downside. Strong norms of mutual support can increase the social and physical burden of those who provide this support. The emphasis on mutual support, which underpins the policies of community based care of people with HIV and AIDS, has significantly increased the demands made on women's time, care skills and emotional resources, as well as on those of children, particularly girls. This has led to the neglect of women's other responsibilities and the withdrawal of children from education. The distributional consequences of such strategies need to be taken into account in their formulation.

The epidemic teaches us that the moral resources that are strengthened in social capital formation, trust and friendship, for example, may not be sufficient to slow the spread of infection. Reflection on the nature of the relationship between husband and wife or between other sexual partners shows the importance, as well as the fragility, of trust as a protective strategy.

Social capital is strengthened through networks, groups and organisations but membership in these may not necessarily lower the risk of HIV infection. Research is emerging in South Africa which shows lower rates of infection associated with membership of some community organisations, youth clubs and sport clubs, but higher rates of infection among members of organisations with social activities that include the sale and/or consumption of alcohol, for example revolving credit associations. Membership of organisations or participation in social occasions where alcohol is sold and/or consumed, or sexual networking condoned or encouraged, may increase the risk of exposure to HIV.

This highlights the importance of community norms and values in determining HIV outcomes. Where there are not strong norms concerning responsible sexual behaviour, alcohol consumption or respect for women and children, the rate of spread of HIV could well be greater. Community norms and values may work against the adoption of effective HIV strategies rather than support them.

There is evidence, however, that communities with stronger social capital may be better able to change harmful norms and values. Such communities are more likely to be able to generate general discussion of these problems, leading to the establishment of new norms, to collective action and to social change. The Salvation Army, the UN Development Programme (UNDP) and others have developed methodologies for creating community conversations about, for example, the unspoken or unspeakable, grief, fear or social hypocrisy, and for making communities more aware of their patterns of exclusion and inclusion, the values practised rather than advocated, and the effects of norms and deprivations on the ability of their members to withstand the epidemic.

Communities with strong social capital may also be able to develop and implement development initiatives more effectively, through the quick diffusion of information and innovations, and through the active participation of members in such work.

The importance of bridging capital

The discussion of the negative dimensions of social capital has led to a distinction between group capital and social capital, or between bonding capital and bridging capital. Groups may have within them strong norms of support, reciprocity and loyalty. The Mafia and wantok groups in Papua New Guinea have strong group/bonding capital, for example. However, the links of such groups to other people or to other groups may be weak, antagonistic or excluding. Such groups have strong group capital but weak bridging capital.

Bridging capital contributes to the transcending of social cleavages. The interlinking ties central to it can contribute to overcoming ethnic, gender, class, caste and other social polarities and to building overall social cohesion. Strong societies need both bonding and bridging capital but the latter seems to be important for achieving positive development outcomes in a society.

Bridging capital makes possible community cohesion, constructive conflict resolution, and collective action for the common good. It can be created by strengthening links among groups with strong group capital, or by the strengthening of dense and horizontal networks that draw into their ambit broad segments of society and so people different from each other. Such inclusive and extensive networks are an important part of a community's infrastructure for the strengthening of social capital. The critical feature of bridging capital is the bringing together of a diversity of people.

Thus, it is not only whether a community has sporting clubs, church groups, mutual aid societies, rotating credit societies and voluntary organisations that indicates the extent of its social capital. It is not only the extent to which people join and are active in a number of these, nor is it only the norms and values that are shared by the members. If the members of these organisations are determined by a particular characteristic and discourage or exclude those different from themselves from joining, then these groups may build group capital, but not social capital. Many such groups in Papua New Guinea have membership limited to a single ethnic group. Cooperation and mutual support within the groups may be strong but, without the interlinking ties, the existence of these groups does not directly contribute to overall social cohesion and well-being.

In some situations the capital that needs to be strengthened may be group capital, as in the case of families and communities torn apart by certain forms of conflict. In other situations, interventions need to focus on the formation of bridging capital.

Implications for research and practice

This analysis has implications for much recent field research on social capital. Social capital is frequently operationalised in terms of civic engagement or participation determined by levels of membership of a range of community and social groups.

Without data on the diversity or otherwise of the membership of the networks or groups, the analysis will not be able to distinguish between group and social capital.

Research into associational affiliation in Papua New Guinea, for example, could show dense networks of organisational membership – church groups, sporting groups, betel nut chewing groups, and others – but the groups to which a person belongs could consist overwhelmingly or exclusively of people from their own language group. Thus, such patterns of social connectedness could enhance group capital without enhancing social capital.

If the way in which people relate to each other, and their norms and values, affect both development outcomes and HIV infection rates, social and interpersonal relations need to become a primary focus of development practice. Methodologies have been developed and interesting work already undertaken in Zambia, Uganda and elsewhere by Ian Campbell, Alison Rader and other members of the Salvation Army teams, and in Malawi, Senegal and elsewhere by UNDP. These can be built upon and expanded.

Conclusion

Both types of social capital would seem to be important in determining the way communities respond to the HIV epidemic. Group capital could influence the extent of support and mutual aid, and that of acceptance of or discrimination against the affected, within a group. Societies with strong group capital may have greater tendencies to blame or to revenge themselves on those outside the group. Bridging capital, with its links to strengthening norms of respect across differences, could lower rates of spread of infection and ensure more supportive reactions in the broader community.

References

- Putnam, R. 1993, *Making democracy work: Civic traditions in modern Italy*, Princeton University Press, Princeton.
- Rossing Feldman, T. and S. Assaf 1999, *Social capital: Conceptual frameworks and empirical evidence: An annotated bibliography*, Social Capital Initiative Working Paper No. 5, World Bank, Washington, DC.

HIV and technology: The issue of prophylactic vaccines

Susan Kippax, National Centre in HIV Social Research, The University of New South Wales

Vaccines are now on the agenda in the fight against HIV. The once-distant possibility of human trialling of prophylactic vaccines is now a reality and vaccine trials are under way in the United States, Thailand and Africa. Trialling of other vaccine candidates is under review and it is expected that this trialling will commence very soon in Australia as well as elsewhere in both the developed and the developing world. In some of these countries, the vaccines will take their place alongside behavioural prevention and treatments as ways to combat the HIV epidemic. In other countries, prophylactic vaccines will complement behavioural prevention efforts, while in some others, notably in sub-Saharan Africa, there may be little else.

Prophylactic vaccines are essential in the continuing battle to stem the spread of HIV. This is especially so in countries that have a high prevalence of HIV, such as Zimbabwe and South Africa where it is estimated that up to 20 per cent of the population is infected and where there is little if any sign of a decline in infection rates.

There is no disagreement that there is a need for the speedy development and trialling of safe and effective prophylactic vaccines in all parts of the world. There is, however, a continuing debate about which vaccines should be trialled, how they should be trialled, and the ways in which their impact on behavioural prevention and access to treatments should be managed. The response of countries to vaccines is likely to depend on the socioeconomic conditions of the country, the capacity of its existing health and medical structures, and a number of other related factors such as the severity of the local HIV epidemic; the success of behavioural HIV prevention efforts; and the ease with which antiviral therapies and the treatment of opportunistic diseases can be accessed by those living with HIV.

I will not deal here with the raft of ethical issues that accompany the trialling of vaccines. My discussion will pay particular attention to two factors: the likely efficacy of a vaccine, and the extremely long process of development and trialling. There is no certainty that prophylactic vaccines will be 100 per cent effective and early candidate vaccines may be only 40–60 per cent effective. Also, there will be a time lag of at least five to ten years between the beginning of trialling and general distribution. If, at the end of this process, a vaccine candidate proves to be successful in reducing the likelihood of HIV transmission, governments will need to address the issues of access to, and distribution and take up of, the vaccine.

The developed world

Ideally, any vaccine initiative should occur within the framework of a thoroughly researched and highly organised prevention,

education and treatment package. Establishing a consortium of basic scientists, community representatives and social researchers is one way to ensure that behavioural prevention and treatments are included within any vaccine initiative. Such an approach has a number of advantages. Social scientists (Kippax 1999) will ensure that there is

- an assessment of at-risk populations' expectations of HIV prophylactic vaccines and their understandings of and motivations to participate in vaccine trials;
- a monitoring of the risk-related behaviours of trial participants and how the trial is affecting participants; and
- an assessment of the impact of vaccine trials on members of communities, particularly those communities and at-risk populations from which trial participants are drawn.

Assessments of the behaviours and beliefs of populations-at-risk and trial participants will enable community educators to dispel misperceptions and confusion about vaccine trials and to educate the populations from which vaccine trial participants are recruited about the continued need for safe practice. However, as Michael Kirby pointed out at the International Conference on AIDS in Asia and the Pacific, held in Kuala Lumpur in 1999, herein lies a paradox for HIV vaccine trials. Assessing the efficacy of a prophylactic vaccine is dependent on unsafe practice.

Community representation and consortium membership will also provide the means to understand the needs and concerns of trial participants and secure a link to principal HIV prevention providers. Community representation will also contribute to the development of policy, particularly in regard to access to treatment issues for trial participants.

In general, the presence of community educators and social researchers will help counter any premature and/or unrealistic optimism with regard to vaccines, not only among trial participants but also among the communities from which they are drawn. In the case of a vaccine with low-to-medium efficacy, say 50 per cent, close monitoring of risk practice among the participants and communities at risk of HIV will be invaluable in addressing behavioural prevention and reducing harm. Without such community and social science input, a possible scenario for a vaccine of low efficacy in the developed world is an increase rather than a decrease in HIV transmission. Indeed, behavioural interventions will need to be reinforced with the trialling and introduction of a prophylactic vaccine.

In some countries in the developed world, such consortiums are already in place, for example the Australian HIV Vaccine

Initiative (AHVI) in Australia. Vaccine development and the planning of trials have been organised and managed in Australia by a consortium of basic scientists, social researchers and community representatives. Among other things, this group is committed to: ensuring that vaccine trials occur within the context of a prevention, education and treatment framework; providing a significant role for social research; and ensuring a central role for community. It is also committed to developing appropriate scientific, community and government partnerships with overseas partners.

At the very least, such a commitment to a coordinated vaccine, behavioural prevention and treatment package will guarantee that vaccines and vaccine development and trialling do *not* adversely affect existing treatment, care and prevention gains. At the very best, it will mean that the combination of effective vaccines, treatments and behavioural prevention should see the eradication of HIV.

The developing world

The developing world is not homogeneous with regard to its response to the threat of HIV. In some countries, such as Thailand, behavioural prevention has been reasonably effective and access to treatments is becoming a reality. Ideally in countries like Thailand, the response to vaccine development and trialling will be similar to that described above for developed countries, that is, a coordinated response in which vaccines sit alongside prevention and treatments.

In countries that have been slow to acknowledge HIV and where there are now very high prevalence rates, the situation is likely to be very different. While such countries provide the best sites for an assessment of the efficacy of prophylactic vaccines, they are also likely to be the ones with weak institutional capacity.

The degree of death and suffering associated with AIDS places pressure on governments to look to treatments and vaccines as a way of responding to the crisis. As Esparza (1999) among others has noted, a country with 20 per cent of its people infected is likely to see things very differently from a country that perceives AIDS as a treatable problem, particularly if in that country prevention efforts are minimal and/or ineffective. In a real sense, vaccines hold out the only promise to containing the epidemic in these countries, but at the same time vaccines or their promise may undermine access to treatments for those already infected and severely diminish behavioural prevention efforts. Writing in 1994 on the influence of the medical profession on post-independence health policies, a Nigerian sociologist (Alubo 1994) argued that a technological curative bias is inappropriate in a country whose most serious health problems are infectious/communicable diseases, nutritional deficiencies and high child mortality. The solutions to these problems are largely preventive: immunisation and vaccination, well-designed health education, and relief from poverty.

The issue of access to treatments is an extremely vexatious and difficult one and continues to be debated. There is little doubt, however, that, given the time needed for the development and trialling of an effective vaccine, behavioural prevention must

be reinvigorated. Moreover, if as is predicted vaccines are unlikely to be 100 per cent effective, keeping prevention in place and doubling efforts to ensure its effectiveness is vital. This may prove to be economically difficult. In Africa, for example, with the possible exception of South Africa and possibly Zimbabwe, no government in southern Africa is likely to be able to bear the cost of a vaccination campaign, much less reinforce behavioural prevention at the same time. Donor organisations willing to fund both vaccination and behavioural prevention campaigns will be needed.

Ironically, where there is little effective prevention in place and little likelihood of access to treatments, vaccines pose, at one and the same time, the greatest hope *and* the greatest challenge. There are some, perhaps the pessimists among us, who fear that, in the short to medium term, a vaccine initiative may make it more difficult to find the political will and financial commitment for treatments and for preventive education. On the other hand, there are optimists who believe that the advent of vaccines will give countries renewed hope and the enthusiasm needed to develop behavioural prevention alongside the development and trialling of vaccines.

Conclusion

In the developed world, the challenge is to keep behavioural prevention and treatment access in place, alongside vaccines. That challenge will, I believe, be met. Vaccines and treatments mean more, not less, need for behavioural prevention, at least until a highly efficacious vaccine has been developed, trialled and distributed.

In the developing world, the scenario is different. Part of that difference lies in the economic and social structural conditions of the countries in question, in the high and increasing HIV infection rates, and in whether effective behavioural prevention is already in place. The challenge is, however, the same, that is to establish and/or maintain effective behavioural prevention alongside vaccine development and trialling. Indeed, in a very important sense, the challenge is accentuated, particularly if treatment access is seen as an essential ingredient in the package.

Alleviating the burden of HIV in developing countries is becoming an increasingly critical international issue. And, although not discussed here, ethical issues around vaccine trials and overall vaccine development must be debated. The issues raised in this paper merely provide a starting point.

References

- Alubo, S. Ogo 1994, 'The medical profession and health policy in Nigeria', *Studies in Third World Societies*, 5, 3–17.
- Esparza, J. 1999, quoted in P. Kahn, *UNAIDS to publish guidelines on ethics of vaccine trials IAVI report*, April–June, www.iavi.org/newpage/ireport.html.
- Kippax, S. 1999, 'Vaccines and health promotion: A coordinated approach to prevention', paper presented at 11th Annual Conference of the Australasian Society for HIV Medicine (ASHM), Perth, 9–11 December.

Australia's international response to HIV/AIDS

Jacinta Cubis, Public Affairs, AusAID

The UNAIDS Special Ambassador, Dr Mechai, warns about complacency in the battle against HIV/AIDS. As one of the architects of Thailand's highly successful response to the rapid spread of HIV/AIDS, he believes that awareness has decreased in his homeland since the late 1980s.

'You don't hear about it so much, don't speak about it so much. People think, "Well, the rain's going away, I can put away the umbrella". And then high-risk behaviour will surely return', warned Dr Mechai at a recent informal address he gave at AusAID, the implementing agency for the Australian Government's overseas aid programme.

No room for complacency

HIV/AIDS remains the biggest health and development challenge that poor countries are currently facing. Ninety-five per cent of those infected are from developing countries. Africa continues to bear the brunt of the epidemic. With less than five per cent of the world's population, countries in southern and eastern Africa are home to close to 50 per cent of those living with HIV, and 60 per cent of all AIDS deaths have occurred there (Annan 1999).

The centre of the epidemic, however, is moving to Asia and spreading alarmingly through the region's vast populations. In India, about 5 million people are now infected. A rise of just 0.1 per cent in prevalence among adults in India would add over half a million people to the national total of adults living with HIV (UNAIDS/WHO 1999:12). Pacific Island countries are also reporting an increase in infection rates. Papua New Guinea is facing a major epidemic, with an estimated 10,000 people already infected with HIV. This number is expected to increase to 25,000 by 2001. HIV/AIDS is currently the leading cause of death at Port Moresby General Hospital.

HIV/AIDS statistics, although grim, do not indicate the total impact of the epidemic. Half of all those infected are in their most productive years, leaving children without parents and countries without workers. This has an inevitable impact on the economic development of poor countries. Orphaned children drop out of school to look after their siblings, and their lack of education and need to earn a living can result in high-risk behaviour, increasing their exposure to infection. Finally, demands on public health care services increase, stretching already meagre infrastructure and resources in developing countries. Whatever the yardstick used to measure the impact of HIV/AIDS, its threat to development is unquestioned.

Sharing Australian expertise

According to Dr Mechai, Australia is a bright light in this gloomy global picture. He applauded its management of HIV/AIDS as a public health issue and the understanding and response by all levels of society to the epidemic, including government, the medical profession and the general public. In particular, he highlighted the success in public education, believing it to be one of Australia's most valuable exports.

Australia is drawing on its domestic experience and expertise in its international response to HIV/AIDS. Through its aid programme, it is working with governments and community groups in the Pacific, South and Southeast Asia, and Africa. In the areas of prevention, public education, treatment and care, it has a broad range of experience and skills to share with developing countries tackling the epidemic. Australia considers HIV/AIDS central to the development agenda, with about one health dollar in nine spent on HIV/AIDS projects.

As with our domestic experience, a comprehensive approach is being taken, involving all political and social sectors. Working through a local non government organisation (NGO) or hospital, for example, would be ineffective if the country's government were not as fully involved. Without this commitment, assistance from donors is not as effective. As Ambassador Mechai says: 'In every country, you have to get to people in the parliament to be involved . . . You have to have that sort of level, otherwise you can bark from the outside, but you can't bite from the inside.'

Programme partners

Australia's international response is consistent with the aid programme's focus on our region, with one-third of aid for HIV/AIDS going to Indonesia and one-tenth each to Papua New Guinea and the Southeast Asia region. One-fifth of the aid for HIV/AIDS is directed to southern Africa, reflecting the extent of the epidemic in that region. Our response is implemented through global, bilateral, regional and NGO programmes. At the global level, Australia is an active participant in UNAIDS and its strategies play an important role in establishing programme approaches.

HIV travels with people, knows no borders and requires comprehensive regional cooperation. Australia is supporting the Mekong Regional HIV/AIDS Initiative which aims to increase the effectiveness of multicountry responses to the epidemic. It

focuses on issues such as increased distribution of condoms; management, prevention and care of sexually transmitted diseases; increased care for affected individuals; and education programmes. Indigenous NGOs can access grants from the Mekong Initiative for grassroots activities, such as health education for sex workers and prevention projects for truck drivers and fishermen. Assistance is also being provided to multilateral organisations such as UNICEF and UNAIDS to support sub-regional coordination and other multicountry HIV/AIDS initiatives.

Bilaterally, the aid programme is targeting HIV/AIDS through significant projects in Papua New Guinea, Indonesia, China and, in the near future, India. The epidemic is spreading rapidly in Papua New Guinea, which is quickly becoming the most significant component of our HIV/AIDS aid allocation. The National AIDS Support Project (\$50 million over five years) will support the implementation of the Government of Papua New Guinea's National HIV/AIDS Medium Term Plan. This follows the successful Sexual Health and HIV/AIDS Prevention and Care Project. The involvement of national and provincial governments, health authorities, and church and community groups contributed significantly to the project's success. For example, research into sexual practices by the Institute for Medical Research led to the development of community based peer education and intervention programmes in Port Moresby and Lae. These programmes target vulnerable groups, including sex workers, transport workers, seamen and police. This behavioural research provided an early warning of the potential for rapid transmission of HIV where STD rates were very high.

India is experiencing the most dramatic relative increase in HIV/AIDS expenditure of any country under the aid programme, with the introduction this year of a substantial project which focuses on New Delhi and the northeast states of Manipur, Meghalaya and Mizoram. In Delhi, the new project will increase the access of people living with HIV/AIDS to counselling and testing services. They will also be able to obtain improved treatment, care and support services. The project will target street children, commercial sex workers and prisoners by intervening to prevent the spread of HIV/AIDS to these high-risk groups. In the northeast states, the project will focus on injecting drug use, improving the ability of state AIDS societies to plan, monitor and coordinate HIV programmes, and supporting NGO and community based responses.

Australia's HIV/AIDS investment in China remains a modest though important contribution, particularly given that it is targeted towards marginal at-risk populations in Xinjiang and Tibet. Xinjiang region reports the second highest number of HIV cases in China. The project's approach is again comprehensive, addressing affected communities and governments alike. It includes social outreach programmes to promote prevention and care; assistance with the development of a legislative and policy framework; harm minimisation; and improvements to HIV/AIDS surveillance systems. The aid programme also targets the Tibet Autonomous Region as it is

increasingly vulnerable and prevention efforts to date have been limited.

Working with local communities

As with all development projects, involving affected communities in every stage of HIV/AIDS projects generally makes them more effective and sustainable. This includes people living with the virus, who have much to contribute in the design and implementation of HIV education and support programmes. Supporting the work of NGOs, whether in Africa, Thailand or India, is essential for community participation. It is central to Australia's international response, as is supporting the global strategies of UNAIDS, the regional approaches of UNICEF and the national HIV/AIDS plans of individual countries. Support for local communities gives the people affected by the epidemic the power to take action, such as education for young people in Malawi, home based care for people living with AIDS in Zambia, and the chance to earn a living and become self-reliant for women living with HIV in India.

One such NGO project which has received funding from the aid programme demonstrates the important role that religious institutions play in responding to HIV/AIDS. The Sangha Metta Project in Chiang Mai in Thailand trained Buddhist monks and nuns to work with local communities on HIV/AIDS prevention, education and care. Monks in several northern and northeastern provinces now work with community leaders, and women's and youth groups to identify ways to manage HIV/AIDS at the local level. Monks and nuns provide counselling and care for people living with HIV/AIDS, run youth camps, and maintain a home for AIDS orphans, training them in life skills or offering them work in temples. An increasing number of monks from Burma and from Yunnan province in southern China are participating in the training courses, taking new skills and knowledge home to work with their communities.

As Ambassador Mechai emphasised during his Australian visit, governments may come and go but religious institutions are more enduring and a valuable conduit to local communities to help in the management of HIV/AIDS.

Injecting drug use

According to David Hook, sector analyst with AusAID, Australia has particular expertise to offer in the area of harm reduction for injecting drug users: 'The Asian Harm Reduction Network, which was established in 1995, began in Australia and is now based in Chiang Mai, Thailand. It has over 500 members and has recently released a manual to support the development of further initiatives in Asia such as blood safety, treatment and care' (personal communication).

Australia also supported the Shalom project in Manipur which established India's first needle exchange programme. In so doing, it not only implemented an approach now being adopted elsewhere in the region but it was also the catalyst for the adoption

of harm reduction within the Manipur State HIV/AIDS policy. It has strong support from the community and the local government, who see this as an issue that affects them all. As a major transportation route for heroin from the Golden Triangle, the northeastern states have a significant problem with intravenous drug use and HIV infection, particularly among young people. Recognition and local community ownership of HIV/AIDS management is the first step to responding to the epidemic.

Lessons in behavioural change

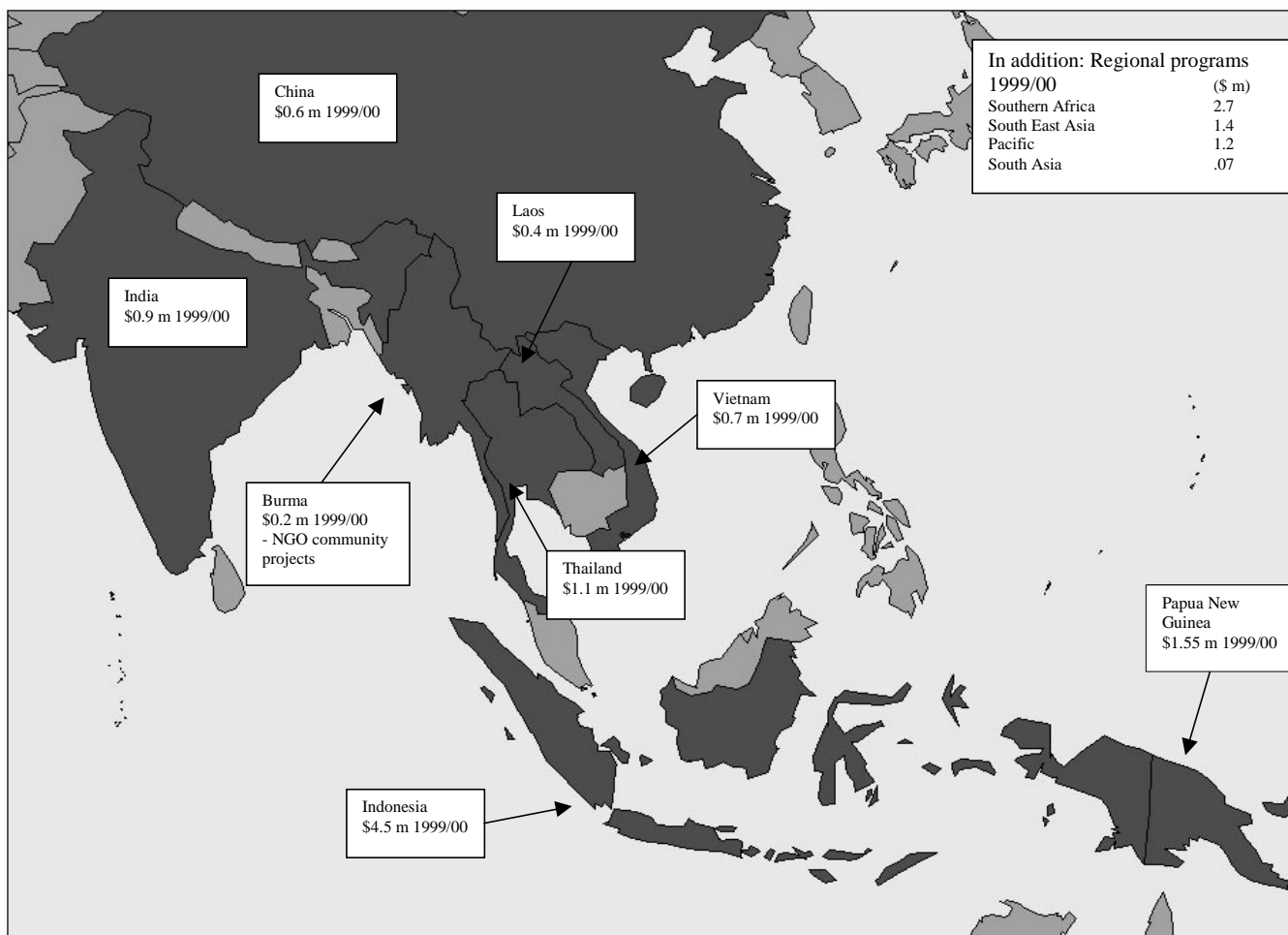
While Dr Mechai is positive about Australia's successful public education campaigns, experience has shown the need to continually assess performance in prevention projects involving behavioural change. Though the problems in Thailand and the Philippines, for example, may be similar, vastly different public information and education campaigns may be required. Education and condom distribution projects, for instance, cannot be considered an effective response unless gender issues

have been taken into account. Generally, the role of women in society may make it very difficult for them to take protection measures.

As stated in AusAID's (1999) *Guide to HIV/AIDS and development*, focusing resources on structural changes to improve the status of women by increasing their access to education, credit, skills training and employment is as much a component of HIV/AIDS prevention strategy in the longer term as raising awareness about sexuality, sexually transmitted diseases (STDs) and condom use. Start-up funding provided under the Australian aid programme helped to establish vocational training units for women in Mumbai. Their market research was so effective that the project now pays for itself through the manufacture and sale of garments and goods they produce.

Similarly, prevention programmes will not reach the majority of women if they target only sex workers or other groups engaged in high-risk behaviours. STD and HIV/AIDS services can be made more available and accessible to all women by integrating the services with family planning and maternal health services,

Australian aid expenditure – HIV/AIDS, 1999/00 expense estimates



Source: Australian Agency for International Development (AusAID).

as has happened with the Women's Health Training Project in the Philippines. The project aims to improve the ability of health care personnel to provide integrated women's health care services, particularly to women of reproductive age. Such integration removes the embarrassment and stigma associated with visiting STD clinics. As reported in Papua New Guinea, a successful trial with female condoms demonstrated the effectiveness of the device in helping women to take steps to protect themselves and their partners.

Education and prevention will have the most effect with the young. In Ambassador Mechai's words: 'Change of behaviour is far easier with "young wood" than . . . "strong wood".' Further, the education of young people is a priority, as each minute five young people are infected with HIV (UNAIDS 1999). Anti-AIDS clubs and peer education in Malawi, for example, are teaching young people in primary and secondary school how to reduce the risk of contracting HIV/AIDS. The project, 'Going to Scale', has resulted in an increased demand for and use of youth reproductive health services, condoms, contraceptives and counselling. The number of community members joining the clubs, youth centres and life skills courses has also increased since the project began.

Conclusion

This brief overview has shown that the lessons learnt from Australia's domestic experience are having an impact in developing countries through its aid programme. Through global, regional, bilateral and NGO programmes, Australia is helping communities and governments to recognise the issues and identify appropriate responses, and is supporting their implementation. The complacency of which Mechai warns is clearly not reflected in the continuing emphasis given to Australia's international response to HIV/AIDS.

References

- Annan, K. 1999, 'Confronting HIV/AIDS "a point of honour, not a source of shame", Secretary General tells partners against AIDS in Africa', UN Press Release SG/SM/7247, Geneva, 6 December.
- AusAID 1999, *Guide to HIV/AIDS and development*, AusAID, Canberra, October.
- UNAIDS/WHO 1999, *AIDS epidemic update: December 1999*, www.who.int/enc-hiv/.
- UNAIDS 1999, World AIDS Day Campaign, 1 December 1999, www.who.int/multimedia/wac/index1.html.

The HIV/AIDS epidemic in India: Are we doing enough?

Indrani Gupta, Institute of Economic Growth, Delhi

There is often a feeling in India that the AIDS epidemic has been given more attention than it deserves. After all, there are large numbers of individuals who are sick and dying from other serious and chronic diseases as well. Why single out the epidemic and give it so much attention, often to the exclusion of other diseases?

While a really good answer to this would require a lot more information and data, there is no doubt that the epidemic has received a lot of attention and funding in the past decade. Even if it is granted for argument's sake that this resource-intensive attention has been disproportionate to the problem, what have we achieved? If at least the spread of the virus had been arrested to a significant extent, some of this would be justified.

The National AIDS Control Organisation states that there were 3.5 million HIV-infected adults (15–49 years) in India as of mid-1998. By its own admission, the virus has spread from urban to rural areas and from high-risk to the general population. But the prevention and control programme has been in place for at least eight years now, with two substantial loans from the World Bank, as well as other assistance from organisations like USAID, Department for International Development, and many other bilateral donors. In addition, the Indian Government has added its own not insignificant contribution to the total funds. Why then has India not been able to make a significant dent in the epidemic?

Integrate development and other programmes

I argue that treating the epidemic as a problem separate from the problems of development has been counterproductive. While no one doubts that separate disease-specific programmes are needed, the rapid spread of the disease and its severe impact both, to a large extent, have to do with deep-rooted developmental problems that cannot be tackled only with such programmes. Over the years, numerous national and international documents have stated that HIV/AIDS is a developmental problem. However, there has not been a translation of this statement into action and programmes. One case in point is the northeast region of India, where some states are in the throes of a terrible epidemic. My experience in Manipur leads me to believe that cosmetic tinkering with interventions, hoping that it will bring behaviour change, is not going to achieve much result. The complete lack of development, the decay of educational institutions, the lack of

employment opportunities all need to be tackled on a war footing, to make any impression. Similarly, until individuals perceive that urban areas are not a better economic haven than rural areas, rural–urban migration will continue unabated, overcrowding the cities, increasing the slum population and leading to growth in the informal and unorganised sectors, none of which is conducive to the arrest of the epidemic.

It is not as though this is the first time these issues are being talked about, but, unfortunately, a concerted effort is not being made at the national level to really address them. The reason is not too difficult to fathom. Recognising that HIV/AIDS, as well as other diseases like TB, leprosy and polio, probably all have to do with a basic want in our societies, development would imply a completely new way of tackling these issues, which may be difficult with the current set-up. With the dubious distinction of being one of the largest countries in the world, with a highly pluralistic and democratic structure and with an administrative and bureaucratic system which often slows down the process of development, it is certainly difficult even to begin to understand how one should tackle the issues. But a beginning must be made. Merely because the problem is gigantic should not bring forth a paralysis of correct policy making.

Tackle economic conditions

To begin with, someone has to seriously tackle the economic conditions under which people live. While both at the centre and in the states annual as well as five-year plans are being routinely implemented, it is probably time for all to sit together and worry about why these plans are not changing things much, especially for the more disadvantaged of the population because they are the most affected by an epidemic. While some states have been making better progress than others, much of India still lives in abject poverty.

Tackling economic development is mainly the job of economists. But have they really delivered in India? If they had, India would not still have more than 30 per cent of its population living below what is essentially a very modest poverty line. Nor would people be fleeing states like Bihar and Orissa in hordes to come to the cities, thereby exacerbating problems like HIV, hepatitis and TB, both at the origin as well as at the destination. While much is currently being made of migrant workers as a potential high-risk population group, the fact remains that, unless the root cause of this migration is tackled, the epidemic will continue unabated.

The fact that very few economists have taken an active interest in the epidemic in India clearly demonstrates that it is still being thought of as merely a 'behavioural' issue that other people should deal with. The fact that this 'behaviour' has to do with the same developmental problems that the economists are trying to come to grips with is not striking too many of them. This is also why economists must stop working in isolation on issues of development, which do not merely comprise economic growth, and see for themselves why the policies and plans they are formulating are not bringing forth the desired results.

The way forward

All this is easier said than done. How should we make a beginning? There are many ways to move forward. I will mention only a few, but the basic message is the same in all. Interventions, programmes and policies need to be integrated with development objectives, and not merely disease. Parallel disease control programmes that try to reach the same population are not cost effective. Greater attention should be paid to how programmes can pool resources, and there must be flexibility in programme financing so that mere administrative reasons do not impede interventions.

From the health sector side, separating out HIV/AIDS as a disease that needs special attention can be more harmful than beneficial if one thinks of stigma and discrimination. There are numerous things that need to be set right in our health care delivery system, both private and public. The quality of, as well as access to, publicly funded facilities are poor, and the costs of private care are very high. Besides, the standards of private care leave much to be desired because of lack of regulation. Under these circumstances, there is every need to ensure that all those who seek care, whether HIV-positive or otherwise, receive quality care without prejudice. While improving the health care system sounds like a daunting proposition, I think that this is what health sector policy making should be all about – to examine the constraints that prevent people from getting quality care at a reasonable price. Spending large amounts on a system that clearly needs revamping is throwing good money after bad.

The same set of issues arises in relation to another aspect of the epidemic: impact. The impact is greatest on the most

vulnerable of the population, but so is the impact of a whole host of other diseases and social ills. It will be very costly and not fair to tackle each issue one at a time. While the peculiarities of the epidemic that set it apart from other diseases do warrant specialised intervention on the care side, realistically it will not be feasible in less developed countries like India to take care of all the individuals infected and affected by the epidemic. As in other health problems, individuals will fall back on their own resources and support networks. But an enabling environment does not yet exist in India. Access to reasonably priced quality health goods and services, as well as to information, a functioning referral system, and insurance, along with an absence of discrimination and stigma, would go a long way towards ensuring that the impact of the epidemic is lessened.

As for HIV/AIDS prevention and control measures, while there are some essential components like blood safety and sexually transmitted disease programmes, others like information, education and communication (IEC) and condom programming leave much to be desired. Both are unlikely to succeed to the extent desired because of the issues mentioned above. Human beings are rational under the best of circumstances, and the circumstances are not best for many. Merely supplying condoms is not going to create a demand for them; the demand has to be genuinely felt. Similarly, merely a message that AIDS can kill does not make much impact on those at whom these messages are mainly targeted. It is my belief that these interventions work best for those who have reached a minimum level of socioeconomic development. For others, the calculations of benefit and cost are very different.

Conclusion

Does this imply that one should not have IEC or condom programmes or impact alleviation programmes at all? The answer is not easy. In the absence of any concerted attempt to improve the circumstances of the majority of people, they may be the second-best option. But the costs must be weighed against the benefits. Unless all those whose job it is to hasten the pace of development make a real effort once more to tackle the backwardness of regions, areas and groups, and to examine the constraints on development, it is unlikely that the HIV/AIDS epidemic will slow down in India in any significant way.

Hope, paradox and the politics of suspicion: Confronting latter-day AIDS in Thailand

Chris Lyttleton, Department of Anthropology, Macquarie University

A decade ago, Thailand was often profiled as the epicentre – the very heart – of a growing maelstrom that was destined to engulf the region. HIV infection levels were escalating across broad sectors of the Thai populace and its presence was being detected for the first time in surrounding countries. Predictions were common in those days that, by the turn of the millennium, Asia at large would be home to the greatest number of new infections. Such forecasts have been borne out. India presently stands out as home to an epidemic of outlandish proportions. Cambodia and Burma also.

In those days, graphs from the UN's Global Program on AIDS were used to showcase projections that new infection levels in Africa would drop during the 1990s, while those in Asia would continue to inexorably rise. Unfortunately, nobody is now optimistic that prevention programmes have won the day in the African continent. Many countries in sub-Saharan Africa remain locked in the grip of the ongoing and brutally devastating spread of HIV/AIDS. Leading into the new millennium, global publications such as the *New York Times* and *Newsweek* issued 'special reports' on the grim reality of life (and death) in those African countries where national levels of HIV infection have soared above 20 per cent.

As a counterpoint, these contemporary reports typically include brief suggestions of hope in reversing the seemingly unstoppable decimation that AIDS brings to countries in the Third World. Whereas ten years ago Thailand was depicted as the volatile heart of HIV in Asia, nowadays it has a very different image. It is more commonly represented as one of the few developing countries that have managed to tame the onslaught and, as such, often receives mention as an HIV/AIDS success story. As a nation, Thailand invites tremendous praise for the wholehearted manner in which government and non government bodies have, over the years, acted to rein in the impact of AIDS. And more than this; people throughout Thailand have effectively mobilised in both body and spirit to emerge (somewhat) from the dire blanket forecast that AIDS offers the social order.

But let us be clear: this is only a partial picture. New infection rates are dropping in many (but worryingly not all)¹ sectors of the Thai populace (Brown 1998), a trend that should be applauded and where possible replicated. But any social phenomenon that engages both the collective order and the human psyche to the extent that AIDS does cannot be simply and surgically isolated and removed. HIV and AIDS continue to have a tremendous impact in Thailand, although in sometimes more subtle and lateral ways than those headlined so effectively by early public health prevention campaigns. Here I wish to describe briefly three arenas where AIDS remains an issue of complicated importance in Thai people's everyday lives. Each

of these instances highlights the fact that AIDS and its effects are broadly and integrally enmeshed with myriad other political, economic and social forces that make up life in contemporary Thailand. Like so much to do with development in general, interventions in one realm have repercussions in others that are not always predictable or desirable.

Safe sex – or how do I know you?

Since the early 1990s, Thai television has aired numerous public health warnings about the danger of unprotected sex and the crucial necessity of condom use. Condoms have been distributed free in the millions to public health facilities and commercial sex venues. While the characters portrayed in health warnings have changed over the years, one message has been absolutely dominant. Commercial sex – and, more specifically, any women inhabiting this world (male sex workers get little attention) have become the 'object' from whom condoms provide protection.

The sheer pervasiveness of commercial sex in Thailand led to this being an effortlessly uniform and seamless image. Commercial sex is dangerous. Everybody got the message. Condom use went up as rates of brothel attendance plummeted. Because the dichotomy was so black and white, criteria of choice could easily be applied. If sex is bought, then men will by and large use condoms. By contrast, intimate relations that are not considered 'commercial' quickly and readily become typecast as 'safe'. In this light, safer sex becomes a variable practice, not based on the consistent use of condoms but on a decision as to 'who' one's partner is. Across the board, 'safer sex' in Thailand has come to increasingly mean choice of partner rather than use of condoms.

This picture has been further complicated by changing social mores born of the rapid period of modernisation that preceded and overlapped the spread of HIV. Village communities provide far less social control over the sexual activity of the young than in the past. At the same time, styles of commercial sex have changed dramatically (for Thais, as opposed to Western men for whom the 'red light' bars remain numbingly the same). Cheaper brothels, at one time a common sight throughout the country, have been closed as a combination of official pressure and changing demands of middle class males for different forms of 'entertainment' venue. Taken together, these changes have two very specific implications. First, whereas in the past many young men might have frequented brothels, there is a growing sense that being part of contemporary youth culture implies freedom for young men and women to casually sleep together. In this context, condoms are used far less commonly than in commercial interactions. Second, in order to diminish the

negative currency of HIV risk associated with commercial sex, the social settings in which sex may be negotiated have broadened. These locales utilise alternative signifying elements as part of their market appeal. For example, traditional massage parlours, karaoke bars and various styles of restaurant have now almost completely replaced the ubiquitous brothel as venues where sex can be purchased. Most importantly, this allows those engaging in these interactions to build narratives that define the liaison as less threatening precisely because the public symbols of commercial sex are disguised or muted. And, likewise, it means that the identity of 'prostitute' is neither so immediately applied nor taken up by women (and men) selling sex.

Thus, we now have a situation where casual sex is more widespread in Thai society and the marked distinction between commercial and non-commercial sex less obvious. This leads to more difficulty in applying the criteria of whether or not to use a condom. What then is of serious concern to HIV/AIDS workers is the possibility that in the absence of the stereotyped symbols of commercial sex emphasised by the long trail of popular and media discourse about AIDS, a large number of sexual interactions take place without the use of condoms, precisely because they are more ambiguous and/or more easily defined as non-commercial. This vulnerability to HIV is pronounced for numerous adolescents who, in addition to emulating so-called 'modern values' of greater sexual freedom, are also finding themselves in the thick of a burgeoning drug culture as amphetamines (and Ecstasy) continue to flood the country.

Civil society and the politics of suspicion

In addition to forthright and committed prevention policies, Thailand has made tremendous steps in coming to grips with the social future faced by roughly one million people with HIV. But, like anywhere else, even as compassion and social support have emerged in numerous contexts, so too stigma and prejudice remain distressingly sharp-edged for many affected by HIV.

At the same time as AIDS has become a high-profile symbol of modernity, the past decade has seen dramatic changes on the political front. Marked most notably by the middle class demonstrations and government violence that saw the demise of General Suchinda Kraprayoon's quest for power in 1992, Thailand has undergone huge steps towards a more broadly representational polity and more widely recognised civil society. This has been capped with the recent national Senate elections that brought a number of social reformists into parliamentary circles, including widely respected HIV/AIDS activist Jon Ungphakorn.

A key area in which civil rights have been actively championed in Thailand concerns the illegality of mandatory testing and the civil liberties of those being tested for HIV. After several ill-fated attempts at forms of registration for both commercial sex workers and those with HIV, the government has progressively enacted policies that guarantee anonymity to those affected by HIV. While these policies might not be practised with the utmost fidelity in every situation – there are still occasional reports of mandatory testing at hospitals and workplace sites – they bespeak a clear mandate for the rights of the individual. Taken as an emblem of the values of a civil society, respect for anonymity

suggests notions of a moral community where social responsibility, trust and cooperation come before strong-arm authority.

The implications of this ethos are that it is up to the individual (if he or she has tested positive) to determine to what extent the public and, sadly, often-stigmatised aspects of identification with HIV infection are taken up. It follows that, while everyone is aware that HIV is hugely prevalent, those infected cannot be automatically identified in policy or practice. This is the appropriate direction that has actively been chosen in attempts to come to terms with HIV/AIDS. Public disclosure is, therefore, a variable practice and how could it be otherwise? But there is, nonetheless, a downside. The application of anonymity raises attendant difficulties for Thai society at large and it causes a wide range of reactions. For example, it has posed obstacles for the establishment of HIV/AIDS support groups (PLWA – People Living With AIDS) in parts of the country (in certain northeastern provinces and many parts of the south) where the first wave of individuals to go public with their HIV status has yet to emerge. At another level, it gives rise to an ongoing politics of suspicion. Given that everyone knows that HIV is tremendously widespread, there is a tendency to use adjudications based on other characteristics. Instead, people find alternative modes of stigmatising individuals for associated behaviours. People judge others based on their appearance, personal history or modes of employment.

The tensions between the social control required of public health programmes, with its supposed impersonal monitoring of an epidemic, and the individual integrity and broad human rights required of a 'civil' society continue to erupt regularly in AIDS work. I have heard of enforced testing of women working in restaurants associated with commercial sex and of hospital workers insisting that patients be tested. Hospices for those with HIV/AIDS have been burned to the ground. Newspapers report increasing rates of suicide in areas most affected by HIV/AIDS and commentators suggest that this is a product of social anomie and fear of discrimination. The *Bangkok Post* (10 July 1998), for example, reported that in Chiang Mai, with high levels of HIV infection, suicides are six times the national average. Prejudice and stigma have not disappeared in the wake of civil approaches; they find alternative modes of exercise – gossip and suspicion find their own constituents, with a very real impact on those affected.

The rise and rise of PLWA groups

Throughout Thailand, personal responses to AIDS prevention discourses are now inseparable from a background of communal response. While stigma continues, there has been a dramatic surge in the number of community based groups and non government organisations that have mobilised in profound and deeply affecting forms of solidarity to dampen the horrors of AIDS. In the northern provinces, there are now more than 225 PLWA support groups, which have sprung up over the past five years. This I believe to be an absolutely unique phenomenon. Nowhere in the world, in such a small area, has there been such a demonstration of *communitas*, drawing concentrated government and local – and, most importantly, public – support

for those with HIV/AIDS. While numbers are fewer in other regions of Thailand, the mobilisation of PLWA groups is now the backbone of community-level government and non-government operations to help those with HIV.

Over the years, the general focus of the activities of these groups has evolved. Initially formed to offer education and moral support, nowadays, in addition to social welfare and economic livelihood, many groups see community and national politics as crucial arenas of operation. Public acceptance by local communities remains a key element. Increasing liaison is sought with the newly important government sub-district development organisations (*Or Por Tor*), both as a source of funding and as local-level political recognition. At the same time as activities are geared to assisting members of the PLWA groups – for example, the production of herbal medicine both as treatment and source of income – there is very often an important community outreach component. Many groups not only provide assistance to those ill with AIDS related disease but also perform a crucial role as spokespersons for continued community care in the broadest sense of the word. Throughout the country, they step forward as advocates for the changes needed to increase acceptance, to allow room for human dignity and to sustain the continued need for care, both in the sense of safe practice and in the sense of social compassion.

And yet the formation and functioning of PLWA groups is by no means straightforward. Social and cultural factors play an ongoing part in their makeup. One notable characteristic of many groups, in particular those outside Bangkok, is the much larger number of women members than men. This is most readily explained as a result of the demise of men with HIV sooner than women. While this, in turn, is usually explained as a sequence of timing of infection, others claim that the very act of joining PLWA support groups provides a crucial means of coming to terms with HIV infection.

Men, alternative explanations suggest, are less likely to want to go public with infection for reasons deeply steeped in gendered ideologies. Social and emotional exchange is considered to be more typically the domain of women; so much leaning on shoulders and public expression of 'need' is less acceptable to some (but obviously not all) men. In addition, men acknowledging HIV infection is assumed to be tantamount, in many people's minds, to an admission of behaviour that has nowadays been coded as negligent, irresponsible and stupid: that is, becoming infected through commercial sex. Some men do not join groups in order to avoid public recognition of this. And in what amounts to a complete reversal of gender characteristics, men with HIV are obliged to dwell on things (*khit mak*), a trait more typically regarded as a key aspect of women's tendency to infirmity. Instead, men are left on their own – they dwell on this and, so it is voiced, they die sooner without the opportunity for emotional or moral exchange.

Another very glaring absence from many PLWA groups is single women – that is, those who may have become infected through boyfriends or, in the case of commercial sex, clients. In the same way that embedded cultural beliefs affect the choices men with HIV make, so too entrenched ideas about modes of

infection and lifestyle influence the choices single women can make in seeking support for the presence of HIV. Just as a politics of suspicion shapes acts of safety (use/non-use of condoms) and social prejudice, so too it influences who fits within the bounds of support group assistance.

Conclusion

In each of the abovementioned contexts – prevention, surveillance and care – Thai initiatives, by and large, have been groundbreaking and serve as models valued for their effectiveness. Yet, if we assume that confronting AIDS is anything but simple, then these arenas must be appreciated not simply for their achievements but also for the ongoing, not always anticipated and sometimes counterproductive ramifications. Lessening the social impact of HIV/AIDS in Thailand and Asia remains an issue firmly stationed at the crossroads of deliberate planning and tremendous uncertainty. There is hope that certain lessons have been learned, certain corners turned. In a more recent arena, task forces have been established to marshal opposition to international trade rulings that effect a prohibitively high cost for many drug treatments. There have been some successes that have reduced drug costs, most notably with Fluconazole (via parallel importing) for cryptococcal meningitis, which is one of the most common opportunistic illnesses afflicting those with HIV in Thailand. But many licensing obstacles still prohibit the affordability of other pharmaceuticals. And just as in each of the above scenarios, complex contradictions emerge that shadow attempts to ease the burden of AIDS. In light of successful trials (and in face of the limited provision of state-funded AZT), cynical stories circulate of infected women deliberately choosing to become pregnant in the hope that the AZT that is given to prevent vertical transmission might remove the virus from themselves as well.

The numerous ways in which the effects of HIV/AIDS on the human and social body are embedded in other key forces that structure the social order – economics, politics, religion, gender roles, and so forth – mean that its dire prescription will only ever be partially addressed by policies. Wherever they are, people will continue to respond to the presence of AIDS in ways that do not conform to optimistic blueprints. In this respect, coping with AIDS both mirrors, and is intrinsically part of, much of what is defined as 'development' and bluntly reinforces the truism that interventions in the lives of people are never straightforward.

Note

1. After three years of decreasing rates, the 1999 Sentinel Survey conducted by the Ministry of Health showed an increase in infection levels amongst pregnant women indicating that downward trends are not yet all inclusive nor inevitable.

Reference

- Brown, T. 1998, 'The relationship of HIV and STD declines in Thailand to behavior change – a synthesis of existing studies', UNAIDS Best Practice Collection, UNAIDS, Geneva.

Reproductive health rights and women with HIV in Thailand

Andrea Whittaker, National Centre for Epidemiology and Population Health, The Australian National University

Introduction

It is estimated that one million Thais are infected with HIV and that an almost equal number will have died of AIDS by the year 2014 (Surasiengsunk et al. 1998). Although initially many more men than women were infected, the male-to-female ratio of infection has declined. This trend is expected to lead to an accelerated number of AIDS-related deaths among women (Gray and Punpuing 1999:28).

As the majority of women with HIV are of reproductive age, this has implications for the delivery of reproductive health services in Thailand. Sentinel surveillance data show that HIV infection among women attending antenatal care was 4–5 per cent in the northern provinces and approximately 2 per cent nationwide (Thai Ministry of Public Health 1999). The changing nature of the epidemic is forcing the government to now address the reproductive health issues for women with HIV and to integrate HIV prevention measures into government family planning and maternal and child health (MCH) services. Thailand has been a leader in many respects in its prevention and care programmes. A perspective concentrating upon the experience of women with HIV reveals a number of issues that are of relevance to other countries' programmes. This paper outlines some of the reproductive health dilemmas facing women with HIV and also calls for further research on these matters.

Reproductive health rights

The broad approach to reproductive health that emerged through the International Conference on Population and Development meeting in Cairo in 1994 linked reproductive health to reproductive rights and freedom. People have a right to a satisfying and safe sex life and a right to the freedom to decide when, if and how often they reproduce. This moves beyond narrow issues of family planning to an emphasis on integrated health programmes in which men and women can make informed choices and have access to: a range of safe, effective, acceptable and affordable contraception; appropriate confidential screening and counselling services; education for healthy sexuality; safe abortion services; MCH care; and treatment for reproductive tract infections (RTIs). It is a perspective which incorporates the sociocultural as well as the biomedical aspects of reproductive health (Pachauri 1994).

In the context of people living with HIV/AIDS, it is an approach which recognises the multiple needs of infected men and women to ensure a healthy, satisfying sexual life, informed choices about reproductive decisions, with the services to provide support for those decisions, informed screening and treatment

for RTIs, and appropriate confidential counselling services. Until recently, emphasis in HIV/AIDS programmes has been upon the prevention of transmission of HIV, with little attention to the reproductive health needs of people already infected.

Screening for HIV

Antenatal screening for HIV is now widespread in Thailand and is the most common way in which women discover their HIV status. The Thai Ministry of Public Health recommends that all pregnant women have an HIV test at health facilities where laboratory quality control is assured and where counselling services are provided in an appropriate manner. It is considered that early diagnosis of HIV infection can be beneficial in several ways: the woman can decide whether or not to terminate the pregnancy; if she decides to continue, the pregnancy can be monitored closely with appropriate protocols to prevent vertical transmission; and testing and care of the sexual partner to prevent further transmission can be undertaken (Koetsawang and Auamkul 1997:125). Such testing is voluntary, however, and the quality of pre-test counselling appears variable. The non government organisation ACCESS (Aids Counseling Centres and Educational Support Services) claims that many women have complained that they did not receive pre or post-test counselling and were left without information about the implications of their condition (Tansubhapol 1997). In some public hospitals with large numbers of women presenting for antenatal screening every day, videos are used for group counselling; other hospitals rely on educational brochures alone as a means of pre-test counselling.

Supporting informed reproductive decisions

Little is known about HIV-positive women's decision making about pregnancy and reproductive health. Based upon their experience at Siriraj hospital in Bangkok, Koetsawang and Auamkul (1997) suggest that a couple's decision to terminate a pregnancy is influenced by whether it is unplanned, whether they already have a child, family or personal problems, fear of an infected child, early pregnancy, and symptomatic HIV illness in the mother. The most important factors appear to be marital and socioeconomic status. Factors associated with the continuation of a pregnancy include asymptomatic infection in the mother, advanced pregnancy, a strong desire for a child, family willingness to care for a child and acceptance of the possibility it may be infected, good socioeconomic status, and religious and cultural beliefs (1997:123). In a sample of 154

HIV-positive women in Petchaburi province, approximately one-quarter (38 women) terminated their pregnancies (Auttgovit 1995, cited in Gray and Punpuing 1999:19). Women whose husbands worked in agriculture were 2.4 times more likely to terminate their pregnancies than women whose households had other occupations. This finding supports the notion that economic status may be one of the most important determinants in women's decision making.

Informed reproductive decision making includes the need for women to have accurate information about the effects of pregnancy upon their health, about the risks of vertical transmission of infection, and about support services for their child. Pregnancy may exacerbate the advanced stages of HIV infection but its effects on progression in asymptomatic women are not known. There is no conclusive evidence regarding any adverse effect of HIV infection on a pregnancy. The major issue for pregnant women with HIV is the risk of vertical transmission of the virus to the child in utero, during labour or postpartum. Various studies suggest that it takes place in 10–39 per cent of children born to infected mothers. Koetsawang and Auamkul (1997) report a rate of 24 per cent at Siriraj hospital. The management of pregnant women with HIV in that hospital includes close monitoring, including periodic and baseline physical and laboratory assessments, and asking women to be attentive to HIV-related signs and symptoms. Procedures during labour, such as early cord clamping, the avoidance of procedures such as early rupture of membranes, and disinfection of the birth canal, have been instigated. Breastfeeding is discouraged through a government programme to supply substitutes to HIV-infected mothers. Advances in retroviral therapy, including the 'Bangkok regime' in which AZT is administered daily to pregnant women from week 36 to delivery and later to the newborn infant, further reduces the vertical transmission rate and is likely to result in more women deciding to continue their pregnancies. The Thai Government is aiming to provide the option of such therapy to pregnant sero-positive women across the country. However, the programmes and standards of care possible in a major teaching hospital in Bangkok are not necessarily available to women in less well resourced parts of the country, reliant upon district hospital services.

After the birth, mothers face disclosure issues and typically wait 18–24 months before a conclusive diagnosis can be made of their child's HIV status. Apart from their own health difficulties, the reduction in income, separation, illness and/or death of a partner or child, as well as the burden of child care responsibilities all impact negatively upon these women. A study by Bennetts et al. (1999) found depressive symptoms and HIV-related worry were common among HIV infected pregnant women in Bangkok. Higher levels of reported depression were found among women who were no longer in a relationship with their partner, who had an infected child, who had not disclosed their HIV status or who felt that their families would be ashamed of their HIV status. They point to the need for psychological support interventions for such women as well as income support for single mothers. Since the early 1990s there has been a growth in People Living With AIDS (PLWA) self-help groups in Thailand, with over 209 operating as of May 1999 in the six

provinces of the north. Although not necessarily woman focused, such organisations have provided an important means for PLWAs to become actively involved in the treatment, prevention, care and policy development surrounding HIV/AIDS. They have also been creative in addressing social stigmatisation by enlisting HIV-positive men and women as educators and role models. One of the earliest of these groups was the Doi Saket group of widows, consisting of AIDS widows who were themselves infected and facing stigma and severe difficulties in raising their children (Tanabe 1999). In a sample of sero-positive women in Bangkok, 58 per cent stated they would attend an HIV support group for women if one were available (Bennetts et al. 1999). The development of such groups should continue to be supported, but it is also important to recognise that many of the most marginalised may not attend such organisations and there remains a need for services to be provided to individual families as the opportunity arises.

Legal status of abortion for HIV-positive women

A major issue in Thailand is the question of legal access to safe abortion services for women who are HIV-positive. Presently, if they do wish to terminate their pregnancy, they technically violate the 1957 Abortion Law that carries a jail sentence of up to three years and/or a 6,000 baht fine (Population Council 1981:101–2). Doctors also face prosecution if they carry out abortions. Despite the legal uncertainties, the Thai Medical Council has been lobbying for changes to the law to make it legal for a woman with HIV to terminate her pregnancy (*Bangkok Post* 9 February 1996, Khaykaew 1995). To date, however, their efforts have been unsuccessful and such abortions remain technically illegal, although widespread. Some hospitals attempt to circumvent the legalities by citing mental health problems on the part of the mother as the reason for a legal termination, but they do so on tenuous legal grounds and the decision is left to the discretion of the medical staff of each hospital. While pregnancy terminations are available to women with HIV in the larger metropolitan government teaching hospitals, anecdotal evidence from people working with PLWAs suggests that a number of women with HIV in rural areas who wish to terminate their pregnancies have had enormous difficulty in locating a doctor prepared to provide this service (Tansubhapol 1997). These women have to resort to illegal private clinics at very high prices they cannot afford or the services of untrained practitioners, with the consequent danger of serious complications.

The importance of access to abortion services for HIV-positive women is evident from a number of studies documenting the large percentages of infected women who choose to terminate their pregnancies. Research at Ramathibodhi hospital in Bangkok reported that between January 1991 and December 1993, 85.7 per cent of 91 HIV-positive women opted for induced abortion. The perinatal transmission rate among the remaining mothers was 19 per cent (Phuapradit et al. 1995). At the same hospital from 1991 to 1995, 90.9 per cent of pregnant adolescent women found to be HIV-positive chose to have an induced abortion (Taneepanichskul 1995). A study of

264 HIV-positive pregnant women undergoing counselling in northern and central Thailand (Kraisurapong 1996, cited in Gray and Punpuing 1999:14) found that almost half wished to terminate their pregnancies for fear the child would be infected, but two in three had found that they were not able to do so as they were more than 12 weeks pregnant.

Following a birth or abortion in Thailand, it is recommended that women with HIV receive counselling regarding either permanent sterilisation or the use of a long-term contraceptive, such as Norplant subdermal implants or Depo-Provera injections, to avoid any unplanned future pregnancies. Couples are also advised to use condoms in every sexual encounter. In practice, however, there appears to be considerable variability in the quality of counselling, with pressure placed upon women to decide in favour of sterilisation. For sero-positive women not using effective long-term contraceptives, access to emergency contraception may be important but currently not available.

Sexual health

Until recently very little attention has been given to the sexuality of HIV-positive people. Yet there are various ways in which HIV infection affects sexuality (Schiltz and Sandfort 2000). For many, the infection totally compromises their sexuality, inducing various sexual problems. Disclosing their sero-status to partners, coping with depressive states, trying to protect partners, the difficulty of maintaining safe sex practices over a long term and the need to protect themselves from further infection with HIV or an RTI are all dilemmas for sero-positive people. Particularly if their partner is already infected, there may be little motivation for couples to engage in safe sex practices, despite the problems of increasing viral load through reinfection. The limited means of protection – condoms and non-penetrative sex – remain largely controlled by men. Thai women are expected to passively accept their husbands' behaviour and decisions and are unlikely to negotiate in sexual relations (Knodel and Pramualratana 1996). For sero-positive women working in the sex industry, the '100 per cent condom campaign' of the Thai Government greatly assists the negotiation of safe sex by encouraging a climate in which it has become standard practice (Rojanapithayakorn and Hanenberg 1996). However, more research is needed on how women successfully protect themselves and their partners while avoiding disclosure of their status. Reproductive health services need to address the need for negotiation skills for sero-positive people, whether their partner is infected or not, and to pay heed to their well-being and problems in order to support them in having safe sexual lives.

The quality of screening and appropriate treatment services for RTIs among men and women attending health services remains variable. On the whole, there is poor integration of such services at the primary care level, especially for women who may remain asymptomatic and hence be far less likely to suspect that they have an infection. Health services need to be able to provide effective screening as well as treatments for common endogenous infections, such as bacterial vaginosis and vulvovaginal candidiasis, which may be particular problems for immunocompromised women.

Conclusion

Despite policies that encourage more integrated reproductive health services in Thailand, the practices of hospitals and health services on these issues remains variable, and dependent upon the attitudes, resources and training of staff. More research needs to be done on the realities for women in ordinary health services, not just at the major teaching hospitals. The social, psychological and economic consequences of HIV infection and how these change over the course of a woman's infection need to be better understood. Some of these issues relate to policy; others require the integration of diagnostic, counselling, care and treatment protocols into services and the appropriate training of staff. The interventions required will improve the quality of care for all women, regardless of their sero-status.

References

- Bennetts, A. et al. 1999, 'Determinants of depression and HIV-related worry among HIV-positive women who have recently given birth, Bangkok, Thailand', *Social Science and Medicine*, 49(6), 737–49.
- Gray, A. and S. Punpuing 1999, *Gender, sexuality and reproductive health in Thailand*, Institute for Population and Social Research, Mahidol University, Bangkok.
- Khaykaew, T. 1995, 'Thailand: Abortion plea for AIDS virus women', *Bangkok Post*, 26 November.
- Knodel, J. and A. Pramualratana 1996, 'Prospects for increased condom use within marriage in Thailand', *International Family Planning Perspectives*, 22(3), 97–102.
- Koetsawang, S. and N. Auamkul 1997, 'HIV and women in Thailand: Severity and services', *International Journal of Gynecology and Obstetrics*, 58(1), 121–7.
- Pachauri, S. 1994, 'Relationship between AIDS and family planning programmes: A rationale for developing integrated reproductive health services', *Health Transition Review*, 4(Supplement), 321–47.
- Phuapradit, W. et al. 1995, 'Routine voluntary antenatal anti-HIV screening in Bangkok, Thailand', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, 35(2), 168–72.
- Population Council 1981, *Abortion in Thailand: A review of the literature*, Bangkok.
- Rojanapithayakorn, W. and R. Hanenberg 1996, 'The 100 per cent condom program in Thailand', *AIDS*, 10(1), 1–7.
- Schiltz, M.A. and T. Sandfort 2000, 'HIV-positive people, risk and sexual behaviour', *Social Science and Medicine*, 50(11), 1571–88.
- Surasiengsunk, S. et al. 1998, 'Demographic impact of the HIV epidemic in Thailand', *AIDS*, 12(7), 775–84.
- Tanabe, S. 1999, 'Practice and self-governance: HIV/AIDS self-help groups in northern Thailand', paper for AIDS, The First Decade: A Civil Approach? panel, 7th International Conference on Thai Studies, University of Amsterdam, 4–8 July.
- Taneepanichskul, S. et al. 1995, 'Adolescent pregnancy with HIV-1 positive in Ramathibodi Hospital 1991–1995', *Journal of the Medical Association of Thailand*, 78(12), 688–90.
- Tansubhapol, K. 1997, 'The right to choose', *Bangkok Post*, 20 September.
- Thai Ministry of Public Health 1999, 'HIV serosurveillance in Thailand: Results of the 16th round, June 1998', *Monthly Epidemiological Surveillance Report*, 30(1), 1–11.

HIV vulnerability and mobile populations: Thailand and its borders

*Allan Beesey, Asian Research Center for Migration, Institute of Asian Studies,
Chulalongkorn University, Bangkok*

The Thai HIV/AIDS epidemic is more than 12 years old, and over that time HIV has spread to surrounding countries. This spread across national borders has been a concern for some time; however, immediate issues of health are sometimes overridden by security, trade and other concerns. The intersection of HIV and movements of people was an important factor in the initial spread of HIV within nations and now those intersections are apparent within transnational movements. The cliché 'AIDS knows no borders' is not a call for the closure of such crossing points and to point blame, but to warn that the spread of HIV does not stop at borders. AIDS spreads through the mobility of people, which can be short and long-distance internal movements or through transnational mobility. HIV spreads out from sites of infection, and the spread may be rapid when there is a large pool of infection.

Large volumes of Asians are moving in search of work. Three types of migration, within unskilled or low-skilled work, can be identified: internal, transnational across land borders, and international. Large streams of migration to urban centres have been occurring in Thailand for several decades, but I focus here on the north and the contribution of this mobility to the HIV/AIDS epidemic. Also, people from neighbouring countries have been crossing into Thailand, increasingly since the early 1990s, and Thais have been moving internationally, formerly to the Middle East and now mostly to other countries in Asia. In exploring HIV vulnerability there are different dynamics to consider within these three migration categories. And in each category it is important to gain an understanding of the host populations with whom migrants and mobile workers have contact.

HIV/AIDS and internal migration

The centre of the Thai HIV/AIDS epidemic is in three adjoining provinces in the north: Chiang Mai, Chiang Rai and Phayao. They have been the major source of sex workers migrating to other areas within Thailand, especially to Bangkok and environs and to the south. Later developments led to women from these areas being recruited for Japan and other overseas destinations. The pale-skinned girls and women of the north have been prized for their beauty and many were sold or trafficked during the 1960s and 1970s, but later streams were more likely to follow sisters and friends into the potentially lucrative trade.

As northern Thailand was increasingly incorporated into central Thailand, in the middle of the century, push-and-pull

factors sent many young people and adults to Bangkok. Factories, building construction and transport infrastructural developments attracted them in large numbers. The south also became a destination for migrating men for fishing, mining and plantation work. Thus, a common scenario in the south was that northern Thai men were visiting northern Thai women in brothels. This was a continuum of behaviour experienced in the north, where brothel visiting was probably more common than in any other region of the country.

The Thai epidemic had its first epicentre in Chiang Mai, largely through a configuration of migration, return migration and commercial sex. The underlying factors appear to be that certain sexual mores and cultural beliefs in the north, configured with rapid economic development and the widespread use of money, led to the emergence of a supply and demand for sexual services. At the risk of oversimplifying, poverty was the factor that saw women entering the industry and development led men to have money in their pockets and to live away from home (Beesey 1996).

In recent decades, the north and the northeast have been the poorest regions in Thailand. The two cultures vary noticeably and the pace of development has differed markedly. The north developed more rapidly, with Chiang Mai becoming a major centre, particularly after a railway line connecting it and Bangkok was established in the 1920s. Large infrastructure developments began in the 1960s and 1970s and, within the environs of any sizeable development project, brothels were common. Increasing trade and other links with Bangkok led to Chiang Mai becoming a tourist destination, offering many entertainment services for the southern visitors. The culture and environment of the north was a major attraction, enhanced for men by the beauty and charm of the women. Thus, at this level, we see again the convergence of economic development and commercial sex.

In 1989 more than 40 per cent of Chiang Mai sex workers were found to be HIV-positive (Brown et al. 1994). In the second phase of HIV spread, it was the customers of sex workers, often young men, who by the early 1990s were dying in many villages of the north. The outskirts of Chiang Mai were the early sites from where women travelled south to work in the sex industry. Men were also migrating from these satellite cities of Chiang Mai. Many of the HIV-positive men were return migrants or highly mobile within the provinces of the north. Chiang Rai also became more oriented to the south and the migration streams followed. By the mid to late 1990s AIDS deaths were occurring in villages near to cities, from which people had

migrated and then returned. Again, a similar pattern of mobility and HIV infection, but a few years behind Chiang Mai. Similarly, Phayao Province, well known for widespread poverty, is infamous as the home of one of the best-known villages in the north for providing women for the sex trade.

Trafficking moved from lowland Thai women and girls to those from minorities in the highland regions in Thailand, and then moved to lowland and mountainous areas across the border as far as China. The border provinces of Chiang Mai and Chiang Rai have served not only as destinations for women from across borders but also, and more commonly, as distribution points for all trafficked women. In such areas, women may be 'broken in' by pimps and others raping them before sending them on their way (see Beyrer 1998). But there are also many girls in their early teenage years who are sold as virgins. Thus, many may have been infected before they actually entered the sex trade, and others soon after.

Internal migration is a varied and complex phenomenon and much of it can be defined as mobility rather than migration, for it can include tourism, pilgrimages, visits home and, of course, trade and commerce. While men are often acknowledged as traders, especially on long-distance routes, women regularly go to markets and may be long-distance traders as well. Female traders have been discussed as important figures in mobile sexual networks (Lyttleton 2000, Pramualratana et al. 1995, Walker 2000). Men regularly attend cattle markets and other trading centres as well as festivals, and whether it be for business or pleasure it often includes drink and sex. This has been the case for a long time, perhaps before brothels appeared in rural areas, but now with the demise of many brothels in Thailand these may be emerging as significant sites for informal commercial and non-commercial sex and the spread of HIV (Elkins et al. 1997, Skeldon 2000). Rural brothels developed later than brothels in cities or large towns. In earlier decades, northern Thai men looked forward to visiting Chiang Mai and other centres for festivals, or for commercial activities, with the added attraction of visiting brothels.

Temple festivities and other fairs which attract very large crowds occur on both sides of the border, as seen on the Thai-Lao border, drawing people from both sides of the Mekong River (Lyttleton 1999). Border areas themselves also attract people; like markets and fairs, they involve transactions of many sorts but with more intensity. Thus, border areas comprise many internal as well as cross-border migrants.

Cross-border migration and migrants

Thailand has been reported as being home to up to as many as 1.5 million migrant workers at any one time, although, because of forced repatriations, this could be far less than 1 million as of late 1999 (see estimates in Archavanitkul 1998, Chantavanich and Paul et al. 1999, Bain 1998). The great majority are from Myanmar and most of the rest are Cambodian and Laotian. Leaving aside the 100,000 refugees along the Thai-Myanmar

border, the research does suggest that most migrants are economic migrants. It is not clear whether this is true for most of the Shan from Myanmar, who are the main victims of relocations and thus are forced into migration, but they are often an invisible population in Thailand.

Cross-border migrants are not vulnerable in and of themselves but become so, given the situations in which they often find themselves en route and at their destination points. Their vulnerability increases due to their illegal status, low education, and limited preparation for entering into a very different world. Crossing into Thailand some may take up temporary residence before moving further inside the country; others will stay within the border regions. For many, this point of contact at border crossings is their first contact with high-risk situations, situations that have arisen as a result of the intersections of mobility, trade and development, and HIV.

Myanmar and Cambodia both have very high rates of HIV infection; however, as with Thailand there is much variability, with many rural areas still not affected by the raging epidemics in their respective countries. Most migrants move from resource-poor areas to centres of trade and commerce; concomitantly, they are generally leaving low-risk situations for high-risk ones. Some border crossings, particularly on the Myanmar border, were the earliest sites of this convergence of risk and migration. Sadly, they remain among the riskiest sites in the region.

At these locations, there are many migrants who do not actually cross the border or who may do so only to seek work on a daily basis. In some of these sites, the risk of HIV may be higher on the other side of the border – particularly true for the Thai-Cambodian border at Khlung Yai in Trat, and Aranyaprathet, due to risk behaviours and the prevalence of HIV on the Cambodian side. At Poipet, in Cambodia, adjoining Aranyaprathet, most migrants are daily commuters to Thailand and thus they are residing amidst a thriving sex industry, where health care is basic and where information on health and HIV has been scarce. Thus, the migrant workers in this instance face their greatest risk from the Cambodian side rather than when they cross into Thai territory. However, as with crossing borders, as they do in Trat, they are entering a risk situation not of their making, entering a border area where mobile and migrant groups, mainly moving internally, have created areas well known for illicit activities such as gambling and commercial sex.

Migrant workers are but one of the groups making up the channels of movement and the labyrinth of networks in border areas. Such populations comprise permanent residents plus internal migrants and mobile groups. These groups include drivers, police, other officials, businesspeople, traders and tourists, who may or may not be crossing the border. In many cases, they may cross temporarily into what is more or less neutral ground, with no visa requirements and perhaps not even border passes (Chantavanich 1999).

Migrants are vulnerable in such cross-border situations for a range of reasons: away from family for long periods, living as illegal aliens, having little knowledge of HIV/AIDS, and with

low literacy in destination or place of origin and limited access to health care. However, other mobile groups may be just as vulnerable, particularly men who, because of their income or position, have the money, power or prestige that gives them ready access to sex workers. Sexual exploitation and abuse is common in these somewhat lawless states where justice and human rights are a poor second to greed and corruption. Having higher education and being more informed does not appear to protect them from risky behaviour. Condom use may be higher but perceptions of what is safe and other attitudes are not always consistent with safe-sex practices.

On the Thai side of most of its borders, Thai sex workers have been replaced by cross-border migrants, even including Vietnamese women on the Thai–Cambodian border. This is changing once again as the Thai police push Cambodian and Vietnamese women back into Cambodia. However, this then leads to Thai men crossing the border for sex. In Thailand, on the Myanmar border, it is still predominantly women from across the border, as it has been for 10 years or more, who are involved in sex work. However, in some instances, commercial sex is now readily available on the Myanmar side.

Many men and women are ill-prepared for the environments in which they find themselves; and many men are prepared to take risks. Simplified, these are the dual aspects that make HIV prevention difficult: not recognising risk and the denial of risk or vulnerability – either can lead to contracting HIV. There is, of course, no clear delineation between migrants who fit into the former category and other mobile populations who fit into the latter. Fishermen are migrant workers who would often fall into the latter. Cambodian police recruits may fit into the former category, although it is to be hoped that they are more informed these days. Truck drivers may fit into either category and, like other groups that are away from home for long periods, there is often a community expectation, including among the wives of such men, that they will patronise sex workers.

International migration

Thailand is both a receiving and a sending country of migrant workers. Where Thai workers once went to the Middle East, over the past decade the shift has been to the Asian region itself, with Japan, Taiwan and Singapore being the major receiving countries but also including Brunei and Malaysia.

The category of international migration has been the least studied in regard to HIV infection, but there is much research on such migrant workers. The media have highlighted the plight of Thai sex workers, especially those in Japan, some of whom have been found to be HIV-positive. It is of course difficult to determine whether they were infected in Japan; it is more likely that they became infected in Thailand or en route, which could have been Malaysia (Caoutte and Saiko 1999). This is the extreme end of the spectrum where human rights abuses can occur among those who have been deceived, cheated or trafficked against their will, and even among those who have gone

voluntarily. Other women migrants may also be vulnerable to sexual exploitation, particularly those working in an isolated context, such as housemaids. There are a small number of reported HIV infections among housemaids returning home to other Asian countries besides Thailand, but so far the numbers are minimal (see Skeldon 2000). Governments are trying to regulate recruitment processes and to implement predeparture programmes in some countries, but this is far from adequate protection in most instances.

Conclusion

Increasing mobility has contributed to the spread of HIV in Thailand, most noticeably in the north. With the transecting paths of various populations moving within Thailand, including to border regions, plus migrants moving to the same junctions and further into Thailand, HIV has spread widely and will continue to do so. The border areas are expanding centres of trade, which includes smuggling and other illicit activities. In some ways, they parallel certain zones in larger cities, but their size, remoteness and status give them an intensity and purpose that is unique. Internal and cross-border sites are clearly linked with economic development, trade, and sexual services – in turn, these are clearly implicated in the spread of HIV in Thailand and beyond.

The future of the epidemic is still uncertain. The current reading suggests a more gradual HIV spread in most countries rather than the rapid spread experienced in Thailand, Cambodia and India. But far from suggesting reduced efforts in combating the spread of HIV, this reading should serve to present new challenges.

Internal migration and mobility must be examined for risk situations and the factors that make people vulnerable. Cross-border migrants need to be studied in their places of origin, the routes they take and their destination points. How these internal movements intersect with transnational movements, particularly on borders, is of crucial importance. Such 'hot spots' occur in all of the countries of the Greater Mekong sub-region and most have been neglected as important target areas for comprehensive programming.

References

- Archavanitkul, K. 1998, 'Transnational population and policy options for importation of foreign labour into Thailand', in proceedings of the Regional Workshop on Transnational Migration and Development in ASEAN Countries, Mahidol University and International Organization for Migration, 25–27 May.
- Bain, I. 1998, 'Southeast Asia, international migration', *Quarterly Review*, 36(4), 553–85 (special edition on migration and HIV/AIDS).
- Beesey, A. 1996, 'Beyond the margins: Redefining sexual relations through traditions and transformations in Northern Thai society', in proceedings of the Sixth International Conference on Thai Studies, Chiang Mai, 14–18 October.

- Beyrer, C. 1998, *War in the blood: Sex, politics and AIDS in Southeast Asia*, White Lotus, Bangkok.
- Brown, T. et al. 1994, 'The recent epidemiology of HIV and AIDS in Thailand', *AIDS*, 8 (Supplement 2), S131-S141.
- Caoutte, T. and Y. Saiko 1999, *To Japan and back: Thai women recount their experiences*, International Organisation for Migration, Bangkok and Geneva.
- Chantavanich, S. 1999, 'Thailand's responses to transnational migration during economic growth and economic turndown', *Sojourn*, 14(1), 159-77.
- Chantavanich, S. and Allan Beesey et al. 1999, *Cross-border migration and HIV/AIDS vulnerability at the Thai-Cambodian border: Aranyaprathet and Trat*, Asian Research Center for Migration, Institute of Asian Studies, Chulalongkorn University, Bangkok.
- Chantavanich, S. and S. Paul et al. 1999, *Cross-border migration and HIV/AIDS vulnerability at the Thai-Myanmar border: Sangkhlaburi and Ranong*, Asian Research Center for Migration, Institute of Asian Studies, Chulalongkorn University, Bangkok.
- Elkins, D.B. et al. 1997, 'Cattle markets and festivals: Development of HIV/AIDS prevention interventions for specific risk situations in rural northeast Thailand', in proceedings of the Symposium on Population Health and the Environment, Chiang Mai Department of Geography, Chiang Mai University and the International Geographical Union, Commission on Population and Environment, 38-48.
- Lyttleton, C. 2000, 'Any port in a storm: Coming to terms with HIV in LAO PDR', *Culture, Health and Sexuality*, 1(2), 115-30.
- Lyttleton, C. 1999, 'Sister cities and easy passage: Mobility and civility in Mukdahan/Savannakhet', paper presented at Seventh International Conference on Thai Studies, Amsterdam, 4-8 July.
- Pramualratana, A. et al. 1995, *Assessment of the potential for spread and control of HIV among cross-border populations along the Thai-Cambodian border*, Institute for Population and Social Research, Mahidol University.
- Skeldon, R. 2000, *Population mobility and HIV vulnerability in Southeast Asia: An assessment and analysis*, United Nations Development Programme, Bangkok.
- Walker, A. 2000, 'Women, space, and history: Long-distance trading in northwestern Laos', in G. Evans (ed.), *Laos: Culture and sexuality*, Institute of Southeast Asian Studies, Singapore.

The challenge of HIV spread among and from injecting drug users in Asia

Alex Wodak, Alcohol and Drug Service, Sydney

Introduction

The epicentre of the HIV pandemic will soon shift from Africa to Asia. The HIV epidemic trails behind an epidemic of injecting drug use that began to spread through the Asian region a little more than a decade ago. HIV infection spreading among and from injecting drug users (IDUs) is an alarming threat to public health in Asia. Half the world's population lives within a few hours' flight by jet from the Golden Triangle. This area, formed by the junction of the borders of Thailand, Laos and Burma (now Myanmar), is a major global source of heroin. The illicit cultivation of opium and refinement to heroin continues to expand in the region, apart from occasional periods when poor weather in opium growing areas temporarily reduces heroin production.

Knowledge of effective strategies to reduce HIV infection among and from IDUs was already extensive by the time HIV was first detected in Asia in the late 1980s, spreading rapidly among Thai IDUs and commercial sex workers. Despite growing acceptance of the effectiveness of a public health approach to HIV control, implementation of harm reduction strategies targeted at IDUs still lags far behind rapidly spreading HIV infection.

Opium production in Southeast Asia

Opium has been cultivated in Asia for centuries. Opium cultivated in India was sold in China during British colonial times to balance trade between the two Asian countries. Following World War II, there was a rapid increase in cultivation in Thailand, which was curtailed somewhat in the 1970s. However, in a now very familiar pattern, once it declined in Thailand, it then quickly increased in neighbouring Myanmar where there was even less opportunity to exercise influence. Opium is still cultivated in Thailand, Laos and Myanmar but it is Myanmar that is now responsible for up to 90 per cent of the production in the region. Cultivation has also recently commenced again in remote areas of China. During the last few years, opium cultivation and heroin production in the golden crescent region of Southwest Asia (Afghanistan, Pakistan, Turkey) have increased rapidly and now exceed production in Southeast Asia. This is mainly because of the extremely sharp rise in production in Afghanistan following the invasion by the USSR in 1979 and the subsequent rise to power of the Taliban.

Decades ago, opium cultivated in Asia was refined into heroin in Europe. Intensification of law enforcement efforts, intended to restrict heroin supply, led to the development of a local refining capacity in Asia. Initially, the refining was carried out in large cities. With increasing law enforcement, production shifted to small villages close to the fields where the poppies were cultivated. Now refining laboratories are highly mobile, carried around packed up on the backs of donkeys during the day. Aerial and satellite surveillance cannot distinguish them from the myriad of other heavily laden donkey trains transporting goods from one area to another. At nightfall, the laboratories are assembled to begin their work.

Most opium cultivation now occurs in remote and mountainous regions in Southeast and Southwest Asia. The cultivation and the heroin production is often linked to guerrilla armies or dissident minority groups. Involvement in the illicit drug trade provides substantial income for military operations and sustains peasants and their families in areas where options for legal income generation are severely limited. There are no roads to carry fresh produce to markets. Opium has been used for generations to assuage pain and to control diarrhoea in areas where there are no doctors or hospitals.

During the last few years, poor weather conditions in the opium growing areas of Myanmar have reduced the production of opium and heroin. Following a worldwide trend from plant-based to chemical-based drugs, the production of amphetamine type substances (ATS) has increased, taking up a slack created by decreased heroin production. Amphetamine produced in Myanmar is now flooding the region, especially Thailand. New markets are being found for new drugs.

Drug consumption in Asia and Southeast Asia

Notwithstanding intensive efforts to restrict supplies of illicit drugs, heroin consumption has grown rapidly throughout Asia during the last decade. Political instability and rapid economic change have been the backdrop to this increased use. Improved transport infrastructure, growing trade and movement of populations, high levels of unemployment, a drift of people from rural to urban areas, and improvements in banking and telecommunications have created a set of conditions conducive to the efficient transport of illicit drugs from suppliers to more and more consumers. Although the high prices of street drugs

are theoretically expected to suppress demand, and the greater risks of detection and more severe penalties for drug use and supply should increase prices, supply of and demand for illicit drugs have both risen rapidly in Asia during the last ten years. High prices also represent lucrative profits for drug traffickers, possibly tipping the balance for some to enter the drug trade and earn their fortune. High-level official corruption is both a cause and a consequence of major drug trafficking.

In a prophetic paper entitled 'The pro-heroin effects of anti-opium laws in Asia', the American psychiatrist, Joe Westermeyer (1976), described the transition from opium smoking among elderly men to heroin injecting among young men within a decade of the introduction of anti-opium policies in Hong Kong, Thailand and Laos. These policies, fostered by international advisers, inadvertently created the conditions for the spectacular HIV epidemic which is now taking place. Reliance on law enforcement measures to control illicit drug use has often inadvertently encouraged a transition from less harmful to more toxic drugs, as well as a shift from less dangerous to more dangerous routes of administration. This transformation is well illustrated in the shift from opium smoking in elderly men to heroin injecting in sexually active young men which took place in Asia over the course of a generation or two.

Although opium smoking was unattractive from public health and other perspectives, its health, social and economic consequences have been dwarfed by the prohibitive costs of heroin injecting. The injection of drugs is perceived by drug users to be a more efficient mode of administration. The higher the price of the drug, the more the desire to use expensive drugs efficiently. Sniffer dogs can more easily detect the pungent smell of bulky opium than the more compact and less odoriferous heroin. Needles and syringes are easier to conceal in a grass hut than large opium pipes. If needles and syringes are unavailable, makeshift injecting equipment is constructed from rubber tubing and ballpoint pens.

During British colonial times in South Asia, registered addicts were able to purchase opium from government maintained outlets. Some outlets still survive in the Indian states of Uttar Pradesh and Rajasthan. Similar outlets were closed in Pakistan in 1979. Following the closure of outlets in the Northwest Frontier Province by President Zia al Huq, heroin users were seen in the area for the first time within a few years.

Vigorous law enforcement in Calcutta brought about a transition from inhaling heroin vapour ('chasing the dragon') to heroin injecting. A similar development occurred in the south Indian state of Tamil Nadu when customs and police officers managed successfully to reduce supplies of heroin. Heroin injecting is now spreading rapidly in China and India as well as many other countries in the region. Under the bridges, in the parks and on the footpaths of many modern Asian cities, drug users huddle together injecting each other or themselves with equipment used by others moments before.

The spread of HIV among and from IDUs

HIV infection among IDUs in the region was first detected in Thailand in 1988. Within ten months, the prevalence of HIV infection increased from less than one per cent to over 40 per cent. Six years later, one in six male military recruits and one in eight pregnant women in northwest Thailand were infected. An epidemic among commercial sex workers also occurred at the same time. There is little doubt that HIV infection among IDUs contributed substantially to its transmission to the general population in Thailand and in neighbouring countries. From Thailand, it spread to IDUs in Myanmar, China, Malaysia, Vietnam and India. These countries were slow to recognise the problem and even slower to respond. Many of the borders between these countries are extremely porous. Villagers in remote areas move frequently across the borders, visiting their families or trading. In some regions, as many as 80 per cent of the IDUs are infected with HIV. Within a few years, the infection is detected in their wives and girlfriends and among commercial sex workers.

In most countries where HIV has moved early into drug injecting populations, extensive spread to the general population has then quickly occurred. Within a few years, many deaths from AIDS are reported. Many of the babies born to drug users are infected. Many children become orphans. In some countries where this scenario has unfolded, deaths from tuberculosis and other health problems have soon increased. Other hard-won public health gains have been reversed. Public health setbacks of this magnitude are accompanied by major social and economic problems.

Responding to HIV among IDUs

Effective strategies to control HIV spread among IDUs were identified in developed countries by the late 1980s. These measures include the explicit and peer based education of IDUs, increased availability of sterile injecting equipment, and expanded and improved drug treatment and community development. These pragmatic measures have now been adopted in most developed countries (including Australia) with great success. At modest cost, HIV epidemics have been averted or early epidemics brought swiftly under control.

The public health approach to HIV infection among IDUs is referred to as 'harm reduction', which focuses primarily on reducing the adverse health, social and economic consequences of drug use without necessarily attempting to reduce the consumption of drugs. Successfully controlling HIV among and from IDUs is an achievable objective. Most attempts to reduce or eliminate illicit drugs production and consumption have been expensive and unsuccessful exercises, often accompanied by serious unintended negative consequences.

The education of IDUs in a harm reduction framework involves explicit and credible information about the effects of drug use and the complications resulting from HIV infection.

Involving such users in the design and implementation of education programmes improves their effectiveness.

Needle syringe programmes were first established in developed countries during the 1980s. The introduction of such a programme in Nepal in the early 1990s was the first one in a developing country. These programmes increase the availability of sterile injecting equipment while decreasing the availability of used injecting equipment. Injecting drug users attending needle syringe programmes are also provided with education and encouraged to enter drug treatment. Australian assistance enabled the establishment of such a programme among hill tribe people in Thailand in the early 1990s.

Methadone programmes have been demonstrated to substantially reduce HIV infection as well as providing many other important health benefits. They reduce drug use and deaths from drug overdose and crime and they improve the social functioning of drug users. There are now programmes in a number of Asian countries, including Nepal, Thailand and China. Local able and committed harm reduction practitioners have begun to emerge in Asia during the last few years. A trickle of foreign aid has produced astonishing demonstration projects.

Harm reduction fits in well with the traditional public health notion of 'never letting the best become the enemy of the good'. Setting out to achieve sub-optimal goals has proven to be far preferable to failing to reach utopian goals. Achieving a valuable silver medal is far better than failing to achieve an improbable gold medal and missing out on medal prospects entirely. Deng Ziaoping once noted that 'it does not matter whether the cat is black or white as long as it catches the mouse'. This is very much the spirit of harm reduction.

Although there is now compelling scientific evidence of the effectiveness of harm reduction approaches in controlling HIV among IDUs, many countries at risk of an epidemic have failed to adopt and implement these programmes in time or on a sufficient scale. This is particularly true in the developing world where there is much greater pressure on scarce resources. A major reason for the failure to implement evidence based, public health approaches to HIV infection is perceived conflict with an entrenched belief in the effectiveness of law enforcement.

The need for global advocacy

It is more difficult to advocate pragmatic harm reduction approaches than to argue for the appealingly simple notion of eradicating all illicit drug use. An important component of any attempt to control HIV infection among IDUs is the need to clarify the concept of harm reduction itself. In most countries in the region that are badly affected, there are few public health advocates to articulate the case for harm reduction. Harm reduction is unfortunately often confused with the legalisation of drugs. Competition for funds in resource-poor communities is always difficult. Management skills are often scarce.

Unfortunately, attempts to advocate more rapid uptake of harm reduction approaches have been complicated by aggressive support for law enforcement emanating from powerful international agencies and some very powerful Western countries. Fortunately, there are now some encouraging signs that some of the more powerful players are beginning to recognise the seriousness of the situation and the need for swift and effective action.

Conclusion

The epidemic of HIV infection among IDUs in Asia is critically poised. The effectiveness of regional responses will shape the region for generations to come. HIV is spreading with alarming rapidity, yet effective control measures are only slowly and grudgingly gaining acceptance. Implementation lags far behind the spread of HIV. In the last few years, there has been increasing recognition that HIV is more than just a public health problem. HIV in the Asian region will have considerable impact on economic as well as major social outcomes. Tragically, a region that is home to half the world's population is now ravaged by an epidemic that was largely preventable.

There are several remarkable features of HIV infection among injecting drug users. First, epidemics of HIV among injecting drug users have spread with astonishing speed in many countries. Second, the multiplier effect of HIV infections from injecting drug users to the general population is probably greater than for any other group at high risk of AIDS. Third, the prevention of HIV transmission among IDUs is one of the most effective interventions in the entire HIV/AIDS repertoire. What is less well known is how to convince policy makers to adopt the measures necessary to control the epidemic in time and on sufficient scale. An entrenched commitment to reliance on law enforcement responses to illicit drugs lies behind the twin volatile epidemics of HIV and injecting drug use in the region. In most discussions of HIV/AIDS in Asia, the topic of such drug use fails to even reach the agenda. When it does manage to get considered, the all-important involvement of HIV infection among drug injectors in prisons is almost always ignored. The flagrant denial of the human rights of IDUs, stemming from an unbalanced application of law enforcement, is currently producing catastrophic consequences in Asia.

Further reading

- Crofts, N. 1999, *The manual for reducing drug related harm in Asia*, Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research, Melbourne and the Asian Harm Reduction Network, Chiang Mai.
- Westermeyer, J. 1976, 'The pro-heroin effects of anti-opium laws in Asia', *Archives of General Psychiatry*, 33, 1135-9.
- United Nations International Drug Control Programme 1997, *World drug report*, Oxford University Press, Oxford.

Harm reduction, HIV and development

*Paul Deany and Nick Crofts, Centre for Harm Reduction,
Macfarlane Burnet Centre for Medical Research, Melbourne*

Introduction

Injecting drug use is changing the face of the HIV/AIDS epidemic and of development. Widespread and often explosive HIV epidemics among injecting drug users (IDUs) are occurring on every continent. Governments and communities are struggling to respond adequately, especially because of the social, legal and political sanctions surrounding illicit drug use. But, at the same time, some of the most outstanding successes in HIV prevention are occurring through programmes specifically targeting IDUs. Often called harm reduction programmes (because they place greater emphasis on reducing the harms associated with injecting drug use, especially HIV, and less on eliminating drug use itself), these programmes are now proliferating in both developed and developing regions. As well as outlining the scale and nature of HIV epidemics among drug users and demonstrating how such programmes are succeeding in preventing HIV where other approaches have failed, this paper will discuss why injecting drug use poses such a difficult challenge to HIV prevention and sustainable human development.

From drug-producer to drug-user countries

In the wake of economic, social and political changes over the last decade, a growing number of countries have experienced massive increases in illicit drug trafficking and consequent increases in drug injecting, needle sharing and, eventually, HIV. Today, more than 200 million people use illicit drugs. The injecting of these drugs is also increasing around the world, involving perhaps 20 million people in 134 countries. Many of these are developing countries where HIV epidemics among IDUs are preceding broader epidemics in the general population. If left uncontrolled, these HIV epidemics among IDUs threaten many of the gains made elsewhere in sustainable human development.

There has been a sharp increase in the use of developing countries for trafficking and transit of illicit crop based and synthetic drugs. Developing countries are also shifting from being producer countries to becoming large-scale consumers of illicit and licit drugs. These changes in production and distribution patterns are exposing new populations to opiates (heroin, opium) and amphetamine-type stimulants, both for their consumption and their trade. Together with increases in

drug consumption, the pattern of drug use is also changing radically. Probably the most common shift has been from the smoking of opium to the injecting of heroin and other injectable drugs. The injecting equipment used is often unsterilised and the sharing of equipment is common. From a public health perspective, this shift is disastrous, as injecting drug use fuels the rapid spread of drug related diseases such as AIDS and hepatitis.

Worldwide, the commonest injected drugs are heroin, amphetamines and cocaine, though many other drugs are also injected, including especially tranquillisers and other pharmaceuticals. The particular drug injected depends on its availability and cost (which, in turn, often depends on geographic proximity to production areas or trafficking routes), personality traits and peer group norms, among other, poorly understood factors (Crofts 1999).

Injecting drug use and HIV infection

It is now estimated that, worldwide, more than 10 per cent of HIV infections (nearly 3.5 million people) are due to injecting drug use (UNDCP 1999). Of all the different ways that the virus can be passed on, directly injecting a substance contaminated with HIV into the bloodstream is by far the most efficient way, much more so, in fact, than through sexual means. Together, therefore, drug injecting and HIV form an explosive combination (Cowal 1998).

The most rapid increases in HIV among IDUs have been in developing countries, such as Kazakhstan, the Russian Federation, the Ukraine, Malaysia, Vietnam and China, where drug injecting is the major cause of infection. The countries experiencing these epidemics are often inexperienced in developing policy and programmatic responses to adequately deal with the problem. Where responses are developed, they mainly target the long-term goals of eradication of drug supply and drug use, rather than the more pressing problem of HIV transmission.

Redressing these imbalances is a major challenge for the development community. The relationship between injecting drug use and HIV transmission is also different in each location. Changes to policies and programmes must therefore be developed separately through a process of ongoing analysis, consultation and trailing of responses.

Snapshot on injecting drug use and HIV infection

- Illicit and licit drugs are injected in many parts of the world, especially in regions where poverty, homelessness, migration, gender inequity and other social/economic problems are common.
- The reuse of contaminated needles and syringes by different people is common in many of these settings where drug injecting takes place.
- HIV is effectively transmitted by the sharing of injecting equipment.
- The reasons for sharing are various and include poverty, cultural factors, lack of availability of or access to needles and syringes, the illegality of carrying injecting equipment, and lack of information about HIV and injecting drug use.
- Drug injectors are a major vector for spreading HIV to their sexual partners and children.

HIV, drug use and development

It is becoming increasingly evident that development problems foster drug problems. Communities in remote areas, which are marginalised and have little control over their economic and social development, are natural habitats for the cultivation, trafficking and consumption of narcotic drugs. Drug production leads to economic dependence on the drug suppliers, not to social and economic development. Increased drug use also leads to increased health problems in developing producer countries, especially where the use and sharing of needles for injecting drugs facilitates the spread of HIV (Ahmed 1998). The reasons for this are not yet well explored, yet may be important to understanding both development and the HIV epidemic.

New patterns of drug use appear similarly influenced by the interplay of macro social, economic and political factors. In the Newly Independent States in Eastern Europe, for example, it seems to be no coincidence that rapid diffusions in drug use and drug injecting have occurred since 1990, paralleled by major social dislocation and change. Shifts to private economic production have occurred in the context of dramatic declines in gross domestic product and have led to dramatic unemployment, increased income differential and poverty, and the rapid expansion of criminal economies. Further suggestion of the link between social condition and ill health is indicated by the parallel increases in alcohol consumption and morbidity (Rhodes et al. 1999a).

Development factors precipitating HIV epidemics among IDUs

- Diffusion in drug use and increases in the size of IDU populations.
- Transitions towards drug injecting associated with law enforcement and interdiction activities restricting drug supply and production.

- Transitions towards drug injecting associated with the transference of new drug production and distribution technology.
- Transitions towards drug injecting associated with the 'globalisation' of drug markets and distribution networks.
- Population migration, mobility and mixing.
- Lack of structures or resources for non government and community organisations.
- Rapid transitions in economic, health and welfare status. (Rhodes et al. 1999b)

In the face of these complexities, there is a small number of programmes developing and implementing effective HIV prevention responses among IDUs, and much willingness on the part of many policy and programme designers to consider the various strategies that could be tried. The most successful and sustainable of these strategies are those known as harm reduction programmes.

Harm reduction programmes

While responses generally lag years behind the epidemic, there is a growing body of experience on successful approaches to preventing HIV spread among IDUs and the broader community. Such approaches include:

- community based harm reduction programmes, including needle/syringe exchange, primary health care, peer education and counselling;
- the sale of clean injecting equipment through pharmacies and other outlets;
- methods for reducing the demand for drugs, including abstinence based approaches, drug treatment and drug substitution programmes; and
- political advocacy and engagement involving different sectors of government and community based organisations.

Where these types of programmes have been introduced, there has been an overwhelmingly positive effect in slowing down the spread of the HIV epidemic among IDUs:

- In India, the community based programme SHARAN is implementing wide-ranging and comprehensive HIV prevention measures among IDUs in the slum populations of Delhi. These measures include rapid situation assessments, HIV counselling, vocational rehabilitation, a drop-in centre, primary health care and needle exchange.
- In the Ukraine, the Ministry of the Interior is working to reduce the risk of HIV/AIDS and STD transmission in Ukrainian prisons. Activities include awareness raising among prison staff, inmates, local authorities and civil society organisations, and promotion of interventions focused on harm reduction and safer sexual behaviour.

- In the Russian Federation, Médecins Sans Frontières–Holland is providing country-wide training and support for HIV/AIDS prevention among IDUs.
- In Asia and the Pacific, the Centre for Harm Reduction and the Asian Harm Reduction Network have pooled their experience to produce the world's first practical guide on harm reduction: *The manual for reducing drug related harm in Asia* (Crofts 1999).
- Globally, national and regional 'harm reduction networks' have emerged as important mechanisms for building expertise, legitimising harm reduction and strengthening supports for HIV prevention programmes targeting IDUs (Deany et al. 2000).

Common to these and other harm reduction programmes is an approach fundamentally different from that of demand-and-supply reduction, in that reduction in the use of drugs is not a primary goal, but these differing approaches should be and can be complementary (Crofts 1999). Where harm reduction initiatives such as these have been introduced rapidly enough and broadly enough, there has been a clear slowing down of the spread of the HIV epidemic among IDUs.

But the introduction of harm reduction is always controversial as it is seen to condone continued illicit drug use. This presents a complex challenge to the international development community and governments alike, as they struggle to balance failing attempts to eradicate drug use with the ongoing reality of HIV epidemics among IDUs.

Gaps in responses

While we know how to stop HIV among IDUs, few governments or agencies are currently implementing or even considering the policies and programmes needed to do so. Most countries are lagging years behind the epidemic for a range of reasons, including:

- low community capacity, in terms of skills, resources and experience for responding to HIV among IDUs;
- donor agencies and governments failing to recognise the long-term threat to development posed by HIV and injecting drug use; and
- the current policy environment, which makes it difficult for community based programmes to initiate harm reduction activities.

Policy responses

The lack of a supportive policy environment is perhaps the greatest obstacle and thus the greatest challenge for controlling HIV among IDUs. Despite the fact that drug use is driving the epidemic in many countries, the relationship between HIV and drug use is a particularly neglected area of national AIDS and drug policies. These policies are often developed at different

times through different processes, so it is no surprise that they have often evolved with varying goals and approaches. Drug policies do not focus on public health issues such as HIV/AIDS. Conversely, HIV/AIDS policies often do not focus on IDUs (Burrows 1999).

Instead, governments and development agencies place priority on finding long-term solutions to the drug abuse problem, rather than addressing the more immediate harms caused by drug abuse, most notably HIV. It seems that the international community cannot reach consensus on how to deal with the problem of illicit drugs, arguing about the merits of demand reduction, supply reduction and harm reduction approaches, while the HIV epidemic among drug injectors continues unabated.

In the absence of effective national policies and programmes for prevention, community based programmes are often the only agencies left to implement responses. But these programmes are inhibited by the fact that government policies may prevent interventions that have been proven elsewhere, such as needle exchange programmes and drug substitution. This situation is changing, but usually only after HIV epidemics among IDUs have taken off. The challenge therefore is to examine and pilot ways in which governments, local programmes and policy makers can be engaged to develop policies that will support the early implementation of effective responses.

To do this, governments and development agencies need to be armed with more comprehensive understandings of the nature and extent of HIV epidemics among IDUs and to be exposed to strategies for consideration and examples of programmatic and policy responses.

Conclusion

Injecting drug use and HIV are huge and interlinked development problems. No single article can adequately cover all the issues for consideration. The impact of injecting drug use on national HIV epidemics, and thus human development, looms large in many countries. But responses are being hampered by a failure to recognise the urgency and scale of the problem and the lack of community capacity and understanding.

The drug problem is a complex one that touches on many issues besides just drugs, dealers and users. When HIV and injecting drug use is added to this mix, the complexities are multiplied. We need to understand the connections among these issues, to see the total picture and not just a single piece of the jigsaw. Rather than stigmatising drug users and focusing mainly on supply reduction, we need to change the social and economic environments that help create a demand for drug use. We need to review and change our development paradigm to one that restores respect for human dignity and equality of human rights, regardless of race, religion, gender, and economic, social or health status (Duongsaa 1998).

The ultimate way to prevent harm from drug use is to completely stop the demand for using drugs. But, just as it is

unrealistic to expect to control HIV/AIDS by asking people to stop having sex, we must also be realistic about the likelihood of the global eradication of drug use in the near future.

Governments and communities therefore need to be provided with options for dealing with the drug problem, space where they can consider these options and practical ways they can be supported in the process of debate and policy reform. Most of all, we need to strengthen political and donor support, mobilise diminishing resources and turn awareness into action. If not, the spread of HIV through injecting drug use will continue to be a glaring and devastating omission in global efforts to eradicate AIDS.

References

- Ahmed, R. 1998, UNDP Co-administrator, UN General Assembly Special Session on the World Drug Problem, New York, 9 June.
- Burrows, D. 1999, 'Policy research on drug use and HIV/AIDS', background paper for National Seminar/Workshop on Addressing the Problems of Drugs, Jakarta, 20 September.
- Cowal, S. 1998, 'Preventing the spread of HIV through drug injecting', UN General Assembly Special Session on the World Drug Problem: Panel on Drug Abuse and HIV/AIDS, New York, 9 June.
- Crofts, N. 1999, *The manual for reducing drug related harm in Asia*, Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research, Melbourne, and the Asian Harm Reduction Network, Chiang Mai.
- Deany, P., et al. 2000, 'Harm reduction networks: A global voice for reducing drug-related harm', presentation to 11th International Conference on the Reduction of Drug Related Harm, Jersey, March.
- Duongsaa, U. 1998, 'Women, gender and drugs', UN General Assembly Special Session on the World Drug Problem: UNDP Panel Discussion on Drugs and Development, New York, 9 June.
- Rhodes, T., et al. 1999a, 'Drug injecting, rapid HIV spread, and the "risk environment": Implications for response', *AIDS*, 13(Supplement A):S1-S11.
- Rhodes, T., et al. 1999b, 'HIV infection associated with drug injecting in the Newly Independent States, Eastern Europe: The social and economic context of epidemics', *Addiction*, in press.
- UNDCP (United Nations International Drug Control Programme) 1999, 'World AIDS Day 1999: UNDCP and UNAIDS launch major HIV/AIDS prevention initiative in Central Asia', press release, 1 December.

The manual for reducing drug related harm in Asia

As a response to the rapid and devastating epidemic of HIV/AIDS among people who inject drugs, *The manual for reducing drug related harm in Asia* has been developed. It builds on the Rapid Regional Situation Assessment carried out by the Macfarlane Burnet Centre on behalf of the Asian Harm Reduction Network (AHRN) for UNAIDS in 1997. Because many agencies and authorities are wary of the applicability of Western approaches in their own communities, the manual is based entirely on the indigenous Asian experience. It has therefore been specifically developed as a resource, a tool for advocacy, and a manual for programme design and implementation that will be appropriate within an Asian cultural context. It was developed from the experience and expertise of many people currently working in Asia to stop the spread of HIV. The range of subjects covered was largely drawn up by members of AHRN who are either based in Asia or have longstanding associations with the region.

The current manual is the generic English-language version. A design process for the production of country-specific versions, which consists of in-country review by national experts, focus group review by programme

managers and clientele, adaptation to local legal and cultural contexts, translation and back translating, and piloting, will be undertaken. This process is beginning in Vietnam, and China is the next country likely to be involved. To enhance a comprehensive understanding of harm reduction and to assist with the implementation of harm reduction programmes, a training programme has been devised to complement the manual.

The manual is free but a charge of US\$15 per copy is required for postage and handling. Copies can be ordered by contacting:

Ton Smits, Coordinator
Asian Harm Reduction Network
PO Box 235
Phrasingha Post Office
Chiang Mai 50200
Thailand
Tel +66 53 801494:
Fax +66 53 801494
E-mail arhn@loxinfo.co.th
Web www.ahrn.net/

Strategies for dealing with HIV/AIDS in the former Soviet Union

Dave Burrows, independent consultant on HIV/AIDS, hepatitis and injecting drug use issues

HIV is spreading with increasing speed among injecting drug users (IDUs) in many parts of the world. In an ongoing project with the Centre for Harm Reduction, it is estimated that there are at least 10 million IDUs worldwide, of whom at least one million now have HIV or AIDS.

To address this spread requires not just appropriate measures (harm reduction) but sufficient numbers of appropriate programmes to 'cover' whole countries or regions. We now know which techniques are most useful in addressing HIV/AIDS and drug issues. This paper describes a process which has been used in the Russian Federation to rapidly increase the number of effective programmes implemented and embedded in Russian society. Similar processes are being considered or implemented in the Ukraine, Central Asian countries, Romania, India, Nepal, Indonesia and other Asian countries.

Health promotion and harm reduction

First, we need to consider the context in which this work takes place. The Ottawa Charter of Health Promotion, the foundation document of public health approaches to drug use and HIV/AIDS, states that five activities must be undertaken together for the effective promotion of public health:

- promoting health through public policy;
- creating a supportive environment;
- reorienting health services;
- strengthening community action; and
- developing personal skills.

These activities need to be provided within a framework of harm reduction. The principles of harm reduction work with IDUs include:

- avoiding increasing harm: for example, a law enforcement only approach to illicit drug use may slightly decrease such use but it increases the likelihood of HIV epidemics among IDUs;
- emphasising short-term pragmatic goals (such as preventing HIV transmission in a specific circumstance) over long-term idealistic goals (such as overall reduction in drug use);
- emphasising the dignity and human rights of all members of a society, including drug users;
- establishing a scale of means to achieving specific goals;
- using multiple strategies to achieve goals; and
- involving drug users in the planning and implementation of programmes designed to

address drug use and HIV/AIDS among drug users.

The riskiest activity for HIV infection during injection is the frequent sharing of injecting equipment with strangers. Needle exchange or distribution prevents or reduces this practice. Needle and syringe programmes (NSPs) have proven highly effective in preventing HIV transmission, especially where they also include information and education programmes for drug users. There are additional transmission risks in drug preparation, manufacture and purchase (such as the purchase of liquid drugs in syringes that may not be sterile). Where sharing continues, even among close friends or sexual partners, cleaning the needles and syringes can reduce HIV transmission among drug users. Information about cleaning needs to be provided by credible sources trusted by IDUs; normally, these are NSP and outreach staff. To accomplish change in the social norms of IDUs and to raise their interest in their health requires prevention programmes to develop educational and other strategies in which active IDUs play a primary role in the education of other IDUs about HIV prevention.

Providing accurate information and individual counselling on HIV risks to around 60–70 per cent of IDUs can decrease the level of needle and syringe sharing, so that HIV transmission is greatly reduced. By reaching a large percentage of injectors and encouraging them to switch to safer behaviours, HIV prevention becomes the norm. Many IDUs do not worry about HIV infection, despite the realisation that it will almost certainly lead to death for themselves and/or many of their friends over the next decade (especially in developing/transitional countries). This is largely the result of internalisation of negative attitudes towards drug users expressed by parents, media, health care workers, police and the general community. Treatment, care and support mechanisms for HIV-positive people, specifically designed to counter the general bias against IDUs, must form an integral part of HIV prevention efforts among IDUs to prevent the formation of a hidden pool of HIV-positive IDUs (see Burrows 2000). Drug treatment programmes have also been found to be effective in assisting drug users to reduce or stop injecting, especially where substitution drug treatments are used.

The Russian situation

Until recently, the Russian Federation appeared to have avoided the rapid spread of HIV infection, with fewer than 1,000 HIV cases recorded prior to 1996. The spread of HIV via shared use

of injecting equipment and drug preparations is the most important factor in the developing epidemic in the Russian Federation. There were no registered cases of HIV among IDUs prior to 1994; two infections in 1994; 2,452 in 1997; 1,655 in 1998; and about 12,000 in 1999.

There are several important features of the Russian Federation which have an impact on its ability to address rapidly spreading HIV epidemics among IDUs. The first is that the country is 'in transition' from a Communist-controlled, centrally planned economy towards a form of capitalist economy which is still being formulated. For a variety of reasons, this transition process has been accompanied by an inability of the government to pay for many services which were regarded as essential under the former system, and to a lack of financial resources to address emerging issues such as HIV epidemics.

Also related to this 'transition' is an ideological conflict between those who believe that the state has a right and a duty to intervene in its citizens' sexual and other personal behaviour and those who believe that protection of human rights precludes the use of compulsory treatment, imprisonment and exile for behaviour the state may view as deviant. The main features of the response until 1998 have been extremely widespread testing and contact tracing, aimed at containment of the infection among certain groups. This extensive testing, which was carried out from the late 1980s onwards, found very few cases of HIV until the mid-1990s. This may have led to official complacency that the country would escape the HIV pandemic.

The second factor is that the Russian Federation is the biggest country in the world. Its size and diversity – an extraordinary range of peoples and climatic and geographic conditions in 11 time zones – can lead to problems in implementing national programmes, especially on sensitive issues such as drugs, sex and HIV/AIDS.

Third, the rise in injecting drug use in Russia and the low age of first injectors has led to particular problems for prevention. The Ministry of Health estimates there are one million IDUs in the Russian Federation. Few studies have examined the age of first injection, but anecdotal reports from Moscow outreach workers of injectors aged 9–10 contribute to a general belief among HIV and drug workers that increasing numbers of young people are starting to inject at an ever earlier age.

Fourth, health facilities tend to be operated by the government in complex structures, with few private or community based health facilities or organisations. Non government organisations (NGOs) tend to be small and young (often only 3–5 years old), existing in perilous circumstances with little or no local funding.

Addressing HIV in Russia

By the end of 1997, several activities had been undertaken to address HIV among drug users. The Russian Duma had discussed the issue several times and the Ministry of Health had stated that HIV prevention among drug users was a priority

for all the nation's AIDS Centres. At the end of 1997, there were four programmes specifically attempting to do just this.

While these interventions are significant, they are not sufficient to prevent or control massive HIV epidemics among drug users in the Russian Federation. In September 1997, Médecins Sans Frontières–Holland (MSF–H) began an extensive training programme to ensure that people working on HIV prevention among IDUs have the skills to:

- conduct outreach to contact and effectively listen to and communicate with drug users and ex-users;
- conduct rapid situation assessments (RSAs) to determine the extent of drug use (especially injecting drug use) and related HIV risk and infection in their city or region;
- plan interventions which reach targeted drug users and encourage them to maintain or adopt behaviours which protect them against HIV infection;
- write proposals for funds to develop these plans; and
- train their colleagues and others in their city or region in these skills.

The programme was based on the *Rapid assessment and response guide on injecting drug use*, developed by the World Health Organization Programme on Substance Abuse in collaboration with UNAIDS and the Centre for Research on Drugs and Health Behaviour in London, and the *European peer support manual*, developed by the Trimbos Institute for the European Commission, both of which were translated into Russian by MSF–H; and on significant scientific articles and books. All of these Russian-language materials are provided to participants at the Initial Training Course, together with comprehensive Training Guidelines and copies of all overheads used in the training. Rapid Assessment and Response (RAR) is an action research approach which has three main components: assessment methods and sources of data; key areas of assessment; and the development of action plans for intervention implementation.

The training programme was given eight times between January 1998 and February 2000, in each case covering a period of four months. An Initial Training Course (of 11 days) in Moscow was followed by 12 weeks work by participants in their cities, attempting to assemble a team and carry out a RSA (with technical support and city visits from MSF–H staff and consultants, where requested and possible). The programme concluded with a Return Training Course (of five days) in Moscow to discuss the processes and results of each city's RSA and to use these results for initial programme planning. The training programmes were scheduled so that they overlapped: participants in an Initial Training Course spent their last day listening to the results of RSAs carried out by participants in a Return Training Course (see Burrows et al. 1999 for details).

Since the evaluation of the first Initial Training Course, applications were only usually accepted in groups of three from

each city, so that there was at least one participant from each group working in a narcological dispensary/hospital, an AIDS centre/infectious diseases hospital, and a non government organisation working in the field of HIV prevention among drug users. Russian narcological and AIDS institutions do not have an exact parallel in Western countries; the AIDS centres provide HIV testing, counselling, diagnosis and (in many cities) treatment, while the narcological centres provide detoxification and other drug treatment services.

Participation in training

A total of 199 participants from 61 cities, from Kaliningrad to Vladivostok and from Murmansk to Astrakhan, attended the MSF-H programme. They mostly comprised doctors working for government institutions, although from the third training cycle onwards there was an increasing number of NGO staff. The largest participant groups were from government AIDS centres (68) and narcological hospitals and dispensaries (60), while about one-quarter of all participants were from NGOs and others were from government infectious diseases hospitals and research institutions.

Of the 61 cities, 57 completed or almost completed the RSA within the period of the training course. Training organisers regard this result as extraordinary, as most of the participants at the beginning of the Initial Training Course believed that the lack of any financial or personnel assistance from MSF-H or other outside bodies would cause great difficulties in completing the assessment within the allotted time.

By 2000, 35 full programme proposals from training participants were approved for funding by the Open Society Institute (OSI-Russia). As there were only four HIV prevention programmes among IDUs in Russia at the beginning of 1998, this amounts to an increase of around 800 per cent in just over two years.

It is interesting to note that recent needs assessments of the first 13 NSPs to be funded by OSI in the Russian Federation and the 20 programmes recently funded by OSI in the Ukraine show marked differences in the needs for technical assistance. While the Ukrainian programmes, which did not undergo the MSF-H training or carry out local RSAs, are mostly concerned about the lack of support at the local level for the NSP, this issue was hardly mentioned by the Russian group, which requested assistance on operational issues of managing ex and active drug users.

This type of training on the use of RAR methodology and HIV prevention among IDUs was useful in assisting participants from Russian Government and NGOs to:

- perceive the need for rapid assessments of HIV and drug use in light of Russia's worsening HIV epidemic among drug users;
- acquire skills and methods of working (many of which are unfamiliar) to undertake rapid assessments;
- undertake RSAs; and
- plan and implement harm reduction programmes on a large scale.

I believe that such a comprehensive training programme (including two courses held three months apart, city visits, and the programme's integration with further capacity development and funding activities) has had a greater practical impact than the many short training courses which have been offered on harm reduction and HIV prevention in Eastern Europe and elsewhere.

The programme stimulates collaboration between: health agencies at the city/regional level; health and law enforcement and other administrative structures at these levels; Ministry of Health structures (for example, narcology and infectious diseases departments) at the federal level; other governmental structures and NGOs; and international agencies.

The combination of RAR methods with the type of training provided by the MSF-H programme, within a strategic framework which also includes additional technical assistance and funding, appears to be an effective approach to assisting countries in Eastern Europe to respond to HIV among IDUs. The approach may also have application in other parts of Central and Eastern Europe, in the Newly Independent States, and in other areas of the world such as Asia, Africa and South America.

References

- Ball, A. 1998, 'Policies and interventions to stem HIV-1 epidemics associated with injecting drug use', in G.V. Stimson, D.C. Des Jarlais and A. Ball (eds), *Drug injecting and HIV infection: Global dimensions and local responses*, UCL Press, London.
- Burrows, D., et al. 1999, 'Training in the Russian Federation on rapid assessment and response to HIV/AIDS among injecting drug users', *Journal of Drug Issues*, 29(4), 811-42.
- Burrows, D. 2000, *Treatment, care and support of injecting drug users living with HIV/AIDS: Implications for Ukraine*, Médecins Sans Frontières (Holland), Kiev, March.

AIDS: A nightmare ingredient in the Indonesian development broth

Chris Green, AIDS activist, Jakarta

Indonesia is bankrupt. Discussion on any development topics must start from this base. And the more so when the topic is AIDS. It is pointless to attempt to allocate blame for this state of affairs, even though it is clear that much of the responsibility lies with the international agencies. The national debt will remain a millstone around the necks of the people of Indonesia for generations to come.

An unacknowledged health disaster

Some maintain that the bankruptcy is not just financial, but also moral. Evidence of this is seen in the huge explosion of drug use over the last several years, with the majority of perhaps two million hard drug users injecting heroin. The inevitable results of this are only now being appreciated as the number of people infected with HIV from communal use of needles is starting to climb. Until very recently, most of those who should have been responding – both the National AIDS Commission and the AIDS non government organisations (NGOs) – accepted the conventional wisdom that Indonesians do not like to inject themselves. And, anyway, our young folk have been properly brought up, they wouldn't do a thing like that! Even now, I am aware of only one brochure in Indonesian which explicitly identifies the danger of sharing needles. The existing NGOs are all too busy working with their traditional target groups and risk behaviours to do more than talk of responding to the threat from injecting drug use.

Which is all a great pity. Because Indonesia must have been doing something right in its response to AIDS during the 1990s. The latest estimates from the World Health Organization (WHO) (June 1999) put the total number of HIV infections among the 200+ million population at 25,000. There is a general consensus that this is in the right range – for sexually transmitted HIV. However, so far there has been no reported serosurveillance anywhere in the country among injecting drug users (IDUs). Such data as we have (which are limited to Jakarta) suggest a prevalence there of around 20 per cent in early 2000. While it would clearly be dangerous to extrapolate this throughout the country, evidence from other countries in the region suggests that we could experience an overall 50 per cent prevalence of HIV among the over one million (increasing every day) IDUs within one to two years. Among them may be a disproportionate number of well-educated young people, since we are seeing an epidemic of drug use in high schools and universities, and among those returning from overseas study. Clearly a disaster already happening, with potential for significant negative impact on development!

The extent of the problem

With fewer than 1,200 cases of infection actually identified by both active and passive surveillance, and with nearly 20 per cent of these among foreigners, it is difficult to draw accurate conclusions as to the real risks or the reasons why the prevalence of HIV infection has so far been low. Such sentinel surveillance as has been carried out has generally shown a low prevalence, even among those groups which might be expected to engage in higher risk activities. The highest HIV prevalence seen among female sex workers has been 2.5 per cent, in Maluku, but few other locations have shown more than 0.5 per cent prevalence. The worst situation has been among transvestites in Jakarta, among whom HIV prevalence rose from 0.3 per cent to 6 per cent between 1995 and 1997 – sadly, no surveillance has been carried out among this group since then. No cases of HIV infection have been found among military recruits, and prevalence among blood donors has never exceeded 0.05 per cent nationally, with a peak of 0.3 per cent in Jakarta in 1998–99.

These low figures do, however, hide some local epidemics. Papua (ex-Irian Jaya, the western part of the island of Papua) has an identified prevalence of 4.26 per 100,000 people, more than four times even Jakarta, the next highest area. Given the remoteness of much of the settlement in Papua and the high prevalence across the border in the western part of Papua New Guinea, it is probable that actual rates are very much higher.

The picture on sexually transmitted diseases (STDs) is also unclear, with the prevalence of gonorrhoea and chlamydia generally high among female sex workers, and chlamydia also moderately high (5–10 per cent) among women who would generally be classified as low risk. Quite why these relatively high rates have not apparently translated into higher rates of HIV has been the subject of intensive debate. Among the possible reasons are high rates of male circumcision, the relatively low 'productivity' of sex workers (clients per night), and low levels of ulcerative STDs.

A natural question is why identified prevalence is so much lower than the estimated figure. Apart from very limited active surveillance, there is very little incentive for people to come forward for testing. First, although there are sometimes special programmes offering free testing in Jakarta, generally one has to pay to be tested – and the cost is beyond the pocket of most. Testing centres are often unfriendly, counselling may be limited and confidentiality may be questioned. HIV infection carries a stigma, and discrimination against people with AIDS is not unusual. On the other hand, it is difficult to identify benefits to an individual from knowledge of his or her HIV status: few

have any form of medical insurance; per capita health expenditure of a few dollars per year clearly does not cover even the treatment of opportunistic infections, let alone antiretroviral therapy; and few doctors are experienced in handling AIDS cases. Why would one want to know?

Who will, or can, respond?

We cannot expect the government to take a lead in the response to this health crisis. The lack of money will exacerbate the problem. The results of the one serosurveillance among IDUs carried out in early 2000 have yet to be confirmed because of a lack of funds for testing. There is no budget for screening the blood supply after mid-year. And to further complicate matters, the government is in the throes of decentralisation and privatisation. The Department of Social Welfare, which was previously responsible for drug addiction, has been disbanded, and the future of a central Department of Health is unclear – the Minister of Health was quoted recently as saying that it might not exist in a year's time. The provinces and districts, which are supposed to take over these responsibilities, have little knowledge or experience. And, while there is at least a National AIDS Strategy, which may be used by the devolved administrations as a guide, there is no national strategy or policy in regard to drug use. Which will naturally throw the response to the law enforcement agencies, well trained under the auspices of the US Drug Enforcement Administration. The risk of even raising the spectre of this epidemic is that those development funds which are available may be allocated to the purchase of helicopters for drug interdiction.

International donor agencies have attempted to take up the slack, and it is pleasing to report that Australia has been in the forefront of this response. A Rapid Assessment and Response (RAR) project was started in January with support from and unprecedented cooperation between AusAID, USAID, WHO, UNAIDS, Ford Foundation and the Program for Appropriate Technology in Health (PATH), plus of course the Indonesian Government. This RAR, following WHO methodology, is being carried out in eight major cities and final reports are expected in July. It is hoped that not only will this provide a much clearer picture of the situation around the country, but that it will also generate a constituency of local institutional support for responses.

But the responses will need to mobilise huge amounts of resources, both financial and human. In its bankrupt state, we can expect little from the government; perhaps, at best, we can hope that they will put into place a framework which will allow the community, the NGOs and the donors to work with minimum restrictions. However, given that the promotion of condoms is still viewed as controversial, it seems unlikely that we will see significant progress in real harm reduction responses (needle exchange, replacement therapy) in the near future. From the point of view of funding, this may be good (how would one pay for four million syringes a day, in a country where needles

are routinely reused in medical environments?). But, in the end, someone must pay for all those syringes – or for the lack of them, in terms of the HIV infection rate which will inevitably follow their lack.

Although it is clear that the future of AIDS in Indonesia will be dominated by the injecting drug user, we must not forget the other risk factors, especially since IDUs tend also to be sexually active and careless of the risks they take. Thus, we can expect to see a corresponding increase in HIV infection moving from their sexual partners and on to their children.

Some good news

The news is not all bad. In an unprecedented joint venture between the government and the community, more than 30 mental hospitals around the country are being mobilised to respond not only to the drug abuse problem but also to the HIV epidemic which is accompanying it. Noting experience from around the world which indicates that treatment for HIV-infected addicts is usually more successful if integrated with other services directed towards the drug user, this has been seen as a better approach than trying to develop the very limited facilities currently available to people with AIDS. One of the hospitals, in Bogor, around 50 km south of Jakarta, is being developed as a pilot and example for the other mental hospitals. Initial experience suggests that the aversion to being treated in such a facility appears to be more easily overcome than has perhaps been the experience elsewhere in the world.

The future

Many forecasts have been made of the future of AIDS in Indonesia; all so far have been wrong. It now seems unlikely that Indonesia will suddenly explode into epidemic in the same way that South Africa has over the last decade. Although few companies are making any real effort to address the challenge of AIDS among their workforce, it is unlikely that AIDS will have a significant impact on their productivity or costs, even those working in remote areas. The IDU threat is probably as much from the immediate effects of drug use, including other health problems, particularly overdose, and the associated social costs, as from AIDS. And other health concerns will remain great, including TB (Indonesia has the third highest incidence of TB in the world – and AIDS always makes the disease worse), malaria, leprosy and dengue fever. Besides, in its bankrupt state, we cannot expect too much from the government in addressing any of these challenges to development.

Reference

WHO (World Health Organization) 1999, *AIDS Watch: News from WHO South-East Asia Region on STDs, AIDS and Tuberculosis*, 4(1 & 2), January–June.

Sex talk, Indonesian youth and HIV/AIDS

Linda Rae Bennett, Key Centre for Women's Health in Society, The University of Melbourne

Introduction

The health of a nation's population is clearly a key indicator of its progress in terms of social and economic development. Considering the threat that an AIDS pandemic poses, HIV/AIDS prevention and treatment represent a critical development issue that requires ongoing commitment from the Indonesian Government and the international donors that provide critical financial support in the health sector. My discussion here is informed by ethnographic research, conducted between 1996 and 1998 in Mataram in Eastern Indonesia, and by a review of recent research and interventions concerned with youth sexuality and reproductive health throughout Indonesia.

Shame and sexual taboo

In contemporary Indonesian societies, sex is often infused with negative connotations and referred to as taboo (Beazley 1999, Pangkahila 1997, Sarlito 1990, Utomo 1997, Widyantoro 1996, Widyantoro and Sarsanto 1990). Cultural taboos inhibit communication about sex, deny and stigmatise 'deviant' sexual practices (particularly premarital sex for women), and are incorporated into sexual cultures characterised by silence, shame and secrecy. Prominent Indonesian sexologist Dr Whimpie Pangkahila (1997) has identified a 'Culture of Shame' as the most significant obstacle to promoting sex education, addressing the unmet reproductive health needs of unmarried people and preventing sexually transmitted diseases in Indonesia. Shame contributes significantly to the reluctance of Indonesian women, particularly those who are unmarried, to access reproductive health services (Bennett 1997, Hull et al. 1996, Sarlito 1990, Widyantoro and Sarsanto 1990).

Wiriwan Sarlito has also problematised sexual secrecy and the stigma of 'deviant' sexual activity in Indonesia, noting that 'the tendency to conceal sexual experiences, particularly those considered deviant, makes people with such experience feel afraid, depressed or frustrated' (1990:515). Recent ethnographic research in Eastern Indonesia on women's sexual experiences prior to marriage supports these observations (Bennett 1997, Jennaway 1996). The stigma and subsequent secrecy of unsanctioned sexual relations for unmarried women heightens their vulnerability because of the threat of exposure (Bennett 2000, Jennaway 1996). Women may be manipulated and coerced within premarital sexual relationships because they are unable to seek support outside of these relationships without

risking public exposure of unsanctioned behaviour. Conversely, the secrecy of premarital sex for women can be enabling, allowing them space for a greater degree of sexual negotiation and autonomy than is often the case within marriage (Bennett 2000).

Public displays of physical affection between the sexes are almost completely invisible among both married and unmarried couples in rural areas and regional cities and are considered shameful and a demonstration of poor character. This invisibility contrasts markedly with public displays of affection in more liberal and cosmopolitan locations, such as tourist centres in Bali and student areas in large cities like Yogyakarta and Jakarta. Prohibitions on physical contact in public are enforced primarily through social disapproval that regulates individual behaviour through gossip, stigmatisation and social exclusion in extreme instances. While any sex, including sex within marriage, is private, 'deviant' sexual relations that occur outside of marriage are typically conducted in absolute secrecy.

Globalisation and 'sex bebas'

Globalisation contributes to the proliferation of Indonesian sexualities through the constant influx of images, values and sexual ideologies that are not indigenous to *adat* (custom) or *agama* (religion), nor consistent with official state ideology. This proliferation encompasses both new emerging sexualities and the assertion of existing practices and identities that in the past were largely concealed. Despite the specificity of alternative sexualities that are manifested in particular sites, generations, subcultures and classes, they are categorically labelled as 'deviant' because they challenge the ideal confinement of sex within marriage. Subsequently, all deviant sexualities are lumped together in state and popular discourse under the umbrella term of '*sex bebas*', literally 'free sex'.

This counter ideology of *sex bebas* is associated with Indonesian interpretations of liberal 'Western values' and the perceived sexual immorality of Western societies. In state rhetoric, *sex bebas* is rejected and condemned on the grounds that it is representative of non-Indonesian values. Another regrettable aspect of the Government of Indonesia's attitude to *sex bebas* and HIV/AIDS prevention has been the failure to actively promote condom use, on the basis of ill-conceived fears that it encourages deviant sexual behaviour (Murdijana and Prihasawan 1994). Studies on condom promotion for HIV prevention elsewhere in Southeast Asia, particularly in Thailand,

have confirmed that it has not led to an increase in premarital or extramarital sex.

Within particular sites and subcultures, Indonesian youth have embraced the practice and ideology of *sex bebas*, regardless of public denial and condemnation of such behaviour. Among middle class youth in Jakarta, Iwu Utomo (1997:123–6) has identified a positive interpretation of the symbolic association between free sex and Westernisation. For these young people, *sex bebas* is often a form of recreation and represents consumerism, affluence and individuality, which they correlate with Western lifestyles. Beazley (1999) has examined further how *sex bebas* is a pivotal aspect of the lives and economies of street children in Yogyakarta. Among the meanings attached to *sex bebas* for *anak jalanan* (street children) are sex for the purposes of initiation, status, protection, pleasure and economic survival. These brief examples demonstrate the multiplicity of motivations, meanings and values invested in *sex bebas* for Indonesian youth in specific cultural milieus. They also highlight the imperative of encouraging expanded dialogue about sexuality, which in turn should promote more open discussion of the multiplicity of Indonesian sexualities.

National development, modernisation and globalisation are parallel and overlapping processes which have a composite impact in shaping current transformations in sexual relations among Indonesian youth. In regional locations such as Mataram, contemporary transitions in the realm of sexuality must be theorised as a response to broader social changes affecting the lives of local youth. These changes include prolonged education, increasing mobility, shifting patterns of residence, greater exposure to mass communications, rising consumerism, the popularity of youth culture, and the encroachment of international tourism. In this climate, young people are understandably challenging traditional notions of the confinement of sex within marriage. Their dilemma is that, in doing so, they must negotiate within a local culture that publicly condemns *sex bebas*. Public opposition to change in the realm of sexuality thus perpetuates the secrecy surrounding an individual's negotiation of sexual relationships and behaviour that are not socially sanctioned.

Sexual communication and social relationships

One would expect sexual secrecy to be accompanied and sustained by silence, yet the silence surrounding sexuality is not absolute. Frustrated observers of Indonesian sexuality have bluntly stated that in Indonesia 'people just do not talk about sex' (Sarlito 1990:515). This oversimplification does not do justice to the nuances of sexual communication in Indonesia, where people do quite clearly discuss their sexuality. Cultural taboos that inhibit such communication operate in specific contexts and between particular groups of individuals. Where there is a collective social agenda, such as education, health promotion or resistance to such initiatives, community

reluctance to discuss sexuality is significantly reduced. For this reason, religious leaders, government officials and respected members of the health profession are regularly invited to participate in and voice support for community forums on sex related issues in the public domain. Members of society who, because of their social ranking, are viewed as guardians or privileged representatives of collective morality have significant influence in initiating or constraining public discourse on sexuality. The responsible discussion and debate of sexuality among religious intellectuals on television and radio has become a regular feature in the mass media. Young people in Indonesia frequently cite such programmes as a popular source of information about reproduction and sexuality. However, these programmes contrast sharply with the sensational reporting of tabloid journalists who frequently represent sexuality and HIV/AIDS in a manner that reinforces stereotypes, stigma and social condemnation of sexuality outside of marriage.

Informal interpersonal communication about sexuality that occurs in more private contexts tends to be shaped by sexual taboos that tolerate or constrain the discussion of sexual matters in accordance with the social identity of individuals. Expressed simply, the more alike people are, the more likely they are to feel comfortable discussing sex and sexuality. Young single women who participated in focus groups in which sexuality was openly discussed commented that they felt at ease with the subject and the group dynamics because we were '*sama sama perempuan*' (all women). The appropriateness of same-sex communication concerning sexual issues was also expressed among married women in Lombok and Java who participated in focus groups designed to elicit information about reproductive tract infections. Their willingness to participate in frank discussions on this subject and related sensitive issues was expressed in the following way: 'As long as it's among women we're not embarrassed; we are all friends' (Hull et al. 1996:232). Qualitative research with different groups of men in Eastern Indonesia confirms that they also experience the same confidence in communicating about sexuality with same-sex peers (LSPP 1997).

While relaxed same-sex communication in specific contexts can subvert the sexual taboos that encourage silence, communication between women of different generations, marital status or social class is not common nor encouraged. Parents' difficulty in talking about sexuality with their children is characteristic of Indonesian families and has been repeatedly identified as an obstacle to promoting family-based sex education (Utomo 1997). Social denial and condemnation of premarital sex for women also contributes to their reluctance to discuss sexuality in the presence of older married women. The importance of shared marital status in defining a 'safe' environment for discussion was demonstrated during my fieldwork in Lombok. When a local women's group attempted to engage teenage girls in dialogue about sexuality and reproduction using focus groups, their initiative was met with uniform silence. The girls were polite and forthcoming with

their names and ages, as requested by the facilitator, but did not volunteer any response to conversation topics related to sexuality. One teenager who had been part of this group conveyed to me her discomfort at having been asked such questions by an *ibu* (mother/married woman), and that she feared the *ibu* would think she was *nakal* (naughty) if she admitted to possessing any knowledge about reproduction and sexuality. The same girl had been vocal and extremely humorous in the context of a focus group discussion held at my house earlier in the month, in which the participants and facilitators were all unmarried women. Later that year the same non government organisation (NGO) adopted an alternative approach to involving local youth in reproductive and sexual education by promoting peer-group meetings run by single university students, which were extremely popular among both teenage girls and boys.

Sexual communication between women and men tends to be considered taboo outside of intimate relationships. This was confirmed by young women's responses when I enquired as to whether they would be interested in mixed-sex focus groups or educational workshops on sexual issues. The majority of women felt that it would be inappropriate (*tidak cocok*), some felt that they would be *malu* (shy; embarrassed) to discuss sexuality in a mixed environment, while others were concerned that they would have less confidence in raising issues and sharing personal experiences. The women who did express interest were all tertiary students, in their early to mid twenties, and had prior experience of discussing sexuality with male partners in premarital relationships. Based on this line of questioning and supporting case study data, it is evident that the degree of sexual intimacy experienced by individuals, high levels of education, and maturity all enhance women's confidence in sexual communication with their male peers.

Cultural taboos that inhibit communication about sexuality clearly constrain attempts to challenge negative understandings of sexuality as inherently shameful. Despite the enduring presence of these taboos, it is important to acknowledge that they have always been contested by individuals and are not universally adhered to. Moreover, in the current political and social climate of regional Indonesian cities such as Mataram, there is steadily growing awareness and support for the need to encourage public and private communication about sexuality, and to promote more positive perceptions of it within the community as a whole. Expanding dialogue on sexuality and the erosion of traditional taboos have been precipitated to a large extent by the imperative of responding to the threat of HIV/AIDS, as well as the growing visibility of changes in intergenerational behaviour in the realm of sexuality. While the Government of Indonesia's response to HIV/AIDS can be characterised as one of denial and reluctance to prioritise reproductive and sexual health education as a means of prevention, international donors and NGOs have been active in funding and supporting community based initiatives. Despite the lack of a uniform national strategy for comprehensive sex education in Indonesian schools, donors such as the Ford Foundation and AusAID continue to support the consolidation

of national networks concerned with youth reproductive health and sex education.

Despite the Indonesian Government's limited commitment to HIV/AIDS prevention, local progress in eroding sexual taboos in Mataram is evidenced by community initiatives that have involved extracurricular school based seminars and peer education about HIV/AIDS and reproductive health. There have also been a number of localised projects focused on 'risk groups', such as male guides and female sex workers, primarily in the tourist areas of Lombok. These have promoted condom use and distribution, and peer support and education. Again, such initiatives have operated outside of official government departments and with the financial support of international donors. Challenging sexual taboos in public discourses is also important because it transfers sexual information into the private realm and fosters more positive attitudes towards sexual communication in personal relationships. This has particularly positive benefits for youth because they are still formulating their sexual values, attitudes, and patterns of sexual communication, and are thus likely to be more responsive to alternative modes of communication than adults.

Conclusion

The promotion of reproductive/sexual health and HIV/AIDS prevention is highly contingent upon expanded dialogue about sexuality in both private and public domains. In rising to the challenge of encouraging communication about sexuality, we must acknowledge the complex ways in which sexual communication is circumscribed by enduring cultural taboos, and also how sexual dialogue operates to subvert and erode those taboos. Successful HIV/AIDS prevention in Indonesia is also dependent upon a shift in prevailing sexual ideals that define premarital and extramarital sex as deviant, and subsequently equate HIV/AIDS only with deviant sex and non-Indonesian values. The imperative of HIV/AIDS prevention thus embodies the potential to foster a social climate in which sexuality is discussed and debated more comprehensively, and narrow conceptions of sexual ideals, norms and values can be challenged openly.

References

- Beazley, H.S. 1999, 'A little but enough': Street children's subcultures in Yogyakarta, Indonesia, PhD thesis, Australian National University, Canberra.
- Bennett, L.R. 1997, 'A preliminary analysis of reproductive health among young women in Mataram, Lombok', paper presented at Seminar Internasional: Bahasa dan Budaya di Dunia Melayu, University of Mataram, Mataram, 21–23 July.
- Bennett, L.R. 2000, 'Sexuality and secrecy: Social change and contemporary courtship practices in Mataram, Lombok', in L. Manderson and P. Liamputtong Rice (eds), *Coming of age in South and Southeast Asia: Youth, sexuality and courtship*, Curzon, London, in press.

- Hull, V., et al. 1996, 'No problem': Reproductive tract infections in Indonesia', in P. Liamputtong Rice and L. Manderson (eds), *Maternity and reproductive health in Asian societies*, Harwood Academic Press, Chur, Switzerland, 227–46.
- Jennaway, M. 1996, Sweet breath and bitter honey: HIV/AIDS and the embodiment of desire among north Balinese women, PhD thesis, University of Queensland, Brisbane.
- LSP 1997, 'Pengetahuan Laki-Laki Tentang Kesehatan Reproduksi' (Men's knowledge about reproductive health), in N. Kollmann (ed.), *Menelusur Benang Kusut Kesehatan Reproduksi: Penelitian Kualitatif Lima LSM di Lombok* (Untangling the complexity of reproductive health: Qualitative research in five communities in Lombok), POGI, DEPKES, BKKBN, AusAID, Jakarta, 1–18.
- Murdijana, D. and P. Prihasawan 1994, 'AIDS prevention in Indonesia', *National AIDS Bulletin*, April, 8–11.
- Pangkahila, W. 1997, 'Perkembangan Seksual Remaja: Masalah dan Upaya Mengatasinya' (Adolescent sexual development: Problems and responses), paper presented at Seminar Nasional Kesehatan Reproduksi Remaja (National Seminar on Adolescent Reproductive Health), YLKI, Bukittinggi, 10–14 March.
- Sarlito, W. 1990, 'Social psychological aspects of health and health care', *Health Transition Series*, 2(2), 515–21.
- Utomo, I. 1997, Sexual attitudes and behaviour of middle-class young people in Jakarta, PhD thesis, Australian National University, Canberra.
- Widyantoro, N. 1996, 'Learning about sexuality through family planning counselling sessions in Indonesia', in S. Zeidenstein and K. Moore (eds), *Learning about sexuality: A practical beginning*, Population Council and International Women's Health Coalition, New York, 158–70.
- Widyantoro, N. and W. Sarsanto 1990, 'Cultural dimensions of an Indonesian family planning service', *Health Transition Series*, 2(2), 509–14.

HIV and development the Papua New Guinea way

Clement Malau, National AIDS Council Secretariat, and Sue Crockett, AusAID Sexual Health Interim Support Project, Port Moresby

Introduction

Papua New Guinea, 25 years after independence, is facing the threat of a potentially devastating HIV/AIDS epidemic. A young developing country, it is experiencing rapid social, political and cultural change as the 800 different language and cultural groups move towards becoming one nation. Development factors such as high rates of unemployment, low literacy, urban migration and settlement, lack of infrastructure, gender disparities, civil unrest, and lack of a skilled workforce not only create a high-risk environment for a HIV/AIDS epidemic, but also situate any response to the threat within the context of competing health and development priorities for scarce resources.

Papua New Guinea has acknowledged the factors and issues associated with HIV and development, and the importance of developing specific interventions to address HIV as a development rather than as a health issue, with policies and programmes which encompass the social and economic determinants of HIV/AIDS. Papua New Guinea has begun the process of implementing a comprehensive multisectoral response, establishing structures at the national and provincial level to monitor and coordinate implementation of the National HIV/AIDS Medium Term Plan (Government of Papua New Guinea and UNAIDS 1998).

The HIV/AIDS situation

The first HIV case was reported in Papua New Guinea in 1987 and, over the past ten years, the numbers have grown exponentially. By 31 December 1999 the total number of reported HIV antibody positive cases had reached 2,342, with 798 new cases being reported in 1999, a 30 per cent increase on the number reported in 1998. It is relevant to note that over 70 per cent of new HIV cases are diagnosed at the Port Moresby General Hospital and that testing is very limited in many rural provinces.

The available data indicate that the predominant mode of transmission is through unprotected heterosexual intercourse (89 per cent), with perinatal transmission being the second most common mode (9 per cent). Transmission through injecting drug use has not been recorded to date and only four cases of male-to-male transmission have been reported. The majority of cases are aged 20–29 years (43 per cent) and the number of persons diagnosed in the 10–19 age group has increased significantly over the past few years.

Papua New Guinea has a high prevalence of curable sexually transmitted infections (STIs), the rate having been estimated

to be 10.6 per 1,000. This high community prevalence is a major risk factor for transmission of HIV and, in addition, it indicates that many people engage in unprotected sexual intercourse. A community based study conducted among 270 highlands women in 1995 found that 26 per cent had undiagnosed *Chlamydia trachomatis* (Passey et al. 1998), and a 1998 study of sex workers in Port Moresby and Lae found a syphilis prevalence of 43 per cent (Mgone et al. 1999).

Although HIV sero-surveillance is limited due to lack of resources, the studies conducted to date do provide some valuable information. The 1998 survey of sex workers found a prevalence of 16.3 per cent (Port Moresby) and 3 per cent (Lae) (Mgone et al. 1999). Annual surveys of new patients attending the STD clinic at Port Moresby General Hospital show a rising prevalence, reaching 6.7 per cent in 1999. Among antenatal patients attending the hospital, the prevalence had reached 0.32 per cent in 1999. Sero-surveillance among the PNG Defence Force in 1999 found a prevalence of 0.4 per cent. Among healthy blood donors, the rate in 1990 was 0.005 per cent; by 1998 it had reached 0.024 per cent (STD Unit Surveillance Data).

In 1999 AIDS was reported as the leading cause of death in medical wards at the Port Moresby General Hospital. The National Capital District, with an estimated population of 295,000 (1999 estimates), had a cumulative total of 1,679 persons with HIV and 592 cases of AIDS reported by the end of 1999.

The HIV/AIDS epidemic is already well established in Papua New Guinea and will require sustained and effective interventions among all sections of the community to reverse the trend. Predictions on the course of the epidemic have indicated that, by 2006, a total of 62,000 people could be infected, with a cumulative total of over 12,000 deaths.

Socioeconomic and cultural factors

Papua New Guinea is a country in the midst of rapid social and development change. Over the past five years, economic problems and the devaluation of the currency have created a funding crisis in all sectors.

The population is about 4.2 million, based on projections from 1990 National Census data, with an average age of 23 years. Forty-two per cent of the population is under 15 years of age. Life expectancy remains low, at 51.4 years for females and 52.2 years for males. The vital health statistics show high rates of infectious and preventable diseases, with an infant mortality rate of 82 per 1,000 live births, and a maternal mortality rate estimated to be 370 per 100,000 live births. The poor health

status of the population has been a major development challenge for Papua New Guinea. Resources and skilled staff are limited and access to basic health services is inadequate, particularly in rural areas (Department of Health 1996).

Development factors relating to limited educational opportunities, low literacy rates and lack of employment options all contribute to the spread of the HIV/AIDS epidemic. Many students leave school early, with approximately 50 per cent attending school through to Grade 6 and a secondary school enrolment rate of only 18 per cent. Literacy rates are low, at 45 per cent of the population, and in some provinces the literacy rate among women is as low as 10 per cent. Low rates of education and literacy, combined with 800 different language groups, make the process of communication to the rural majority a daunting task. The high rates of unemployment and the lack of income-generating opportunities have resulted in significant economic hardship for a large proportion of the population, and research indicates that economic need contributes to the high rates of commercial sex by both women and men in PNG society (NSRRT and Jenkins 1994).

Violence continues to be a major problem at all levels of society, with high rates of violent crime, ongoing tribal disputes in rural areas, and widespread violence against women. Women are particularly vulnerable, with rape, including group rape, being tacitly accepted by many sections of the community. The disparity in status between men and women frequently leaves women vulnerable in sexual relationships and unable to negotiate safe sexual practice (Lepani 1997).

In addition to lack of control over their sexual health, many women also lack knowledge or awareness of personal risk of STIs and HIV/AIDS. The 1996 Demographic Health Survey found that, among the 65 per cent (3,177) women respondents who indicated that they had some knowledge of HIV/AIDS, only 19 per cent identified condoms as a means of protection against HIV transmission. In addition, 73 per cent said that they did not perceive themselves to be at personal risk of acquiring HIV/AIDS (National Statistics Office 1997).

There are a number of cultural practices in Papua New Guinea that increase the risk of HIV transmission. Polygamy is still practised in the highlands region. Traditional tattooing and scarification lead to risk of HIV transmission if instruments are shared. Male circumcision is thought to prevent HIV and STIs and is said to be increasing. Ritual homosexuality, previously practised during male initiation ceremonies, has largely disappeared (Government of Papua New Guinea and UNAIDS 1998).

The diversity of the country, both in terms of culture and geographical terrain, makes it difficult to communicate with the rural communities. Many can only be reached by sea or by light plane. In addition, myths about HIV/AIDS have created an atmosphere of fear and blame in different parts of the country. Many varying religious philosophies are being imposed which create significant differences in the way people perceive HIV/AIDS messages and thoughts about improving the general well-being of individuals and communities.

Not only is there a diversity of cultures but also all are themselves in transition. Although over 80 per cent of the population is still village based and practising subsistence farming, internal migration is common and large urban settlements have been established in the major provincial cities. This shift from rural subsistence to an urban way of life, and the subsequent mixing of cultures and subcultures, make sexual behaviour and networking more complex. Education for behaviour change becomes a very challenging task.

The evolution of the HIV/AIDS response

In Papua New Guinea, as in many other countries, the response to the threat of HIV/AIDS was slow to evolve. Initially, the programme focused on ensuring safe blood supplies and establishing HIV antibody testing throughout the country. Working closely with the WHO Global Programme on AIDS, the health sector established a National AIDS Surveillance Committee in 1986 to be responsible for surveillance and monitoring and for developing HIV policy guidelines. The first Short Term Plan for HIV/AIDS came in 1988, and then, in collaboration with the WHO programme, the first Medium Term Plan in 1998.

The HIV programme managers in the health sector recognised early on the implications of HIV/AIDS for social and economic development. A programme plan was developed which not only addressed health sector needs but also included the establishment of an intersectoral, multipartisan National AIDS Council and multisectoral Provincial AIDS Committees. In addition, the plan proposed political advocacy, mobilisation of the church and non government sector, and the development of HIV/AIDS policy. While the health sector had recognised the urgency of developing effective prevention measures, coordination was problematic and political commitment inconsistent.

During the early 1990s, positive attempts were made to sensitise political leaders to set up a structure that would respond to the complex impact of the epidemic. Workshops were conducted for journalists and political leaders to advocate the development of an appropriate multisectoral response. The challenge then was to make the invisible visible to political and community leaders. However, it was difficult to make an issue out of HIV/AIDS when there were very few reported cases in the country. STIs were used as a model to illustrate the spread of HIV, but only some people were able to visualise the real threat of the disease. Thus, political realisation of the problem took time, as in many other countries. The National Executive Council failed to pass the National AIDS Council Act, despite repeated presentations, and programmes lost technical and funding support when the Global Programme on AIDS was withdrawn. In addition, the economic problems of the mid-1990s led to funding constraints in the health sector, including the HIV programme.

In 1993, the government requested financial assistance from AusAID to support the implementation of the HIV programme, and the AusAID Sexual Health and HIV/AIDS Prevention and

Care Project was developed in response, commencing in late 1995. The project provided funding and technical support to the National Department of Health.

In late 1997, there was a major breakthrough when an Act was passed by the parliament, establishing a multisectoral National AIDS Council (NAC) as a statutory authority. The NAC, which first met in June 1998, is responsible for policy formulation on HIV/AIDS and for the fostering, monitoring and coordination of the HIV/AIDS programme. It comprises representatives from all government departments, the Council of Churches, the National Council of Women, the Chamber of Commerce and the non government sector. Currently, the legislation is being reviewed to include a representative of people living with HIV/AIDS. The NAC is supported by a secretariat of nine staff.

At the provincial level, structures are being set up to coordinate the implementation of the Medium Term Plan (MTP). The Provincial AIDS Committees have been established in several provinces and will be supported by a small secretariat comprising a HIV programme manager and a counselling and community care coordinator. The committees are to be endorsed by the Provincial Executive Committees to ensure that they have political support at the provincial level and are sustainable, and they will be responsible for the implementation of the MTP at that level.

Over the same period, 1997–98, the National Plan (MTP) was developed. The initial proposal was developed by the Office of National Planning and the Department of Health in consultation with the UNAIDS theme group. Six working groups, involving 80 key people from different sectors of the community, met over a period of six months to produce a plan which addressed six components: education, information and media; counselling, community care and support; legal and ethical issues; social and economic impact; monitoring, surveillance and research; and medical laboratory. The plan was launched by the Prime Minister at Parliament House in July 1998 and a representative of people living with HIV/AIDS addressed guests at the launch. The establishment of the NAC and the completion of the plan finally heralded the beginning of a comprehensive multisectoral response for Papua New Guinea.

The NAC secretariat became operational in April 1999 and during the first year of operation the major objective has been to establish structures to facilitate the multisectoral approach at the national and provincial levels, mobilising all sectors. In 1999 the secretariat conducted five workshops to support the multisectoral response. The first attempted to bring together all the different sectors at a national level to begin the process of response to HIV/AIDS. The other four focused on setting up provincial structures and on conducting a situation analysis of risk and resources for all provinces and districts. In addition, the secretariat advisers began a review and revision of all policies and legislation relevant to HIV/AIDS, working with advisory committees and prioritising policies relating to human rights, discrimination, confidentiality, and condom access.

A major undertaking of the secretariat for 2000 will be to begin the social and economic impact component of the MTP, this being most important in relation to HIV and development. The initial activity will be a comprehensive study on HIV and

development, and the findings will be used to inform the development of specific interventions in all sectors.

Conclusion

The potential impact of a HIV/AIDS epidemic was recognised early by a few key people in Papua New Guinea and they have worked hard for many years to achieve the support of political, church and community leaders. The early programme was based in the health sector but still worked towards a multisectoral approach which mobilised the government and non government sectors to work together, provided access to information, and worked for the rights of people living with HIV/AIDS. The threat of HIV/AIDS has now been acknowledged by the government and by many churches and non government organisations, and even the private sector has begun to support HIV/AIDS initiatives. However, there is a long way to go. Fear, ignorance and apathy are still widespread in the community, and people living with HIV/AIDS are experiencing discrimination, rejection by their communities and in some cases violence. The ongoing economic problems impact on all sectors of the community and all sectors are faced with severe financial constraints. The NAC Secretariat has a commitment from AusAID to provide ongoing support for the implementation of the HIV/AIDS Medium Term Plan, and the Secretariat is working closely with other agencies including the UN agencies, World Health Organisation and the European Union. The most important factor in controlling the epidemic in Papua New Guinea will be to address the development issues which deny people the social and economic circumstances that allow choice.

References

- Department of Health 1996, *National Health Plan 1996–2000, Volume One*, Government of Papua New Guinea, Port Moresby.
- Government of Papua New Guinea and UNAIDS 1998, *Papua New Guinea National HIV/AIDS Medium Term Plan 1998–2002*, Government of Papua New Guinea and UNAIDS, Port Moresby.
- Lepani, K. 1997, 'Women, development and HIV/AIDS', paper presented at Seminar of HIV/AIDS in Papua New Guinea, Port Moresby.
- Mgone, C., et al. 1999, *HIV/AIDS and other sexually transmitted infections among sex workers in Port Moresby and Lae. Final report on research proposal*, PNG Institute of Medical Research, Goroka, July.
- NSRRT (National Sex and Reproduction Research Team) and C. Jenkins 1994, *National study of sexual and reproductive knowledge and behaviour in Papua New Guinea*, Monograph No. 10, PNG Institute of Medical Research, Goroka.
- National Statistics Office 1997, *PNG Demographic and Health Survey 1996, National Report*, NSO, Port Moresby.
- Passey, M., et al. 1998, 'Community based study of sexually transmitted diseases in rural women in the highlands of Papua New Guinea: Prevalence and risk factors', *Sex Transm Dis*, 74, 120–7.

The sociocultural and economic context of HIV/AIDS in Papua New Guinea

Gina Koczberski, Research Unit for the Study of Societies in Change, Curtin University of Technology

Introduction

In a recent article in the *Development Bulletin*, Clement Malau, director of the National AIDS Council Secretariat in Papua New Guinea, noted that 'with the rapid spread of HIV/AIDS, the future development of the country is seriously threatened' (1999:70). His remark highlights the fact that AIDS in Papua New Guinea is more than a health issue: it is a disease that potentially poses major challenges to the economic and social base of the nation. Presently, Papua New Guinea has the highest rate of HIV/AIDS transmission in the Pacific region, and AIDS is now the main cause of death in the Port Moresby General Hospital adult medical ward (Malau 1999).

HIV/AIDS was first recorded in Papua New Guinea in 1987 and, since then, the number of diagnoses has grown considerably. Although there is widespread under-reporting, it is estimated that 16 new infections for every 100,000 people are reported each year (Malau 1999). Most infections are through heterosexual transmission, with some mother-to-child transmission. The most affected group is the 20–39 age cohort, with 40 per cent of infections occurring in the 15–24 age group (*Post Courier* 12 March 1998). The young age structure and mobility of the population, together with existing high rates of sexually transmitted diseases and tuberculosis, low literacy rates and poor health infrastructure, provide the conditions for the rapid spread of HIV over the next decade.

Four key sociocultural and economic factors in the spread of HIV in Papua New Guinea need to be considered: contemporary sexual culture; the position of women in society; migration; and health services.

Contemporary sexual culture

Alongside the broader socioeconomic changes occurring in Papua New Guinea, sexual norms are being transformed, with a shift towards more permissive attitudes to sexual behaviour and greater opportunities for sexual networking (Hughes 1991, NSRRT and Jenkins 1994, Kramer 1995, Malau et al. 1994). These shifts reflect major changes in the context of sexuality and include the loss of sexual ritual and the weakening of community social control mechanisms:

With the decline of secret male cults and warfare, the individual male and female has fewer proscriptive rules, far greater freedom to travel, and less fear of casual interpersonal relations, particularly in urban settings. Rules governing sexual behaviour in these newer situations are unclear (NSRRT and Jenkins 1994:76).

Such changes create many more opportunities for sexual networking.

Recent studies on sexual behaviour reveal increasingly younger engagement in sexual activity, growing commercialisation of sex, an active premarital sex life and considerable extramarital sexual activity (Friesen et al. 1996). The latter is supported by several surveys. In a study of attendees at the STD clinic at the Porgera health centre in Enga Province, 60 per cent of men admitted that they had engaged in extramarital sex in the previous three months (Kramer 1995). A national survey revealed that 71 per cent of men claimed they had extramarital sex at some time during their marriage and 21 per cent of married women reported having extramarital sex (NSRRT and Jenkins 1994). The range of sexual behaviour described in Papua New Guinea, where knowledge of HIV/AIDS and AIDS prevention and safe sex practices remain very limited, are issues of great concern in the spread of HIV in Papua New Guinea.

Yet, within Papua New Guinea's changing sexual culture, some 'traditional' beliefs surrounding sexual norms and reproduction remain and have implications for the spread of HIV/AIDS. For example, it is commonly believed across all cultural groups that repeated acts of sexual intercourse are necessary for conception to occur. The men in the NSRRT and Jenkins study (1994) considered it 'safer' to change sex partners frequently than to stay with one partner (unless a spouse) in order to avoid getting a woman pregnant. The study suggested that, although 'it is not possible to assess...to what degree this belief encourages frequent sex partner change...it may be a hidden factor in this aspect of sexual behaviour, contributing to increased risks for acquiring HIV infection' (NSRRT and Jenkins 1994:40).

By foregrounding sexual behaviour, my aim is not to advocate policies of chastity in HIV/AIDS prevention programmes but rather to highlight the context of sexuality in which HIV/AIDS is spreading in Papua New Guinea. Greater sexual freedom among married and unmarried people is the reality in contemporary Papua New Guinea and, as such, prevention strategies must acknowledge this fact and place more emphasis on safe sex than on anti-promiscuity messages. Given the strong presence of various Christian denominations in Papua New Guinea, there is a risk that such anti-promiscuity messages may become the dominant discourse in prevention strategies. Kramer (1995) reports that Radio Enga, the main source of information about AIDS in the Porgera District, avoids promoting the use of condoms in their AIDS prevention messages as it is considered to conflict with Christian principles.

Position of women in society

In Papua New Guinea, most marriages involve the payment of bride wealth or brideprice which in effect gives the husband, or

his clan, some authority in matters relating to female reproduction and labour. Although marriage imposes certain rights and obligations on both husband and wife, men generally control sexual relationships and women have little power to negotiate their sexuality. For example, women accused of adultery are often dealt with more severely by village courts than are men, and forced sex and sexual and domestic violence within marriage are common (Banks 2000). In a national survey of sexual reproduction and behaviour, almost 50 per cent of married women interviewed reported being forced into sex by their husbands and violence was used in a third of these cases. The study revealed that women refusing sex to their husbands 'were most often beaten as a result' (NSRRT and Jenkins 1994:137). Women's lack of control over their sexuality is no more clearly illustrated than by the severity and regularity of sexual assaults and gang rapes (Borrey and Kombako 1997, PNG Law Reform Commission 1992). Although societal acceptance of rape is on the decline, there remains a disturbing degree of violence in female sexual assaults.

Certainly, it seems that the position of women in Papua New Guinea manifests itself in their having less control over their bodies and sexuality than men, and consequently this places them in a vulnerable position in the transmission of HIV/AIDS. Because women have little power in sexual relationships, it is unlikely that they will be able to negotiate safer sexual practices (such as use of condoms), even though many married women know or suspect that their husbands are engaging in extramarital sex. In one survey, 77 per cent of married women interviewed claimed that they 'knew or suspected' that their husbands were having sex with other women (NSRRT and Jenkins 1994). HIV/AIDS education campaigns, especially those promoting safer sex, need to acknowledge the gender inequalities in sexual decision making and the cultural factors constraining women's ability to demand safer sexual practices.

Migration

When considering HIV/AIDS transmission in Papua New Guinea, it is necessary to take into account the extent of circular migration. The convergence of increasing mobility, urbanisation and changing sexual behaviour has the potential to lead to the rapid transmission of HIV into all parts of the country.

An important characteristic of internal migration in Papua New Guinea is its temporary and circular nature, mostly from rural areas to towns and cities – although the growth in the mining industry over the last decade has increased rural-to-rural migration. Temporary and circular migration has been well established in some parts of the country since the early colonial period. The implementation of the Migrant Labour Scheme in the 1950s and later government policies of resettlement almost institutionalised migration as a rite of passage for young males. Since then rural-to-urban migration has grown and for many rural areas, where population pressures and access to incomes are limited, out-migration is often the only means by which to earn an income. The development of strong social and kinship networks linking migrant source and destination sites has also facilitated and strengthened rural-to-urban migration.

Most short-term circulation is undertaken by males, particularly young men, to raise brideprices, to gain status, and/or as a rite of passage into adulthood (see Curry and Koczberski 1998). Although the sexual behaviour of young male migrants in Papua New Guinea has not been researched, studies in Africa and Asia have shown that highly mobile populations increase the potential for the spread of the virus, and young mobile adults are most at risk of HIV infection (UNAIDS and IOM 1998). (This is not to argue that all young migrants are at risk or are engaging in behaviours that place them at risk of infection).

Several behavioural factors make young migrants an important group in the transmission of HIV/AIDS. First, they are the most sexually active age group and more likely to be engaging in risky sex. In Papua New Guinea, most new diagnoses are in the 15–25 year age cohort (Pollard 1999). Second, migration increases opportunities for casual sexual encounters without the social constraints of village life. And, for married couples, long periods of separation may increase the possibility of extramarital relationships. It is therefore not too surprising that among the high-risk groups are those employment sectors that require or are characterised by a mobile workforce: transportation (truck drivers), military and police. Given the large number of migrant workers attracted to many of the new mine sites in Papua New Guinea, it is also likely that these too could be categorised as high-risk employment sites. For example, following the opening of the Porgera gold mine (and the broader socioeconomic changes that occurred), sexually transmitted diseases increased rapidly with the influx of workers, and the majority of patients attending the Porgera STD clinic were from outside the district (Kramer 1995). Other sites of high circular in-migration, such as resettlement schemes and urban informal settlements, may also be considered high-risk sites for HIV transmission. Hence, some recognition of these sites must be incorporated into intervention and prevention programmes. However, before effective HIV/AIDS prevention strategies can be developed for migrant populations, further research is necessary on the links between migration and the spread of HIV in Papua New Guinea.

Health services

A final factor in the spread of HIV in Papua New Guinea is the current state of the country's health services. They have been deteriorating since the 1980s and many rural communities still have extremely poor access to basic health services. Over the last ten years, half of the aid posts have closed because of staff shortages and the lack of essential medical supplies, and many health centres are no longer fully functional. In the mid-1990s the Minister for Health reported that 60 per cent of the health facilities in the provinces were closed, unstaffed or had no medicines or equipment (Connell 1997). Poor basic health services and a lack of trained staff place Papua New Guineans in a very vulnerable position in the transmission of HIV/AIDS as they are denied access to sexual health education, AIDS prevention information, and STD/AIDS clinics and surveillance. Further, inadequate medical supplies such as rubber gloves and disposable needles and syringes pose significant risks for both health workers and the wider population (Government of Papua New Guinea 1998).

With a declining health budget, it is unclear how Papua New Guinea is going to cope with the increased pressure on health services. Economic reality prohibits large increases in per capita health expenditure to adequately cover both the treatment and prevention of HIV/AIDS. In the 1998–2002 National HIV/AIDS Medium Term Plan, it is estimated that the cost of HIV/AIDS patient care will increase to K45 million over the next decade. To meet this cost, the government will have to shift resources from other priority areas within the health sector to HIV/AIDS care and prevention (Government of Papua New Guinea 1998). Such a move has serious implications in a country where infant mortality rates have increased in some provinces since the 1980s (Duke 1999) and where the health status of the population is already the worst in the Asia–Pacific region (Connell 1997).

As well as funding problems, health services have another set of challenges when it comes to providing HIV/AIDS education. Promoting changes in sexual behaviour is a necessary step in reducing the spread of HIV/AIDS, but this will be no easy task. For example, as the study of male attendees at the Porgera STD clinic revealed, a greater awareness and knowledge of AIDS did not lead to risk-reduction behavioural changes (Kramer 1995). Also, in Papua New Guinea where indigenous concepts of health and illness remain strong, it is essential that the design of health messages be sensitive to the specific local social and cultural contexts of health and illness. Underestimating the persistence and resilience of indigenous belief systems will hinder the success of AIDS prevention programmes.

Conclusion

Several challenges lie ahead in controlling the spread of HIV/AIDS. A major hurdle is the lack of development: poverty, low educational levels, inadequate and declining health services, poor nutrition and health status of the population, and growing inequalities between rural and urban areas create the conditions for rapid transmission. Issues of poverty and socioeconomic development must also be addressed in tackling the spread of HIV/AIDS. Yet, as Clement Malau has recognised, AIDS also has the potential to undermine or jeopardise some of the gains of economic development already achieved. AIDS is undoubtedly a major development issue, and its human and economic impacts are likely to be exacerbated in a country such as Papua New Guinea with its fragile economic and political infrastructure.

In this paper I have avoided writing on the potential impacts of AIDS, as this is especially difficult for a country like Papua New Guinea. Its tremendous geographic, agricultural and cultural variations, together with rapid socioeconomic change, make assessing likely national trends and impacts prone to large inaccuracies and generalisations. At a local level, the potential burden that AIDS may place on families could affect household agriculture, labour, income and the education of children, as it has in other countries (see Barnett et al. 1995). The specific ways in which households will respond to this new situation is uncertain. Given Papua New Guineans' capacity to respond to change, I tend to agree with Katherine Lapani, coordinator for the HIV/AIDS Medium Term Plan:

Papua New Guineans have that incredible skill and knack of sitting down and confronting things, they are very receptive. In some ways it [HIV/AIDS] is not going to be that different from everything else they are called on to absorb (cited in O'Callaghan 1999:35).

References

- Banks, C. 2000, 'Contextualising sexual violence: Rape and carnal knowledge in Papua New Guinea', in S. Dinnen and A. Ley (eds), *Reflections on violence in Melanesia*, Hawkins Press and Asia Pacific Press, Leichhardt.
- Barnett, T., et al. 1995, 'The social and economic impact of HIV/AIDS on farming systems and livelihoods in rural Africa: Some experience and lessons from Uganda, Tanzania and Zambia', *Journal of International Development*, 7(1), 163–76.
- Borrey, A. and B. Kombako 1997, *The reality of sexual violence in Papua New Guinea – a pilot project in Port Moresby*, National Research Institute, Port Moresby.
- Connell, J. 1997, 'Health in Papua New Guinea: A decline in development', *Australian Geographical Studies*, 35(3), 271–93.
- Curry, G. and G. Koczberski 1998, 'Migration and circulation as a way of life for the Wosera Abelan of Papua New Guinea', *Asia Pacific Viewpoint*, 39(1), 29–52.
- Duke, T. 1999, 'Decline in child health in rural Papua New Guinea', *Lancet*, 354, 1291–4.
- Friesen, H., et al. 1996, 'Assessment of HIV/AIDS knowledge, attitudes and behaviour of high school students in Papua New Guinea', *Papua New Guinea Medical Journal*, 39(3), 208–13.
- Government of Papua New Guinea and UNAIDS 1998, *Papua New Guinea National HIV/AIDS Medium Term Plan 1998–2002*, Government of Papua New Guinea and UNAIDS, Port Moresby.
- Hughes, J. 1991, 'Impurity and danger: The need for new barriers and bridges in the prevention of sexually-transmitted disease in the Tari Basin, Papua New Guinea', *Health Transition Review*, 1, 131–41.
- Kramer, P.B. 1995, 'Knowledge about AIDS and follow up compliance in patients attending a sexually transmitted disease clinic in the highlands of Papua New Guinea', *Papua New Guinea Medical Journal*, 38(3), 178–90.
- Malau, C. 1999, 'The evolving AIDS epidemic: Challenges and responses in Papua New Guinea', *Development Bulletin*, 50, 70–1.
- Malau, C., et al. 1994, 'HIV/AIDS prevention and control in Papua New Guinea', *AIDS*, 8(Supplement 2), S117–S124.
- NSRRT (National Sex and Reproduction Research Team) and C. Jenkins 1994, *National study of sexual and reproductive knowledge and behaviour in Papua New Guinea*, Monograph No. 10, PNG Institute of Medical Research, Goroko.
- O'Callaghan, M. 1999, 'PNG-positive', *Australian Magazine*, 13–14 November, 29–36.
- PNG Law Reform Commission 1992, *Final report on domestic violence*, Report No. 14, Papua New Guinea Law Reform Commission, Boroko.
- Pollard, R. 1999, 'From personal to political', *National AIDS Bulletin*, 12(5), 24–5.
- UNAIDS and IOM (International Organisation for Migration) 1998, 'Migration and AIDS', *International Migration*, 36(4), 445–68.

Safe sex or healthy sex?

Bernard Broughton, Project Design & Management, Canberra

Introduction

The main argument in this paper is that we may be relying unreasonably on condom promotion in HIV/AIDS prevention programmes in developing countries and that it may be more realistic to accept that, in many settings, sex will continue to be unprotected and that it may be more effective to put much more emphasis on the promotion of genitally healthy sex. This is an area in which we need to tread carefully, not least because it may undermine the level of condom use that has been achieved. Nevertheless, if the risk of transmission between genitally healthy partners is relatively low, should we not say so?

Focus of the problem

By the end of the twentieth century, approximately 40 million men, women and children were living with HIV. In 1999 alone, 5.6 million more people became infected with HIV and 2.6 million more died (the highest annual death toll yet). HIV/AIDS is a poor person's disease in so far as 95 per cent of the people living with HIV are in the developing world, close to 70 per cent of them in sub-Saharan Africa. Around half of all people acquiring HIV become infected before they turn 25 and die before they turn 35. This includes babies born to HIV-positive mothers, who acquire the virus at birth or through their mother's milk (UNAIDS/WHO 1999).

Overall, more women and girls are infected than men and boys and many of them become infected before they even turn 20. In a recent study conducted in four African cities, a large female-to-male divergence was found among 15–19-year-olds, most notably in Kisumu in Kenya where 23 per cent of female teenagers were infected compared with only 3 per cent of male teenagers (UNAIDS 1999a). Young women and girls are particularly vulnerable and bear a considerable burden, given that they are often coerced/cajoled into sex by older men and given that roughly half will pass the virus on to their babies.

In some if not most African countries, the incidence of HIV infection among teenage girls is rising rapidly. Reuters reported on 8 March 2000 that the results of a survey conducted by the Cape Town Health Department found that the HIV incidence among teenage girls, who are already the population most at risk, jumped by nearly two-thirds between 1997 and 1998 (*Reuters medical news* 2000).

Over-reliance on condoms

The strategy of most preventative interventions is to sensitise individuals to personal risk and social responsibility and encourage behavioural change, including typically the use of condoms. This generally includes supportive activities like improving negotiation skills and communication about sex between couples. Efforts are sometimes also made to address contextual and structural factors, recognising that too much emphasis on individual behaviour change with a focus on the cognitive level detracts from an understanding of the complexity of HIV transmission and control (UNAIDS 1999b:8).

Nevertheless, condom usage remains problematic to say the least in many settings. This is well enough known but my impression is that there is some burying of heads in the sand by agencies and organisations on this issue. Condoms are potentially very effective, but there is a big difference between promoting them in commercial sex work (as has been done with considerable success in Thailand and to a lesser extent in Tanzania) and promoting them for general use. In most societies women and girls are not able to insist on the use of condoms and will not be empowered to do so in the short or medium term. Moreover, although it is certainly appropriate to encourage condom use in casual sexual encounters, it is probably unrealistic to promote them in stable, longer-term relationships. Indeed it is hard to understand how we could expect couples to use condoms *forever*. In this context it is important to consider that occasional condom use may be worse than none, in so far as the condom can increase the risk of abrasion to both parties and thus the risk of transmission in subsequent unprotected sex.

There have been some reports of success in reducing the incidence of HIV among young people, most notably perhaps in Uganda. However, it is not at all certain that this has involved increased condom use. It is possible that the reduced incidence is a result of sexual activity being delayed until a later age.

Lack of frankness

A related matter is the lack of frankness in much of what is communicated to people about HIV transmission. Although it is often stressed that transmission is far more likely if other sexually transmitted diseases (STDs) are present, not much is made of the other side of this argument – that the risk of transmission is relatively low if neither partner has a sore or ulcer. Is this an area into which we fear to venture?

The information provided needs to be fuller and more accurate, with less emphasis on trying to scare and deter (an approach which tends to lead to fatalism in any case) and more willingness to countenance unprotected but healthy sex as an option. Risk behaviour itself needs to be redefined. It has come to be synonymous with unprotected sex (no condom), but risk behaviour should also be understood to include sex in the presence of sores and ulcers.

Given that adolescents are at such great risk there needs to be franker information provided to this age group about the crucial role of genital ill health in transmission. Perhaps we can go as far as telling them that HIV is unlikely to be passed on if both partners are free of sores. Adolescents should be given explicit material describing STDs in order to increase their familiarity with them. Perhaps the approach in deterring boys and men from genitally unhealthy sex is to encourage women and girls to put them off by emphasising that they have a sore and that HIV could easily be transmitted in either direction. Perhaps lubrication by natural harmless oils should be promoted to reduce the risk of abrasion.

Primary and secondary schools would be an appropriate place to provide this information and push this approach. Indeed, it is a wonder that health, including reproductive health, is not a subject taught in schools irrespective of the HIV/AIDS crisis.

Best practice dictates that HIV/AIDS not be addressed in isolation and that an integrated approach to reproductive health and gender rights should be adopted, both through schools and health centres. I would suggest adding the dimension of cultural survival – investing locally in the future of peoples and clans. This approach will require additional training and supervision of teachers and health workers and more involvement of communities in education and health services.

Ideally, countenancing unprotected sex should not undermine condom promotion. But even if there is some risk that it will confuse our messages, we have to accept the reality of unprotected sex and do something to make it safer. This is not to say that unprotected sex should be promoted. People should be made to understand that condoms virtually eliminate all risk, whereas unprotected sex is risky and should not be considered an option other than in the context of long-term, ideally monogamous, relationships.

Nor does it mean that all sexual behaviour should be sanctioned. Certain practices should be discouraged, even attacked, including the enduring prevalence in Africa of considerable age disparities leading to the much higher incidence of HIV among female adolescents. I think brothers and cousins should be enlisted as allies to protect their sisters and female cousins against older men, and that parents should be fired up to regard it as aberrant behaviour and do more to protect their girls and young women. It would also be appropriate to encourage girls and young women to put off sexual activity and, when they do become sexually active, to seek long-term partners.

Inadequate understanding of sexual behaviour

There is still a lot that is not well enough understood about sexual behaviour and how sexual practices can be influenced. Big assumptions are often being made about how change occurs in individuals and in communities and successes are frequently claimed without hard evidence. The starting-point in remedying this is the identification of the theories or models of behavioural change that underpin each approach to prevention.

The theories and models that may be involved, implicitly or expressly, cover a lot of ground, from those that focus on the individual's psychological processes (such as attitudes and beliefs), to those emphasising social relationships and those that stress structural factors in explaining behaviour. A recent UNAIDS paper (1999b) examines this in detail and, within the individual focus category, includes the health belief model, social cognitive (or learning) theory, theory of reasoned action, stages of change model and AIDS risk reduction model (the only one developed specifically for HIV/AIDS). Social models discussed include diffusion of innovation theory, social influence or social inoculation model, social network theory and theory of gender and power. Structural and environmental theories and models discussed include theory of individual and social change or empowerment model, social ecological model for health promotion and those emphasising socioeconomic factors.

The apparent presence of so much theory may surprise many programme designers and implementing agencies and organisations, but the foregoing taxonomy does serve to demonstrate that far too much is assumed and unexamined, particularly about risk behaviour. An understanding of theories, models and assumptions is critical and it will always be more difficult to implement an activity in the absence of a conceptual framework of behaviour. If theory has not been adequately considered, monitoring and performance information is not likely to be well founded and evaluating the impact of the activity at completion will be harder. Looked at positively, interventions based on theory have a better chance of success and theory can make it easier to understand why an intervention was or was not successful (UNAIDS 1999b:32). This discipline should be immediately applied to better understand the gap between knowledge and practice in so many interventions that are having difficulty moving beyond awareness raising.

Coordination

The donors that fund interventions and the organisations that implement them can help by designing interventions with an eye to demonstrating more scientifically what is most effective and by subsequently documenting and sharing their experiences. This means more attention to modelling behavioural change and to coming up with performance indicators that efficiently demonstrate changes. This is as relevant to condom promotion as to the promotion of genital health.

This should not result in individual interventions that take up the first half of a project cycle answering basic questions that have been answered by others. Coordination is required to ensure that everyone starts from the plateau that has already been reached, and that the basic research conducted is a high priority in terms of better determining what does and does not work. Some research should be conducted collaboratively because many individual interventions cannot justify the expenditure required to do the research thoroughly.

Can UNAIDS ensure this happens? I am not sure that it can and to the extent that it cannot it falls back on funding agencies, in collaboration with UNAIDS, to make sure that funded projects and programmes incorporate what has been learned, address priority concerns and disseminate results.

The ideal would be to have regional HIV/AIDS prevention and care plans, overseen by UNAIDS, that donors and their implementing partners plug into. The contributing players would of course have to be able to influence these plans and their implementation. As for the discipline required of non

government organisations, the national donors are the gatekeepers to much of the funding and they should perhaps do more to enforce a more rational, integrated approach.

References

- Reuters medical news* 2000, 'HIV incidence soars among young women in South Africa', 8 March, medscape.com/reuters/prof/2000/03/03.08/ep03080b.html.
- UNAIDS 1999a, 'Differences in HIV spread in four sub-Saharan African cities', September, www.unaids.org/publications/documents/epidemiology/determinants/lusaka99.html.
- UNAIDS 1999b, *Sexual behaviour change for HIV: Where have theories taken us?*, UNAIDS, Geneva.
- UNAIDS/WHO 1999, 'Global summary of the HIV/AIDS epidemic', November, www.unaids.org/publications/documents/epidemiology/surveillance/wad1999/Una99e53.doc.

Young people, HIV/AIDS, and intervention: Barriers and gateways to behaviour change

Christine A. Varga, Health Transition Centre, National Centre for Epidemiology and Population Health, The Australian National University

A good way to begin understanding South African young people's sexual behaviour – and thus the dynamics of behaviour change – is to view it within an adaptive framework.¹ South African youths' socio-sexual environment and behaviour have been moulded by the country's turbulent history. Centuries of European colonisation and missionary presence, decades of apartheid rule and the ongoing process of 'reconstruction and development' in the new South Africa have all immeasurably altered the sociocultural, political and economic fabric of young people's lives and thus the context in which their sexual relationships take place.

The chaotic environment in which contemporary South African youth come of age is reflected in their sexual lives. Many social institutions which previously assisted them through the transition to sexually active adulthood, and often instilled safe sex practices, have undergone radical change or disappeared altogether. Erosion of traditional peer education networks, extended family systems, and changes in household and marriage structures have combined with rapid urbanisation and Westernisation to create an environment of mixed messages, confusion and few resources for young people to rely upon in the process of sexual socialisation. This has led at least one scholar to aptly describe South African youth as 'caught up in a web of change' (Nash 1990:147). The result is a sexual behaviour profile characterised by high-risk practices such as early initiation of sexual intercourse, low (male and female) contraceptive use rates, multiple sex partners and broad sexual networks, and poor sexual negotiation skills (Boult and Cunningham 1991, Flisher et al. 1999, Sai et al. 1993). A combination of sociopolitical instability, social transformation and high-risk sexual behaviour among young people has been noted elsewhere in sub-Saharan Africa (Bledsoe and Cohen 1993, Meekers 1994). However, the state of the HIV/AIDS epidemic in South Africa creates an especially dangerous mix and makes youth-targeted sexual health intervention a special priority.

The epidemic is among the most devastating harbingers of change in South Africa. Although AIDS is a relative newcomer, most, if not all, South Africans are acutely aware of the danger it poses. Moreover, for both social and political reasons, HIV and individuals infected with it are highly stigmatised in South African society. While HIV/AIDS has received considerable attention from media, government, non government organisation and industry sectors, intervention efforts have generally been disorganised, disjointed and superficial. Although

young people have been identified as a target group for intervention, coverage is uneven and programmatic content often confined to information dissemination. The current situation is one in which general HIV/AIDS knowledge is adequate to high among young people but where risky sexual behaviour persists (Attawell 1998, Flisher et al. 1999, HST 1999).

This paper reports selected results from a recently completed (1999) study that explored sexual dynamics and decision making among young people between the ages of 11 and 24 years in KwaZulu/Natal Province. Data were collected in three phases: (1) a series of focus group discussions (n=12); (2) narrative research component (role play workshops and community questionnaire (n=680); and (3) in-depth follow-up interviews with selected questionnaire participants (n=36).

Two aspects of youths' sexual behaviour – condom use and abstinence – as responses to HIV/AIDS are discussed here. We explore the manner in which these practices have begun to adapt (or not) to the threat of HIV infection and social contextual factors which can encourage or inhibit behavioural change. Attention to the social environmental determinants of sexual behaviour is a crucial component of recent calls for an 'expanded vision' and a more ecological perspective in HIV prevention strategies (Tawil et al. 1999, UNAIDS 1999).

Rapid escalation of HIV/AIDS in South Africa

The HIV/AIDS epidemic in South Africa is best described as recent and swiftly escalating. It is generally recognised that the current rate of infection – between 1,500 and 1,700 new cases each day and close to 4 million HIV-positive individuals – makes South Africa's among the fastest growing HIV epidemics worldwide (UNAIDS 1998a). According to some estimates, in 1998 half of all new infections in the nine worst-hit southern African countries occurred in South Africa alone and its epidemic accounted for one in every seven new infections on the continent (UNAIDS 1998b).

Though the first few cases of HIV/AIDS were identified in 1982, as late as the early 1990s infection rates remained low in the general populace. Public antenatal clinic surveillance began in 1990, when the recorded national infection rate was less than 1 per cent. Thereafter it increased rapidly, such that by 1994, the year of the first democratic election, the antenatal seroprevalence rate among women aged 15–45 years was 7.5 per

cent. Recently available data (1998) revealed 22.8 per cent, an increase of one-third over the previous (1997) figure. Estimates suggest that this translates into 12–14 per cent of the general adult population being infected with HIV. In KwaZulu/Natal Province, site of this study, the 1998 antenatal sero-prevalence rate was 32.5 per cent, the highest in the country. Certain sub-regions of the province have found close to 40 per cent of public antenatal clinic attendees to be HIV-positive.

As is common elsewhere on the continent, young people in South Africa are particularly at risk for HIV infection. The 1998 survey found 21 per cent sero-prevalence among 15–19-year-old antenatal clinic attenders, a 65 per cent increase over the previous year's 12.7 per cent. This was the single largest recorded increase in any age group surveyed. For those 20–24 years old, the HIV rate was 26.1 per cent. In KwaZulu/Natal, an estimated 200 new infections occur each day among young people aged 15–24 years.

Typical of most sub-Saharan African countries, the HIV epidemic in South Africa is primarily heterosexual. Sixty per cent of HIV infections occur through heterosexual contact, and slightly more than half of those affected by the disease are women (UNAIDS 1998c).

Abstinence for (South) African youth

While abstinence is an obvious and frequently offered means of protection against HIV infection, how realistic an option is it for (South) African young people? In response to the spread of HIV/AIDS among youth, certain regions (primarily KwaZulu/Natal Province) have recently witnessed a resurgence of the traditional practice of female virginity inspection (intact hymen). Some districts, including the rural site of this study, now have mass inspections several times a year, and those certified as virgins proudly display a certificate which includes a small AIDS ribbon in one corner. This is, however, an extremely controversial practice, socially and medically, which is unlikely to be adopted in any widespread or systematic way in South Africa.

For the young people in this study, sex and being sexually active were integral to their concept of a normal contemporary young person. Having sex symbolised many things, often with different connotations for boys than girls. Among boys, it meant power, excitement, social status and a way to satisfy natural male physical urges. For girls, sex was primarily about love and commitment, or a means towards material and financial gain. Regardless of the specific meaning behind the act, most young people agreed that sex must be a part of a serious love affair and take place early in the relationship. This is clear in the words of both rural and urban youth:

Sex makes love stronger. If you don't have sex with your girlfriend you lose the thrill of it. She is no longer interesting to you. (rural male aged 20)

To fall in love...means that by definition you are going to have sex. If you are in love it means sex. (rural female aged 22)

You have sex because...it is important to show your partner how much you love him because kissing doesn't mean much. (urban female aged 21)

Many other factors posed significant barriers to the feasibility of abstinence as a means of protecting against HIV infection. Among the most obvious was peer pressure. The issue of fulfilling peer and partner expectations through having sex was a recurrent theme throughout the study. Among sexually experienced questionnaire participants, 41.4 per cent reported having felt (social, peer or partner) pressure to become sexually active. Moreover, such expectations affected both boys and girls. Boys often worried about being rejected if they did not have sex with their girlfriends. Noted one rural 20-year-old, 'A girl may leave you if you don't have sex with her. She will call you an idiot'. An urban young woman in her early twenties described being compelled by her schoolmates to be sexually active:

We confused each other with our talk...My friends would come and tell me what they did with their boyfriends [have sex]. Then I would want the same thing with my boyfriend, just to feel nice like they did. You find most girls are into relationships not because they love the guy, but because of peer pressure.

Coercion and the threat of physical violence also limited (girls') ability to practise abstinence. One-third (32.5 per cent) of sexually experienced girls in the questionnaire segment reported having been subjected to some form of sexual coercion, a figure which rose to 42.6 per cent for urban women. Close to 80 per cent of those reporting forced sex experienced it from a boyfriend or acquaintance. A significant point in this regard is that many study participants, both men and women, viewed coerced sex as a normal part of a sexual relationship. This is reflected in the following quotes:

If a girl is having an affair with [some other] boy and her boyfriend finds out, then he has a right to force her if she refuses to have sex with him. (rural female aged 13)

There is nothing wrong with [forced sex]. If she says she loves you, [she] is yours. You need to teach [her] things [and] some should be learned by force. Force exists in this world. We cannot change that. (urban male aged 23)

The condom conundrum

In South Africa, condom use is a contentious issue infused with many negative connotations. This is due at least in part to the manner in which condoms were introduced into the health care system. Until the advent of HIV/AIDS, family planning services targeted women almost exclusively and distributed pills or injectables as the primary means of contraception. Condoms were promulgated only with the advent of HIV/AIDS. Furthermore, contraception in general was long considered a tool of the apartheid government to keep the black population in check. As a result, many South Africans (youth included) associate condom use with HIV risk itself, and with socially unacceptable behaviours such as (female) infidelity, promiscuity

or prostitution. There is a belief among youth and adults alike that 'real sex', true intimacy and love can only be achieved by having unprotected intercourse (see Varga 1997a and b).

These data suggest that concern over potential HIV infection has up to now had an uneven impact on young people's ideas regarding the acceptability of condom use. Both qualitative and quantitative results indicate that most youth would themselves be loathe to introduce condoms into an intimate personal relationship or be most likely to use them with a partner they did not trust. Moreover, many were disturbed by the conflicting symbolism behind condom use or felt uncertainty between what they *knew* to be prudent sexual practice and how they *felt* about it. Such turmoil is evident in the following quotes taken from in-depth interviews:

[A guy who carries condoms] is clever because he is trying to protect himself from AIDS. But he might also be cheating on his partner. It is hard to know which one is the case. (urban male aged 21 years)

On the issue [of a girl carrying condoms] I am of two minds. The education I have received about condoms says one thing. But my first reaction is simply that she is [an] *isifebe* [slut or whore] . . . It is because of the way I have been socialised. (urban female aged 19 years)

Despite such confusion, there was substantial evidence to suggest that condom use is undergoing de-stigmatisation in response to recognition of the need to prevent HIV infection. When asked what they would think of a boy their age who carries condoms, 60 per cent of questionnaire respondents characterised such an individual as 'careful, serious about life and future, or fearing AIDS'. Furthermore, a significant minority reported that they would be relieved if a partner took the initiative to use condoms in their relationship. When asked how they would feel if a boyfriend or girlfriend wanted to use a condom, 52.4 per cent of rural respondents and 68.5 per cent of urbanites reported feeling happy or relieved that a partner would look out for their well-being ($p < 0.001$). Noted one 22-year-old urban woman, 'If he wants to use a condom, I don't complain that I won't enjoy it or feel him right. I can see he is taking precautions'. Focus groups and interviews also revealed commitment on the part of many young people to use condoms to protect themselves from HIV infection:

I would tell the guy, 'It's either you use a condom when we have sex or you don't get any [sex]'. (urban female aged 14 years)

I always use a condom now. I used it to prevent infection because things are bad due to AIDS. It is not that I don't trust her, but these days you cannot tell who is safe and who is not. (urban male aged 21 years)

Conclusion

While young people have begun to re-evaluate their beliefs and standards concerning appropriate sexual comportment in response to fear of HIV infection, significant barriers to

behaviour modification remain. Such obstacles are clearly a reflection of and adaptation to historical, political and sociocultural factors in their environment. By providing an ecological perspective on human behaviour and dynamics, qualitative, anthropological research is an important tool in clarifying the determinants of (sexual) behaviour change and in suggesting means to encourage it. Such work can also make a vital contribution to all phases of (HIV and other) intervention and programming: as part of needs assessment, baseline research, and monitoring and evaluation (Tawil et al. 1999). While recent epidemiological research on HIV/AIDS suggests a trend towards sexual behaviour modification, such studies are of limited use in their lack of ability to tell us *why* and *how* such changes are taking place (Asiimwe-Okiror et al. 1997, Kamali et al. 2000, Kilian et al. 1999).

It is clear that, for the vast majority of young South Africans (and probably those in many other countries), abstinence is not a realistic or sustainable option because of the continued social and cultural value placed on full sexual intercourse. Further, although condom use is an increasingly acceptable practice, the continued negative connotations of protected sex mean youth engage in such practices inconsistently, limiting the effectiveness of condoms in preventing HIV spread. Finally, young people's sexual dynamics are hampered by factors such as poor communication and negotiation skills, gender stereotypes and gender power imbalances. Given this context, sexual health and HIV intervention programmes should incorporate the following:

- Life skills improvement – especially values clarification targeting gender norms and power dynamics
- Acceptability and de-stigmatisation of condom use – eroticisation of condom use in serious and long-term relationships
- Consistent condom use – they only confer protection if used every time with every partner
- Sex can be a normal, healthy, enjoyable part of life – as long as it is practised responsibly

Note

1. In this context, 'South African' refers specifically to the black ethnic groups which make up the majority of the population. The terms 'young people' and 'youth' refer to those aged roughly between 11 and 24 years.

References

- Asiimwe-Okiror, G., et al. 1997, 'Change in sexual behaviour and decline in HIV infection among young pregnant women in urban Uganda', *AIDS*, 11, 1757–63.
- Attawell, K. 1998, *Literature review: HIV/AIDS knowledge, attitudes, beliefs and behaviours in South Africa*, HIV/AIDS Directorate, National Department of Health, Pretoria.

- Bledsoe, C. and B. Cohen 1993, *Social dynamics of adolescent fertility in sub-Saharan Africa*, National Academy Press, Washington, DC.
- Boult, B.E. and P.W. Cunningham 1991, 'Black teenage pregnancy in Port Elizabeth', *Early Child Development and Care*, 75, 1–70.
- Flisher, A.J., et al. 1999, *Review of research involving health of South African youth: Report submitted to the Youth Development Trust*, Department of Psychiatry, University of Cape Town.
- HST (Health Systems Trust) 1999, *South African health review*, HST, Durban (annual publication).
- Kamali, A., et al. 2000, 'Seven-year trends in HIV-1 infection rates, and changes in sexual behaviour, among adults in rural Uganda', *AIDS*, 14, 427–34.
- Kilian, A.H.D., et al. 1999, 'Reductions in risk behaviour provide the most consistent explanation for declining HIV-1 prevalence in Uganda', *AIDS*, 13, 391–8.
- Meekers, D. 1994, 'Sexual initiation and premarital child-bearing in sub-Saharan Africa', *Population Studies*, 48, 47–64.
- Nash, E.S. 1990, 'Teenage pregnancy – need a child bear a child?', *South African Medical Journal*, 77, 147–51.
- Sai, F., et al. 1993, *Reproductive health and family planning consultancy: National review and recommendations*, report to Commission of the European Communities, Special Programme for South Africa.
- Tawil, O., et al. 1999, 'HIV prevention among vulnerable populations: Outreach in the developing world', *AIDS*, 13(Supplement A), S239–S247.
- UNAIDS 1998a, 'New World AIDS Day report finds global HIV infections increased', press release, London, 24 November.
- UNAIDS 1998b, 'AIDS in Africa', press release, Johannesburg, 30 November.
- UNAIDS 1998c, Epidemiological fact sheet on HIV/AIDS and sexually transmitted diseases, Geneva.
- UNAIDS 1999, *Sex and youth: Contextual factors affecting risk for HIV/AIDS: A comparative analysis of multi-site studies in developing countries*, UNAIDS, Geneva, 99.27E.
- Varga, C.A. 1997a, 'Sexual decision-making and negotiation in the midst of AIDS: Youth in KwaZulu/Natal, South Africa', *Health Transition Review*, 7(Supplement 3), 45–8.
- Varga, C.A. 1997b, 'The condom conundrum: Barriers to condom use among commercial sex workers in Durban, South Africa', *African Journal of Reproductive Health*, 1(1), 74–88.

A national disaster: A social analysis of AIDS in Zimbabwe

Diana Patel, Department of Sociology, University of Zimbabwe

AIDS prevalence

In December 1999, the Government of Zimbabwe declared the AIDS epidemic to be a 'national disaster'. Zimbabwe has one of the highest reported HIV sero-prevalence rates in Africa and is feeling the effects of its impact both economically and socially. In a population of just over 11.7 million (UN estimate for 1997), one-fifth (20.3 per cent) of adults, or 10 per cent of the total population, were reported in 1996 to be HIV-positive. By 2005, it is estimated that 1.2 million people will have died due to AIDS, about one-tenth of the current population, with 73 per cent of annual deaths due to AIDS. Consequently, by 2010, life expectancy in Zimbabwe will have dropped to approximately 30 years.

The epidemic is currently at its peak and AIDS cases will probably begin to decline only after 2010, about eight years after HIV prevalence begins to fall. In the 15-year period between 1996 and 2010, Zimbabwe will experience the main impact in terms of illness and death (Loewenson 1999). Furthermore, the seriousness of this epidemic is seen in the increased morbidity and mortality, the decreased productivity of the workforce and the detrimental effects on family and community. Indeed, the epidemic is having far reaching consequences and no aspect of the economy or society will be left untouched.

Zimbabwe has 25 sentinel surveillance sites where blood is taken anonymously from pregnant women as a way of tracking HIV infection. Data for 1997 showed that HIV prevalence remained below 10 per cent in only two sites. In the remaining 23, between one-fifth and one-half of all pregnant women were found to be infected with HIV. Moreover, it is estimated that at least one-third of these women are likely to pass the infection on to their babies.

AIDS cases peak in the 20–29 year age group in females, and in the 30–39 year age group in males. Females have a five times higher HIV risk than males, with early onset of sexual activity in young females and sexual activity between adolescent females and older men, driving the spread of HIV into the next generation (Woelk 1997). Indeed, as the epidemic progresses, there is evidence that men are in search of even younger women as sexual partners on the assumption that they will not be HIV infected. Once infected, women may also be increasingly vulnerable to developing AIDS more rapidly – through reinfection, multiple pregnancy, untreated sexually transmitted disease, which is more difficult to diagnose in women, and lower

nutritional status through economic hardship – and they die more quickly after HIV infection than men.

Thus, AIDS is causing deaths in the economically important age group (15–45 years), which was previously relatively protected from mortality, and in perinatal transmission (0–4 years), which threatens hard-won gains in the reduction of infant mortality. Furthermore, Sanders and Sambo (1991) report that since 1989 AIDS has been the major cause of childhood death in Zimbabwe's urban hospitals.

An additional indicator of the growing epidemic is the increased incidence of tuberculosis (TB), which, together with infections of the digestive system, some skin diseases, herpes zoster, pneumonia and meningitis, are the most observed opportunistic infections of AIDS patients in Zimbabwe. TB is now the major cause of morbidity and mortality among HIV-seropositive patients; of about 1 million people currently infected with HIV, about 75 per cent have TB. There is no doubt that this increase can be directly attributed to the AIDS epidemic, and it is estimated by the Ministry of Health that 50–60 per cent of adult TB cases are HIV-positive. The incidence of tuberculosis is likely to increase in the years to come, with a growth in the proportion of HIV among TB patients.

HIV prevalence varies across Zimbabwe, with urban areas having 2.5 times higher rates than rural areas. However, the HIV sero-prevalence rates for many rural areas are steadily increasing. This is a consequence of the high rate of labour migration and mobility of people within the country. Zimbabwe has a good infrastructure and movement between urban and rural areas is frequent. High rates of HIV infection have also been shown in the provinces along trucking routes – for example, 38 per cent of the population in Mutare and 46 per cent in Beitbridge. In addition, in some urban areas such as Bulawayo and Harare, there are indications that HIV prevalence may be declining, while rural rates are increasing (NACP/MoHCW 1998).

The burden of AIDS on the family

With adults dying young or in early middle age, children are left grieving and struggling to survive without a parent's care. Many of those dying have surviving partners, who are themselves infected and in need of care. Furthermore, their families have to find money to pay for their funerals, and their employers – schools, factories, hospitals, civil service, armed forces, and so on – have to train other staff to replace them. From 15,000

orphans in 1990, the population of orphans under 15 is projected to rise to 1.3 million or one-third of all children under 15 years of age between 2000 and 2005 (UNICEF 1990).

Subsequently, for children this may lead to increased pressures for child labour and street work, while the care of orphans in every tenth household places a further burden on households and social systems. In the rural areas, moreover, the children and the elderly share the burden of agricultural production in an effort to maintain their right to the land. As a result, subsistence and even commercial agriculture is being greatly affected as a result of premature deaths from AIDS. In urban areas, the struggle is primarily centred around the maintenance of the family accommodation, the alternative being either to join those sleeping on the streets or in squatter settlements.

Much of the burden of care for the orphans will fall on the elderly, since there are unlikely to be a significant number of AIDS-related deaths in the over-55 age group (although, over time, with AIDS deaths in the 15–45 age group, there are likely to be fewer people reaching this age group). Alternatively, older children will be the care providers. Indeed, in the current harsh economic conditions, women, particularly in the rural areas, are having to leave their children, with the older ones in charge of the younger siblings, while they go to growth points to sell vegetables or to enter prostitution in order that their families might survive.

Traditionally, orphans received care from the father's extended family – that is, from the father's brother or parents – but, with urbanisation and industrialisation, the extended family is being weakened. Forster et al. (1992) have indicated that often the father's side of the family traditionally took the property but not the children, who would be sent to the mother's relatives, usually the maternal grandmother. This would almost certainly happen if the brideprice (*lobola*) had not been paid in full. Furthermore, it is frequently difficult to trace extended family members who might care for the orphans.

With the estimated 1.3 million AIDS orphans by the year 2005, alternative arrangements will have to be made for these children that will allow them to remain part of the community with the minimum of stigmatisation. This will place a heavy financial, social and emotional burden on communities. However, in Zimbabwe, people are rising to the challenge. Many village headmen have designated land to be cultivated by all villagers to feed the orphans and families of those suffering from debilitating illness, usually AIDS related. Also, in some areas, church groups have begun orphan-visiting programmes. Women are trained to identify the neediest orphan households in their area; they then visit them on a regular basis, providing all-important guidance and emotional support and helping with basic necessities. Because these programmes work from within the community, they are affordable and will help keep orphans woven into the fabric of society.

Individuals with HIV and AIDS patients suffer the social as well as the health consequences of infection. Social and family

rejections, stigmatisation and discrimination with respect to employment, health care and housing all too frequently follow the identification of an infected person. As a result of AIDS, households devote increased time, money and resources to medical and dependent care, special diets and transport needs. However, poor households, which are not covered by any form of social security or medical aid, bear a greater burden (Hanson 1992).

Cost containment approaches in the health care system and the resultant shift to home based care have placed an extra cost burden on households already stressed by the labour and income losses due to AIDS. Additionally, this raises problems in the quality of care and the management of HIV risks to the caretakers (Woelk et al. 1997). Households have sold land and cattle to finance these costs and there have been reduced consumption levels among other household members, including the removal of children from school (NACP/MoHCW 1998). Moreover, households have frequently lost revenue due to AIDS from loss of labour, reallocation of productive labour to care provision, reduced remittances due to the death of wage earners, and shifts from cash crops to subsistence crops. The AIDS-related death of a breadwinner in peasant areas has been shown to lead to a 61 per cent fall in production (Kwaramba 1998). The loss of wage incomes has significantly exacerbated poverty and the demand for wage remittances and public assistance has increased with the AIDS epidemic, in a situation where real formal sector incomes are falling and public assistance has been found to be inadequate, poorly financed and with coverage rates of 20 per cent or less of the target population (Chisvo and Munro 1994).

The costs of AIDS to society

As in other African countries, AIDS in Zimbabwe is hitting hardest the productive and most sexually active age groups between 15 and 45 years. There are no available data in Zimbabwe to clearly indicate which socioeconomic groups are being most affected. However, data from other countries in Africa (Adamchak et al. 1990, Hunt 1989, Whiteside 1991) indicate that AIDS was first discovered to be present among the elite and that the behaviour of the affluent put them at high risk of HIV infection. If in fact the professional/technical groups are disproportionately infected with HIV, one of the most devastating impacts of the AIDS epidemic will be the destruction of political and economic infrastructures.

It is thought that HIV infection will probably run its course through all socioeconomic groups, although probably at different speeds. Those in the lower socioeconomic categories are more likely to become AIDS patients sooner after HIV infection because they are more vulnerable. They have a lower nutritional status, live in poor environmental conditions and, therefore, are more subject to opportunistic diseases and have less access to medical care. In the long run, the level of HIV may be higher among the low-income and less educated members of the

population because they may not have access to information that will influence their behaviour and may not have the resources to make behavioural changes.

With the combination of Zimbabwe's drought in the early 1990s (the worst in living memory, with crop failure rates of 80–100 per cent in the communal areas and a considerable reduction in production in commercial farming areas) and the Economic Structural Adjustment Programme (ESAP) introduced in 1991, the Zimbabwean economy is going through a period of extreme difficulty, resulting in economic hardship for the majority of the population. For most people, the ESAP – and its second phase, the Zimbabwe Programme for Economic and Social Transformation (ZIMPREST) – has meant rising prices and cuts in consumption subsidies. There have been sharp declines in standards of living as a result of rising inflation, declining real wages and increasing unemployment. Indeed, such is the gravity of the current situation that the significant gains which have been made since independence in 1980 in the social sectors – the expansion in health, education, housing and social services – are in danger of being undermined, largely through price rises, growing unemployment and the implementation of cost recovery programmes.

Within the present economic climate, the cost of the AIDS epidemic to the Zimbabwean economy is considerable. In the productive sectors, losses in labour quality and quantity are spread across all categories of employment and are estimated to cost, on average, US\$20–200 per worker per year in formal business (ILO 1995, Loewenson 1999, NACP/MoHCW 1998). Workplaces have encountered more frequent and longer periods of absenteeism, losses in skills and experience, and diminishing returns on training investments, with an overall shift to younger and less experienced employees. This potentially reduces output and incomes, if inadequately managed (Forgy 1993). AIDS has also led to increased demands on and costs of spending for health and social welfare, and to greater claims on and costs of insured benefits (Murimi 1998). Life insurance premiums quadrupled in just two years because of AIDS-related deaths, and some companies have reported a doubling of health bills.

The colonial legacy, the market economy under ESAP (and ZIMPREST) and the most severe drought have produced migrant labour, rapid urbanisation and poverty that have transformed family life and traditional culture. Social conditions have contributed to the transmission of HIV through their effects on sexual relationships within and outside fast-changing family structures. Polygamy has been adapted to new social and economic conditions. The urban migrant may find it useful to have one wife in the city and another managing the small farm holdings. An unmarried man in wage employment might choose to spend his money acquiring several 'wives'. Also, older men with land may take advantage of young men's absences by marrying several village women, who will cultivate the land in return for stable economic support. Sexual relationships in both

urban and rural areas are much more complex than has previously been thought. In just 15 years, AIDS has reached crisis level in Zimbabwe, with an estimated 25 per cent of people between the ages of 15 and 49 being infected with HIV.

Policies, practices and participation

Zimbabwe has had a national programme of action in place for the last 15 years under the leadership and guidance of the National AIDS Coordination Programme (NACP) within the Ministry of Health and Child Welfare. This programme has contributed to a high level of awareness of HIV/AIDS throughout the country, but behavioural change still remains insufficient despite the high level of knowledge. These interventions have included programmes targeting the youth in and out of school, women, the workplace, people living with HIV/AIDS, the control of sexually transmitted infections, and counselling and care initiatives.

In recent years, there has been the introduction of HIV voluntary counselling and testing, in an effort to reinforce other behaviour change interventions and to foster greater openness about HIV/AIDS. Also, in order to create and promote a supportive environment in the workplace for a rational response to AIDS, which is free from discrimination and stigmatisation, the Government of Zimbabwe gazetted the Labour Relations HIV and AIDS Regulations under Statutory Instrument 202 in 1998. This provides a clear code of conduct for workplaces.

In its most recent initiative, in December 1999, the Government of Zimbabwe declared the AIDS epidemic a national emergency and adopted the National HIV/AIDS Policy. This policy is commendable. First, it acknowledges that a multisectoral approach is required to deal with the epidemic and it calls for the involvement of the government, the private sector, non government organisations, community based organisations, churches, the media and international agencies to take up the challenge of fighting HIV/AIDS in prevention, control, care and impact mitigation efforts. In recognition of the severity of HIV/AIDS and the need to promote and coordinate an appropriate national response, the government is establishing a multisectoral National AIDS Council. Second, the policy declares the importance of respect for the human rights of people living with HIV/AIDS. Third, the gender character of the HIV/AIDS epidemic is explicitly recognised.

There is acknowledgment that women are more at risk in the HIV/AIDS epidemic because the sexual transmission of the disease is four times more efficient from men to women than from women to men. Their economic dependence on men makes it difficult for women to refuse unsafe sex or to negotiate safer sex. Double standards encourage men to have many sexual partners, with the result that more women, even those who are monogamous, are at risk. This situation is compounded by power asymmetries between men and women, the lack of an affordable women-controlled method of infection prevention,

and poor intra-gender communication, which have all contributed to an alarming increase in the female infection rate.

In Zimbabwe there is now full recognition of the severity of the problem of HIV/AIDS and its disastrous impact on individuals, families, society and the economy. It is hoped that the National HIV/AIDS Policy will transform these concerns into action, through the implementation of the proposed strategies, in order to contain HIV/AIDS and promote the health and development of the society.

References

- Adamchak, D., et al. 1990, 'Male knowledge of and attitudes and practices towards AIDS in Zimbabwe', *AIDS*, 4.
- Chisvo, M. and L. Munro 1994, 'A review of the social dimensions of adjustment in Zimbabwe', a report produced for UNICEF, Harare.
- Forgy, L. 1993, 'The economic impact of AIDS in Zimbabwe', REDSO/ESA mimeo, Zimbabwe, January.
- Forster, G., et al. 1992, 'Orphans in Zimbabwe: A descriptive and enumerative survey', poster presentation at VIII International Conference on AIDS, Amsterdam, July.
- Hanson, K. 1992, 'AIDS: What does economics have to offer?', *Health Policy and Planning*, Health Policy Unit, London, 7(4), 315-28.
- Hunt, C. 1989, 'Migrant labor and sexually transmitted disease: AIDS in Africa', *Journal of Health and Social Behaviour*, 30.
- ILO (International Labour Organisation) 1995, *The impact of HIV/AIDS on the productive labour force in Africa*, EAMAT Working Paper No. 1, Addis Ababa.
- Kwaramba, P. 1998, *The socioeconomic impact of HIV/AIDS on communal agricultural systems of Zimbabwe*, FES/ZFU Working Paper No. 19, Economic Advisory Project, January.
- Loewenson, R. 1999, 'The impact of HIV/AIDS on human development in Zimbabwe', Training and Research Support Centre Monograph, Harare.
- Murimi, R. 1998, 'Employee benefits and HIV/AIDS', paper presented to ZNCC workshop, Harare, 2 July.
- NACP/MoHCW (National AIDS Coordination Programme/Ministry of Health and Child Welfare) 1998, 'HIV/AIDS in Zimbabwe', Visual Graphics, Harare, July.
- Sanders, D. and A. Sambo 1991, 'AIDS in Africa: The implications of economic recession and structural adjustment', *Health Policy and Planning*, 6(2).
- UNICEF 1990, 'Children and women in Zimbabwe: A situation analysis update', July 1985-July 1990.
- Whiteside, A. 1991, 'HIV infection and AIDS in Zimbabwe: An assessment', paper presented at Southern African Foundation for Economic Research, Harare, 14 August.
- Woelk, G. 1997, 'Assessment of the health context of the AIDS epidemic in Zimbabwe', paper prepared for National AIDS Coordination Programme, Harare, October.
- Woelk, G., et al. 1997, 'Do we care? The cost and quality of community home based care for HIV/AIDS patients and their communities in Zimbabwe', UZ Medical School, SAFAIDS, Ministry of Health and Child Welfare, Harare.

The socioeconomic implications of HIV/AIDS in sub-Saharan Africa

J.R.S. Malungo, PhD candidate, Demography Program, The Australian National University

Introduction

Of the global 34 million people living with HIV/AIDS, some 95 per cent are in the developing world, with more than two-thirds in sub-Saharan Africa (UNAIDS/WHO 1999), a region that is home to about 10 per cent of the world's six billion population. A similar proportion of the global 5.6 million new infections in 1999 occurred in this region. Sub-Saharan Africa has also experienced more AIDS related deaths than any other region in the world and, with the adult prevalence rate at 8 per cent, such deaths are likely to continue. Considering that the lifetime risk of dying from AIDS is between three and five times the HIV sero-prevalence rate (Blacker and Zaba 1997), this translates into lifetime chances of dying from AIDS of around 30 per cent for the whole region, and 70 per cent in Zimbabwe and Botswana where the adult (15–49 years) HIV rates are over 25 per cent. This situation generates a lot of policy concerns in all sectors because the loss in human resources has serious repercussions on socioeconomic development at household, community, national and global levels. The increase in AIDS-related illnesses and deaths also puts an additional burden on already constrained social services.

Health aspects of the pandemic

In 1999 alone, global estimates for AIDS related deaths were 2.6 million, higher than in any other year since the beginning of the epidemic. While many lives were saved in richer countries by the new antiretroviral therapy, the mammoth share of the deaths occurred in developing nations, and in sub-Saharan Africa in particular. Already an estimated 13.7 million of the 16.3 million AIDS related deaths have been in Africa (UNAIDS/WHO 1999:2–3). Failed efforts to curb the pandemic will have daunting consequences for the continent.

With rising infection rates throughout the region, except for Uganda and Zambia (Malungo 2000), the number of deaths is expected to rapidly increase. Even then, probably about 90 per cent of people dying from AIDS do not know why they are dying. Some may suspect that they are infected by the virus, but lack of adequate and reliable testing facilities, fear of discrimination if they are found to be sero-positive, costly testing procedures, and few or no envisaged incentives make population based and HIV-sero status testing unattainable. A case in point is a 33-year-old unmarried urban Zambian woman who died from an AIDS-related illness. Although she suspected that she was sero-positive after she discovered that her previous boyfriend

had recently lost a wife and was himself sickly, no tests were conducted to confirm her suspicions. However, she had a number of miscarriages and two infant deaths, with severe complications at one of the births. From this birth onwards, she was continually being treated for many opportunistic infections. When she became terminally ill, she was taken back to her parents in the village whom she had rarely visited while still healthy. Her parents nursed her until her death.

South Africa believes that it is more able than all other African countries to sponsor antiretroviral therapies to prolong the lives of those infected by the virus and also to prevent mother-to-child infections. Even there, however, some organisations, including labour movements and HIV/AIDS societies, are accusing President Thabo Mbeki of giving more attention to 'dissident scientists' who hold the generally discredited view that AIDS is not caused by HIV but by lifestyles in the West and by poverty and malnutrition in Africa (*Weekend Australian* 13–14 May 2000:18). Critics say that these theories might be used to justify the withholding of expensive medical treatments, a situation likely to ultimately lead to millions of unnecessary deaths in a country with the highest rate of HIV infection in the world, where about 1,500 infections occur daily. Since South Africa is home to many documented and undocumented migrants, such a high infection rate has disastrous effects on the region. The attitude of the South African Government is generating fears that the labour movement and HIV/AIDS societies will stage a disruptive protest demonstration at the July 2000 conference on AIDS in Durban.

In Zimbabwe, the money from the controversial AIDS levy, introduced in March 2000, is said not to have been fully accounted for. It is suspected that funds meant to benefit people infected or affected by HIV/AIDS will be used instead either in the Democratic Republic of the Congo (former Zaire), where the Zimbabwean Government is supporting the embattled government of President Laurent Kabila, or in the forthcoming general elections. Many Zimbabweans and non government organisations working on AIDS programmes fear that the HIV sero-positive rate, which is the highest ever recorded in history, will only further increase.

Many Africans argue that their governments have turned a deaf ear to the realities of the pandemic in the region. Many interested parties argue that government commitment to securing, or making attempts at producing or lobbying for, lower prices for the antiretroviral drugs has been appalling or, at best, haphazard. There must therefore be a reallocation of resources,

especially away from supporting wars and corrupt practices. Wars are breeding grounds for further HIV transmission because soldiers who are sero-positive are likely to infect sexual partners in the war zones. When they return to their countries, they will probably infect other partners, especially because most people do not practise safe sex (Malungo 1999).

The demography of the pandemic

Current information suggests that, for every 10 African men, between 12 and 13 African women are infected (UNAIDS/WHO 1999:4). The reasons for this include: the greater efficiency of male-to-female HIV transmission (more than 80 per cent of infections in the region are through heterosexual sex, seconded by mother-to-child transmission and almost zero intravenous drug use); the younger age at initiation of sex of females than males; the lower educational attainment of females, which reduces their chances of obtaining formal employment; and cultural factors that give them less bargaining power in sexual encounters. Throughout the region, except in Uganda and Zambia which have experienced declining rates of infections in these age groups, most women are infected by age 25 (UNAIDS/WHO 1999). Such younger ages of infection increase the risks of HIV transmission to many other partners in the ensuing period before they die, 8.5 years later, the average number of years from infection to death (Caldwell 2000:118).

The epidemic is bound to deplete Africa's population and, consequently, its human capital. The population of 29 African countries with a high prevalence of HIV was estimated to have been 446 million in mid-1995, 5 million lower than it would have been in the absence of AIDS (UN 1998:6). The rate of growth in these countries is also projected to decline, from about 2.4 percent in 1998 to 2.1 per cent by 2015 (UN 1998). The reduction in life expectancy at birth is equally likely to continue. In southern Africa, where the epidemic is heavily concentrated, life expectancy, which rose from 44 years in the early 1950s to 59 in the early 1990s, is expected to drop to just 45 between 2005 and 2010 (UNAIDS/WHO 1999:4).

Despite the high risk of contracting HIV, and consequently dying, some people still have fatalistic ideas about the disease. One in Zambia, who usually had sexual relations with strangers, including prostitutes, said:

Foot and mouth disease or corridor disease came for animals and AIDS is for people. Everyone is going to die, whether from AIDS or malaria or accident. Death is death regardless of the cause! AIDS is just one such cause!

Such people do not always use condoms when having sex with multiple sexual partners (Caldwell et al. 1999).

In a study site in urban Tanzania, married males were reported as having multiple 'secretive' extramarital sexual relations with both married and unmarried partners. Such practices were attributed to lust or the appeal of beautiful women, the need for variety, excessive drinking and sexual prowess (Pool et al. 1996:214). Only after five years of a sexual

behavioural change project to mitigate the spread of HIV/AIDS were 18 out of 37 in the sample recorded as having altered their behaviour. The main change was a reduction in number of sexual partners; less change had occurred in regard to condom use, as up to 60 per cent of respondents consistently said that they had never used one. Among the reasons offered for the observed change were fear of contracting AIDS, having become a Christian and the high cost of maintaining multiple partners. Fourteen remained promiscuous, while the others did not change because they were not initially engaged in high-risk sexual behaviour (Pool et al. 1996:207-8).

Numerous reasons are given for the non-use of condoms: they are impregnated with HIV with the aim of depopulating Africa; they have minute holes, purposely built to let the virus through; they are associated with promiscuity and distrust; they make sex less enjoyable; and people get drunk and forget to use them (Pool et al. 1996:210-17).

A 37-year-old Zambian man married to a Botswana wife and based in Botswana said:

Having sex with women, especially unmarried women, is not a problem here. If you set yourself a goal to have 10 sexual partners in a day, you can easily meet that target. Girls are very loose here. The other trouble is that people [in Botswana] are poorer than what the world has been made to believe, so women who want material and monetary support acquire lovers. In addition, there is more-like a tradition here that girls have to prove that they are fertile before they are married by having a child. Sometimes already married men are fathers of such children. Surprisingly this is also the case among those who claim to be religious!

A Kenyan professional nurse in her late fifties, who was buying and reselling cars from South Africa, revealed that she was the only one remaining from a group of ten women who had been involved in the business with her across a period of ten years. The rest of the women had died from AIDS as they had had multiple sexual partners during that time. Some of these women had been married. With such negative attitudes towards the epidemic, infant, child and adult morbidity and mortality rates are likely to be exacerbated.

While the disease may not severely affect fertility in the short run, it may eventually damage reproductive capacities. Among men, the motility and quality of sperm decrease as the disease progresses, while among women positive sero-status may lower fertility rates in all infected birth cohorts as more negative pregnancy outcomes occur, including miscarriages, spontaneous abortions, and stillbirths (Batter et al., cited in Setel 1995:2). Children who are infected by their parents may increase the number of AIDS orphans. This will put further pressure on health care and home based programmes.

Effect on education and human resources

Specific studies on the impact of AIDS on education and human resources are very rare, despite the loss of government personnel, teachers and students. During the Lusaka conference, for

instance, a 21-year-old HIV-positive female from Namibia claimed that she had been infected by her teacher who took her virginity when she was 17. Whether such teachers know their sero-status, and how many schoolchildren have been lured into such sexual acts, remains to be known. This underscores the need to put corrective measures against such practices into place, including changing the law if necessary.

Mwiinga (1995:i) observes that HIV/AIDS can be expected to affect various institutions in several ways: increased sick leave and absenteeism, high medical expenses, lower productivity, higher worker turnover, loss of highly skilled managers, increased training costs, and increased expenditure on health and death benefits. To reduce such costs, financial institutions should support prevention programmes and introduce health schemes aimed at prolonging their employees' lives. This is not the case, however.

The increase in AIDS related illnesses and deaths are likely to create shortages in the skilled labour force, a situation likely to put pressure on the remaining human resources. This scarcity of skilled labour could trigger increasing wage bills and consequently affect the profit margins of the companies. Otherwise, the companies may be forced to overemploy in a bid to compensate for potential AIDS employees or to conduct HIV/AIDS tests before employing staff, a situation likely to attract protests from human right activists and to increase legal bills. AIDS-related illnesses are also likely to increase demand for medical care and insurance premiums.

Conclusion

Coordinated HIV/AIDS programmes by government, non governmental and community based organisations and religious institutions could bring about positive socioeconomic developments. However, currently there are few or no networks among these stakeholders, partly because of mistrust and a lack of umbrella bodies. Scarcity of resources also often creates rivalry among organisations soliciting funds from the same donors. This is especially critical because local, private businesshouses, although affected by the pandemic, are yet to be engaged in provision of resources for AIDS programmes.

After almost two decades of the disease, there is still some resistance to practical solutions in prevention, including condom use, and in the care of people infected or affected by the disease. This has sustained stigma, denial, blame apportioning and suspicion of witchcraft when someone dies from an AIDS-related illness. Regional political and economic bodies, such as the Common Market for Eastern and Southern Africa (covering most countries in the region, except South Africa), the East Africa Commission (Kenya, Uganda and Tanzania), the Economic Commission for West African States, the Southern Africa Development Committee, and the Southern Africa Customs Union (Botswana, Lesotho, Namibia, South Africa, Lesotho and Swaziland), have not been fully utilised to curb the disease. Ironically, these bodies emphasise political and economic integration, including conflict resolution, liberation of trade zones and reduction of tariffs among member countries,

without due regard to that other crucial variable in the equation: HIV/AIDS. How to protect from infection the soldiers sent to conflict zones, and the effect of AIDS on the regional economies, are yet to be seriously addressed.

The easier movement of people, including prostitutes, across many borders deserves regional consideration. Since some poor people cannot afford to buy them, free condoms should be made available at the various entry and exit points. Similarly, the regional bodies should facilitate the establishment of well-equipped clinics, to provide screening, treatment and counselling in border areas. These facilities should also factor in adolescent sexual activity. To effectively implement these measures, health programmes and personnel should be reoriented to become more sensitive. Various line ministries and existing non governmental and religious organisations would run such programmes. If the mistrust among stakeholders is not ironed out, and HIV/AIDS not placed at the centre, all efforts aimed at development in the region are bound to fail.

References

- Blacker, J. and B. Zaba 1997, 'HIV prevalence and lifetime risk of dying of AIDS', *Health Transition Review*, 7(Supplement 2), 45-62.
- Caldwell, J.C. et al. (eds) 1999, *Resistances to behavioural change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in Third World countries*, National Centre for Epidemiology and Population Health, The Australian National University, Canberra.
- Caldwell, J.C. 2000, 'Rethinking the African AIDS epidemic', *Population and Development Review*, 26(1), 117-35.
- Malungo, J.R.S. 1999, 'Challenges to sexual behavioural changes in the era of AIDS: Sexual cleansing and levirate marriage in Zambia', in J.C. Caldwell et al. (eds), *Resistances to behavioural change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in Third World countries*, National Centre for Epidemiology and Population Health, The Australian National University, Canberra.
- Malungo, J.R.S. 2000, *Sexual behaviour and networking in the era of HIV/AIDS: Continuity and changes in socioeconomic and cultural aspects in Southern Province of Zambia*, PhD thesis, The Australian National University, Canberra.
- Mwiinga, M. 1995, Study of risk factors caused by HIV/AIDS, unpublished report, Lusaka.
- Pool, R., et al. 1996, 'The price of promiscuity: Why urban males in Tanzania are changing their sexual behaviour', *Health Transition Review*, 6(2), 203-21.
- Setel, P. 1995, 'The effects of HIV/AIDS on fertility in East and Central Africa', paper presented at The Continuing Demographic Transition, John C. Caldwell Seminar, The Australian National University, Canberra, 14-17 August.
- UN (United Nations) 1998, *The demographic impact of HIV/AIDS. Report on the technical meeting*, UN, New York.
- UNAIDS/WHO 1999, *AIDS epidemic update: December 1999*, www.unaids.org/hivaidinfo/documents.htm/