

AIDS, Security and Conflict Initiative

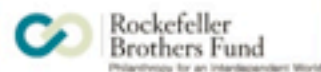
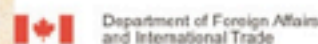


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The Political Dimensions of Responses to HIV/AIDS in Southeast Asia

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About ASCI

The AIDS, Security and Conflict Initiative (ASCI) officially launched in September 2006. ASCI is a global research initiative to inform policy and programming by strengthening the evidence base and addressing critical gaps in knowledge across several thematic areas:

1. HIV/AIDS in uniformed services, including military, peacekeeping and policing
2. HIV/AIDS, humanitarian crises and post-conflict transitions
3. HIV/AIDS, fragile and crisis states
4. Cross-cutting issues of gender, data collection & measurement, and media representation

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1. The Epidemic in Southeast Asia

While southeast Asia is a common geographic and political construct, now given political expression through the Association of Southeast Asian States [ASEAN], it is a remarkably diverse region, embracing almost every form of political system, religion and degree of wealth in the world. Not surprisingly, this diversity is reflected in the HIV/AIDS epidemic in southeast Asia, so that transmission via infected blood, both heterosexual and homosexual sex and sex work, as well as shared needles, are all important factors. The proportion of transmission due to each factor will of course vary: needles are a more important factor in Burma, Malaysia and Vietnam; the proportion of the overall infection amongst men who have sex with men is highest in Singapore [as it is in the other rich countries of East Asia]; Thailand and Cambodia have more generalized epidemics. Infection via blood transfusions is now very limited, although blood safety remains an issue in several countries.

The figures available for HIV infections in southeast Asia suggest very low prevalence, with only three countries, Burma, Cambodia and Thailand, reporting infection among over 1% of the adult population [Burma 1.3; Cambodia: 1.6; Thailand 1.4]. The most recent data from Cambodia suggests this is an over-estimate, and the figure may be closer to 0.9% [Rao 2007]. Other than Vietnam and Malaysia the other countries of the region, including the large states of Indonesia and the Philippines, show remarkably low prevalence, and in much of the region infections are found largely amongst discrete populations, primarily injecting drug users and men who have sex with men. This is consistent with James Chin's recent debunking of alarmist projections, which includes criticism of UNAIDS and WHO for over estimating likely infections in Thailand and Cambodia [Chin: 155]. As in the former Soviet Union, a discussion of HIV in southeast Asia must take account of the centrality of needle use in its inception and spread.

Overall prevalence in the region is considerably lower than was feared fifteen years ago, when the emergence of the Thai epidemic led to fears of a rapid spread of HIV across southeast Asia. Without minimizing the impact of the epidemic on those affected, and on particular communities, defined both by practice and geography, it does not appear very likely that there will be a massive escalation of the epidemic across this part of the world in the foreseeable future. It would be nice to attribute this to successful policies, but there is little evidence

to support this, although both local and international NGOs have been active in most of the region.

There is no clear correlation between wealth and HIV rates: thus HIV infection is more widespread in Malaysia than the Philippines, although the former has a far higher GDP. [Indeed, the low rates for the Philippines remain a constant surprise, given the factors that should allow for greater infection.] Nor does there appear to be any correlation between AIDS and insecurity, at least at the national level. It could be argued that the relatively high rates of infection in Burma and Cambodia reflect ongoing political instability, but far lower figures in Indonesia, Timor Leste and the Philippines would seem to modify any generalizations that might be made.

2. Southeast Asia and the Jaipur Paradigm

The Jaipur paradigm was advanced by researchers after a policy meeting at the Indian Institute of Health Management Research in 1996. Its basic conclusion was that: “The susceptibility of a society to HIV spread, and thereby the profile of its epidemic, are determined by two variables: the degree of social cohesion and the overall level of wealth.” [Whiteside 488; see also Barnett & Whiteside]. The analytic problem is that ‘social cohesion’ is a vague term, and one for which it is difficult to find agreed upon measurement. It is doubtful that the paradigm accounts for a higher incidence of HIV in Malaysia and Singapore than in Indonesia and the Philippines, although it might be applicable if we break down figures to a sub-national level.

If we were to take a crude measure of social cohesion and equate it with state fragility, there might be a way of linking this analysis to the overall concerns of ASCI. Only two states [Burma and Timor Leste] appear among the 41 states listed in the 2007 Foreign Policy index of failed states. While it is difficult to assert that HIV is a major contributor to state failure, even in a country with a significant epidemic such as Burma, the reverse does seem true: a weak state will be less effective in responding to HIV [and this has been compounded in the case of Burma by reluctance of many donors to work with what is regarded as an illegitimate government.]

The emergence and spread of HIV does not appear to be primarily due to political or economic factors, but rather is directly linked to sexual and needle practices. These in turn are certainly determined in part by socio-economic forces and by cultural practices. There is probably more commercial sex in Thailand than, say, Malaysia, and religious prohibitions in Islamic and Catholic countries [ie Indonesia; Malaysia; Brunei; the Philippines] limit some expressions of sexuality. A larger sex industry in Thailand and Cambodia to the rest of the region appear to be very important in explaining the relatively fast spread of the epidemic in those countries; the legacy of war and the consequences of a shift to needle use amongst former opium smokers is significant in Burma and Vietnam. The lower than expected rates of infection in some parts of southeast Asia [Whiteside points to the Philippines as an example] may be explained by a mixture of cultural factors and effective interventions. There seems no reason to doubt the reports of low prevalence in the Philippines, although every now and then there are claims that the official figures, of less than 15,000 infected in a population of 80 million, are gross underestimates [Lerner 2003].

3. Responses

The first significant reports of AIDS in southeast Asia occurred in Thailand, and Thailand has been regarded as the model for responses across the region [see below]. But responses have varied very considerably across the region, and indeed within each country have often fluctuated depending on political and economic change. [Thus under President Ramos the Philippines seemed more committed to controlling the spread of HIV than has been true under his successors. Arguably the Philippines has less effective prevention programs in place now than ten years ago]. Any measure of responses has to reflect the current and likely trajectory of the epidemic: we would not expect the same level of response in those countries [Brunei; Laos; Timor Leste] where the epidemic appears very limited, as we would in Thailand or Cambodia.

The political systems across the region have changed considerably over the past twenty years, which makes it particularly difficult to suggest any links between government responses and political systems. Over the life of the epidemic Burma, Laos, Vietnam and in a rather different way Brunei have had authoritarian governments; Malaysia, Singapore, Cambodia and the Philippines have had flawed democratic ones; Thailand and Indonesia have undergone various

transitions between authoritarian and democratic systems, and Timor Leste is too recent as a state to be included. The 2007 *Economist* measures of democracy rates the Philippines, Indonesia, Timor Leste and Malaysia as 'flawed democracies' and places Singapore, Cambodia and Thailand amongst hybrid regimes. By next year it is probable that Thailand will have changed categories once again.

A moment's reflection shows how difficult it is to use these sort of measurements. Space for CBOs and NGOs to organize and be critical of government has been consistently stronger in Thailand than in Malaysia over the past two decades, even under military rule. Vietnam and Burma are both authoritarian, but the reach of government services, as well as the ability to maintain order, is far greater in the former than the latter. Freedom of the press, which it has been argued is a relevant factor for responses to HIV [Bor 2007], is equally contradictory: the 2006 listings from Reporters without Borders, which are somewhat different to those of Freedom House, rates Malaysia ahead of Indonesia, Cambodia, Thailand and the Philippines, with Singapore, Vietnam, Laos and Burma well behind. Yet in some ways the government of Vietnam has been more willing to engage with the epidemic than that of Indonesia or the Philippines.

Again, social and cultural factors are significant. The states of southeast Asia all display varying forms of official puritanism, and even Thailand has had difficulties in recognizing the extent of male to male sex and drug use and incorporating them into its prevention programs. Catholicism in the Philippines and Timore Leste, and Islam in Indonesia and Malaysia, are important obstacles to adopting programs promoting widespread use of condoms, but so too is Communist ideology in Lao and Vietnam. Despite some public discussion of abolishing the British laws against homosexual behavior in Singapore, as has been argued by the senior leader of the country, Lee Kuan Yew, the government has refused to do so, even though there are strong arguments that this would be a sensible public health measure. [This seems more due to a strong Christian lobby than any Confucian tradition.] In Vietnam, as we shall see, there has been constant tensions between campaigning against 'social evils' and promoting HIV prevention programs.

Any measurement of response need examine government commitments, available resources [both indigenous and from donors], civil society mobilization

and programs for both prevention and treatment/care. There are several attempts to rate countries according to all these criteria, but it remains difficult to find any generally agreed upon measurement. At the time of writing it may well be that the most successful country in slowing the epidemic in the region is Cambodia. Indeed in 2007 the Global Fund To Fight AIDS, Tuberculosis and Malaria, USAID and the United Kingdom's Department for International Development decided to scale back HIV prevention funding in Cambodia, because the country reportedly has achieved satisfactory progress in curbing its HIV/AIDS epidemic. HIV prevalence has declined from about 3.3% in the 1990s to about 0.9% in 2005.

3.1 Thailand

Limited cases of HIV among homosexual men and idus were reported in the mid to late 1980s, but by 1989 surprisingly high rates of HIV amongst women working in the sex industry led to a fear of a more generalized epidemic [UNAIDS 1988]. That Thailand had a competent Ministry for Public Health and a Centre for Communicable Disease Control was obviously crucial in recognising the new epidemic, in ways less possible in neighbouring Burma, for example [Beyrer]. But so too was the development of a civil society response: there were early tentative moves to develop peer education in the large homosexual worlds of Bangkok and Chiang Mai, and the development of sex worker education through the group EMPOWER, which remains an important resource. The key figure was Meechai Viravaidya, whose Population and Community Development Association was already doing significant family planning activities, and who became known as 'Mr. Condom' for his work in promoting 'safer sex'. As a member of the Thai political elite who was also a genuine activist he represents a key figure in linking various strands of the Thai response.

In 1992 Ananad Panyarachun, who became Prime Minister after the military coup of the previous year had failed to establish a permanent government, took leadership of the AIDS issue. He appointed a National AIDS Commission, which he chaired, with Khun Meechai as a key player. The Thai response focused on the very extensive sex industry, and instituted the '100 % condom policy'. The emphasis on condoms, and tacit acceptance of commercial sex, was a clearly different policy approach to that associated with U.S.-influenced approaches elsewhere, and is usually seen as very successful, at least in halting spread of the epidemic in particular populations, although sex work organisations have

been critical of its implementation [Network of Sex Work Projects]. Thailand did not do well in dealing with drug users and the spread of HIV through needles, but subsequently it would become one of the leaders of the developing world in seeking to expand access to HIV treatments. Most significantly, the Thai response did not depend upon overseas experts or finance; there were significant programs from international donors, both official and NGO, but the basic frameworks were clearly set by the Thai government.

The key question is what put HIV on the agenda of the Thai Prime Minister at a time when very few heads of government were prepared to even discuss the epidemic. There is little doubt that Meechai was a key figure, as were Chawlit Natpratan [Thai CDC] and Praphan Phanupak [Thai Red Cross]. A crucial factor was that AIDS was defined as a cross-sectoral issue, and that responsibility for developing a National AIDS Plan was placed in the hands of the National Economic and Social Development Board. But equally important, there was a sufficiently robust civil society to incorporate concerns for human rights in the national response, and to recognise the role of PLWHAs “as an essential resource for prevention and care, rather than a political reservoir or unfortunate consequence of the epidemic as was often the case in earlier phases of the response.” [Phoolcharoen et al: 7] The then Australian Ambassador has claimed to me in conversation that he had a significant influence through his own contacts with Prime Minister Annan, but it is difficult to evaluate this claim.

Thailand is generally regarded as one of the most successful middle income countries in ensuring access to ARVs, although as late as 2003 over half of those in need of such therapies did not have access to them. However, growing government commitment to health meant that Thailand, along with Brazil, is one of the few middle income countries able to offer universal access to ARVs. A study of the two countries concluded this rested on three factors: legislation for free access to treatment, public sector capacity to manufacture medicines; and strong civil society action to support government initiatives to improve access [Ford et. al.]. The Thai government has been amongst the most willing to use provisions in international trade agreements providing for limitations on pharmaceutical companies patent protection in order to produce crucial drugs at low cost [Hookway & Zamiska 2007].

Most observers suggest a decline in the effectiveness of prevention from the time of the economic crisis in the late 1990s, which led to real cuts in the AIDS programs. Thailand showed real progress on almost all indicators, but the strong political commitment of the early 1990s seemed to lag as other issues came to the fore. By the time of the International AIDS Conference in Bangkok [July 2004] warnings of a resurgent epidemic were common, and Prime Minister Thaksin Shinawatra was embarrassed by attacks on his then policy of police killings of suspected drug users. At the Bangkok Conference there was considerable evidence that infections among drug users and MSMs were rising, and international observers warned of a new epidemic [eg Baxter; External Review]. The following year Meechai called for a new prevention campaign, and some steps have been taken to address the groups now seen as at particular risk. Latest data does not suggest that sufficient measures have been taken to create effective prevention programs for the most vulnerable, especially needle users [Human Rights Watch 2007]

3.2 Vietnam

In a private report which cannot be attributed, a senior NGO observer wrote at the end of the 1990s: "...the epidemic and the program are uniquely Vietnamese, so cannot easily be compared with those in Myanmar, Thailand and Cambodia. It is also unique among other countries with economies in transition. Vietnam's national program has many progressive elements: there is little or no denial of the epidemic by national, provincial or local government officials, progressive pilot programs such as needle exchange are being implemented, the government has been partly responsible for a condom –friendly environment, and support groups for people living with HIV receive government support."

The crux for the spread of HIV in Vietnam has been widespread needle use, due to high degrees of heroin addiction, Chris Beyrer has written movingly of the reasons for this in the aftermath of the long wars of the 1950s through 1970s [Beyrer: 98-100]. HIV came relatively late to Vietnam, and was originally blamed on foreigners, whether Cambodians in the South or Chinese in the North. By 2006 it was estimated that 40,000 people were being infected each year, which is proportionately more than in Thailand. Infections are predominantly through needle use and commercial sex, and this has been very influential in determining responses, as both drug use and prostitution have been officially treated as

'social evils'. Thus some early government responses increased stigma against people with HIV, as in prohibitions on them working in certain sectors of the economy, since repealed.

Government responses date back to the second half of the 1990s, and there is some evidence that by then officials were concerned by the rise of HIV in Thailand, and worried that a growing sex industry, especially in Ho Chi Minh City, could fuel a similar epidemic [Richburg 1996]. In 2000 the Prime Minister established a National Committee for AIDS prevention and for drug and sex work control. By early 2004 there was a national strategy in place for 2004-10, with a vision for progress by 2020. Gradually, and under some international pressures, the government has moved away from punitive measures, and allowed both peer education and needle exchanges for users. During this century the government has put increasing emphasis on HIV prevention, and has moved towards a multi-sectoral response. Civil society in the western understanding of that term is, of course, weak, but the state has considerable capacity to reach large groups of people through organisations like the Women's and Youth Unions, and its control of media [Giang & Huong]. However the language of 'social evils' means that different sections of government often seem at odds in their policy responses.

Gradually the infection has become more generalized, but the attention of both government and donors has continued to focus on drug users. Vietnam has had a punitive attitude towards drug use, with a large number of detention centres for detoxification and 'moral education' of users. By 2007 it was estimated that there were 50,000 people detained in these '06 centres' [Hammett et al: 6]. But the National AIDS Law, effective from the beginning of 2007, provides for harm reduction, including the provision of needles and syringes and opioid maintenance treatment. These developments are the direct result of growing concern with HIV transmission, and a pragmatic awareness of international best practice.

In 2004 Vietnam was the only Asian country included in the Bush Administration's emergency relief AIDS program [PEPFAR], after Congress asked that at least one country be added to the original 14 that was in neither Africa nor the Caribbean. The choice of Vietnam was attributed to its willingness to cooperate, and was part of a larger American détente with a former enemy. It also both signaled and increased the importance of external NGOs in policy

formulation, as the extra monies meant more foreign workers entered Vietnam to work on HIV, supplementing those international NGOs already in place.

The 2007 AIDS law provided for a new and scaled up response across the country, and addressed issues of care and treatment, prevention and stigma. There were quite extensive consultations leading to the passing of the law in 2006, some of which involved PLHA groups, whose organisation in Vietnam has been assisted by international donors. PEPFAR funding has meant increased access to ARVs, and the Clinton Foundation has also provided some assistance. Ironically the rapid opening up of the Vietnamese economy, and the consequent surge in urban population, which is welcomed by the United States, is also contributing to the behavioral changes which increase vulnerability to HIV [Giang & Huong]. The World Bank estimates that Halong is growing at about 12 percent per year, Ho Chi Min City and Hanoi about 7 percent per year, and the growth fuels greater opportunities for both commercial and non-commercial sex.

3.3 Indonesia

Awareness of HIV came late to Indonesia, which continues to show low overall figures, with a concentration in certain areas and amongst a couple of key populations. Thus rates of HIV amongst injecting drug users in Jakarta are estimated to be very high, and there is a growing rate of infection in Tanah [West] Papua, where estimates suggest an emerging serious epidemic. A 2006 study for AusAID suggested that Indonesia could approach a generalised epidemic by 2025, but with prevalence amongst adults as high as 7% in Papua [Kaldor 2006: 11]. This has led to a number of conspiratorial explanations, but the most likely explanation is a rather different pattern of sex work and sexual networks than in other provinces of Indonesia, probably more like the pattern in neighbouring Papua New Guinea. According to the data presented in Risk Behaviour and HIV Prevalence in Tanah Papua 2006, "around 5% of the ethnic Papuan population is circumcised, compared to 70% of the non-ethnic Papuans. HIV prevalence among residents who have non-permanent partners and are circumcised is 1.0 %, while among those who are not circumcised it is much higher at 5.6%" [Irmanigrum, 2006]. This may seem *prima facie* evidence for the usefulness of circumcision as a preventive measure, but given that it is correlated with Islam it is not possible to be definitive about whether circumcision or Islamic cultural values are the crucial variable. There is a lack of available data on sexual

behavior in West Papua that allows us to be sure how different it is to that of the rest of predominantly Muslim Indonesia.

Unlike Thailand, pressure to take seriously the possibility of an epidemic came largely from external sources, with both USAID and AusAID supporting programs from the early 1990s. Given the low number of cases and the other issues facing Indonesia during the 1980s and the 1990s this is not surprising: there were many other immediate issues demanding a response. An already slow government response in the 1990s was further hampered by the economic and political crises of the late 1990s, and serious government commitment did not come until this century. By 2002 UNAIDS was warning of “a dangerous new trend in Indonesia” [UNAIDS 2002], based on evidence of growing infection amongst needle users. That year a special cabinet meeting endorsed a new national strategy, and President Megawati Sukarnoputri [2001-4] spoke out strongly on several occasions against stigma and discrimination. In 2004 the Sentani Commitment between the national government and six of the most affected provinces pledged a comprehensive response including harm reduction, condom promotion for high risk sexual activities, reduction of stigma and discrimination and the provision of ARVs to at least 5000 by the end of the year. A national policy is being developed to promote universal access to treatments.

The rather complex processes of policy making in Indonesia have involved several ministries, particularly the Coordinating Ministry for People’s Welfare and the Ministry for Health, as well as provincial governments and a range of local and international NGOs. Since 2006 the key figure has been Nafsiah Mboi, who was appointed Secretary of the National AIDS Commission, which is chaired by the Coordinating Minister for Welfare. Mboi, who is well known in both political and public health circles, and had previously been Director of the Department of Gender, Women and Health at the World Health Organization, could be seen in some ways as an equivalent figure to Meechai in Thailand. However while Indonesia at the time of writing may well be the most genuine democracy in the region, community based organizations, though numerous, do not appear to have great impact on policy formation.

4 Implications

There are several models which seek to account for the degree and quality of government responses to HIV/AIDS. International rhetoric tends to stress 'political commitment' and 'leadership', although these terms are rarely problematised. [While there is a 'leadership track' at the International AIDS Conferences, this rarely encourages critical analysis.] In a briefing note for ASCI, Alex de Waal has suggested: "...In many countries health policies are made and implemented by an elite group of technocrats within the bureaucracy, who are responsive to political dictat from above but much less responsive to direct pressure from organized interest groups, NGOs, the media and the general population....In some countries this may reflect a Confucian tradition of elite science-based administration." [de Waal 2007] There is some evidence for this in Vietnam, especially in the shift towards harm reduction for drug users, but even in Vietnam international pressures and local stakeholders were more significant than de Waal's formulation would suggest [see Hammett et. al.] In Burma/Myanmar government leadership came primarily from the Minister for Health, Professor Kyaw Myint, and the Chair of the National AIDS Committee, Min Thwe, who were responsible for developing governmental responses, which accepted a number of UNAIDS recommendations [International Crisis Group 2004]. While the Confucian tradition is not strong in Burma, the argument that senior bureaucrats were the drivers of the national response seems justified.

Daniel Tarantola has argued there may be a larger influence on policy making from civil society than is often acknowledged, and that we need more research on the role of civil society, and on specific community-based initiatives. He suggests that the quality of response to HIV is influenced by both good governance and the capacity and resilience of affected communities. This leads him to suggest that: "The mismatch between selected elements of governance on the one hand and expectations of communities with regards to select factors known to impact on the spread of and response to HIV exacerbates or mitigates community vulnerability to HIV." [Tarantola 2007] [Note: Tarantola is proposing a number of potential research paths, not asserting any causal connections.] In his work, Jacob Bor concludes that the main determinants of political commitment are press freedoms, income inequality and HIV prevalence [Bor 2007: 1585].

In some countries there is evidence that effective responses to HIV began within affected communities and were only later adopted by governments. But we should bear in mind the caution of Godwin et. al: “NGOs have indeed played a major role in developing innovative approaches and conducting much of the initial ground-breaking progress in the region—but their reach has generally been limited. In many countries, the vulnerability, isolation and stigmatisation of the target groups arise largely from behaviors which are socially and legally unacceptable within these countries. Paradoxically, only governments can really work effectively, on the scale required, with these groups” [Godwin et. al: 3]. In most countries initial leadership appears to have come from community level organisations, and was often supported by external funders and agencies. This is obvious in Malaysia, where the Malaysian AIDS Council, whose initial President, Marina Mahathir was a high profile figure, and recognised as the nation’s foremost spokesperson on the epidemic, played a central role in developing national capacity and policies.

The Thai response clearly reflected the ability of several key figures in government or with close links to government to put HIV high on the political agenda. There are other examples of this sort in the region, such as the unexpected decision of the Malaysian Health Minister, Chua Soi Lek, several years ago to allow initiative pilot programs of needle exchange to prevent transmission. It is difficult to be certain what factors led to this policy shift in Malaysia, and it has not been accompanied by equal shifts in attitudes to other policies, such as promotion of condoms or recognition of homosexuality. At a minimum we can expect governments not to hinder community care and prevention, but unfortunately Burma, like China, has a history of government harrassment of AIDS activists. Indeed, it appears that mobilisation around HIV in Burma helped create ‘civil society’, and accordingly AIDS activists were involved in the risings against the military at the end of 2007, and repressed accordingly. There is room for further exploration of HIV as a catalyst for civil society organisation and political radicalisation, as has been the case with the growth of the Treatments Action Campaign in South Africa.

It is interesting that none of the writings on what creates political commitment appears to examine pressure from business, although in recent years mobilising business around HIV has been a tactic of both UNAIDS and some donor governments. The Thai Business Coaltiiion on AIDS has been a significant

organisation for at least a decade, and in the past few years there have been moves to establish similar organisations in most countries of the region, including such apparently unlikely places as Burma and Vietnam.

International pressures for particular policies came at both programmatic and discursive levels. Indeed, it is likely that the constant invocation of the spectre of an African-style epidemic spreading to other parts of the world created both resistance and panic in other parts of the world. But it also generated international resources and real pressure on governments to be seen to act, even if their own estimates, as may have been the case in some southeast Asian countries, was that HIV was a second order priority. There is room for a careful analysis of the impact of organisations such as UNAIDS, the World Bank and ASEAN and bilateral donors on the countries in the region. From its inception, the Global Program on AIDS, then UNAIDS, saw part of their role as encouraging governments to develop responses to HIV, and events such as UNGASS and international and regional conferences, and attendant ministerial meetings, increased the pressures. Inviting heads of government to defend their policies before an international audience, as P.M. Thaksin did in Bangkok, and as President Ramos and P.M. Mahathir did at the regional ICAAP meetings in 1997 and 1999, often leads to a flurry of governmental activity. When the regional meeting was held in Melbourne in 2001 the Australian Foreign Minister hosted a ministerial forum which led to the establishment of the Asia Pacific Leadership Forum [APLF], aimed specifically at increasing political commitment across the region.

While most attention focused on the wording of the 2001 and 2006 UNGASS meetings, it is probable that the more significant effect was at country level, where governments were forced to respond to the need to report progress against international criteria. As funding for programs has dramatically increased since the inception of the Global Fund it is not surprising that governments have responded. Put crudely, HIV/AIDS is fashionable, and governments wish to be seen to be responsive. There are limits, however, to the flexibility of governments, as Burma showed in 2005 when its actions lead to the Global Fund withdrawing from operating in that country. In its own words, the Fund found that various government restrictions on travel and procurement “would prevent the implementation of performance-based and time-bound programs in the country, breach the government’s written commitment to provide unencumbered access,

and frustrate the ability of the Principal Recipient to carry out obligations”[Global Fund press release August 19 2005]. Following the withdrawal of the Fund a few donor nations, including Britain, Sweden and Australia, established the Three Diseases Fund to ensure some assistance continued for Burma’s own programs, which appear to have continued even after the brutal repressions of the past year.

I can find no serious attempt to measure responses to HIV against religiosity, but in western countries it is clear that it was the most secular societies that were most successful in adopting a full range of prevention strategies. A discussion of this goes beyond the scope of this paper, but the major differences between U.S. responses and those in northern Europe and Australasia are often explained as a consequence of different pressures from religious moralists.[Kirp & Bayer] In Asia the relationships are more complex, because of the range of religious traditions and the existence of a certain sort of puritanism even in countries that seem largely secular [eg. Japan] or where Communist ideology makes for official hostility towards organised religions. There are some obvious points, such as the opposition from both Catholics and many Muslims to the promotion of condoms, or indeed any acknowledgement of extra-marital sex. Asians often speak of themselves as sexually conservative, and it is notable that there appear to be greater barriers to school-based sex education and acceptance of homosexuality in many parts of the region than there are to harm reduction programs.

To summarise, I would postulate that there are five elements that affect official responses to the epidemic:

i: the size [or perceived size] of the epidemic, in particular whether it is seen as ‘generalised’;

ii: bureaucratic structures and capacities;

iii: pressures from outside government from civil society, media etc, including key individuals;

iv: international influences;

and v: dominant social and sexual cultures. [While it is difficult to generalise about sexual cultures, especially in large and multi-ethnic societies, the extent of commercial sex in Thailand and Cambodia seems greater than other parts of the region. It is likely that both cultural attitudes towards prostitution and socio-economic conditions make commercial sex more widespread than in the Islamic or Catholic societies [Lyttleton], although the differences may be less stark than is asserted by proponents of particular religious values. There is a problem in any realistic assessment of commercial sex, given how much of it is casual, unpremeditated and not widely acknowledged, which makes terms like 'non brothel-based sex workers', to quote one anonymous informant, misleading.

A comprehensive analysis of political responses would need to consider all of these points, and in larger countries, such as Indonesia, would also need to take regional variations into account. Because there is little data available on how 'political commitment' is achieved, despite a great deal of rhetorical agreement as to its importance, there is an important niche here for ASCI.

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