Building dynamic democratic governance and HIV-resilient societies

Lee-Nah Hsu

Are we really doing all that we can to stop the spread of the human immunodeficiency virus (HIV) and the resulting acquired immune deficiency syndrome (AIDS)? It would seem not, judging from the speed with which the pandemic is gaining ground. Responses to HIV and AIDS – outside the domain of public health initiatives – still remain quite limited. Could responses to HIV and AIDS be improved? The answer is yes.

Much of the research and evaluation in the various AIDS programmes ignore the impact of development on HIV epidemics and, conversely, the impact of AIDS on development. Little empirical research has been conducted to assess the impact of infrastructural development projects on the spread of HIV epidemics. For example, when a dam or road is being constructed in a remote, mountainous area of a developing country, there is a sudden influx of young and often risk-taking male workers who will reside in the area for an average of 3–5 years (see also Giang 2004). The rural residents in such areas are often poor, so their typical response to this influx of salaried outsiders is a welcoming one. The presence of so many unattached workers will enable the villagers to sell food and to provide lodging, entertainment, and other services. However, most of the villagers have no knowledge about HIV and AIDS or access to preventive measures against infection. Unfortunately, the unintended outcome of such development projects can be the further spread of HIV and AIDS. This does not mean that infrastructural development projects must be stopped, but it does mean that decision-makers require more information and contextual knowledge before making choices on policies, programmes, and resource allocations (du Guerny and Hsu 2002).

After serving as the Manager of the UNDP South-East Asia HIV and Development Programme from 1998 to 2004 and as the Convener for the United Nations Regional Task Force on Mobility and HIV Vulnerability Reduction from 2000–2004, Lee-Nah Hsu taught at Johns Hopkins University. With a DSc from Harvard University, her focus is to bridge the gap between the development and AIDS sectors through multisectoral action research, linking contributions beyond medicine alone to include agriculture, construction, rural development and poverty reduction, aimed at building HIV resilience and using research findings as the evidence-base for policy advocacy, strategic planning and programmatic actions.
Email: zeehsu@hotmail.com.

No single checklist will suffice: responding to HIV and AIDS is technically complex and resource-intensive (de Waal 2003). However, one of the critical elements that decision-makers must consider, especially in anticipating outcomes and responding effectively and consistently to HIV and AIDS, involves an elemental principle promoted by the United Nations: human rights.

An elaboration of our example illustrates why this is so important. As people move into new areas, so do diseases. This phenomenon was well demonstrated by the outbreak and rapid spread of the severe acute respiratory syndrome (SARS) in 2002–2003, and that of avian influenza in 2004–2005. (As this paper was about to go to press, the latter disease began spreading among wild birds and poultry beyond

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Asian countries into Europe.) Similarly, HIV does not respect national borders. However, unlike the regional response and global concern caused by the "bird flu", most responses to HIV and AIDS have been country-specific. As a result, large proportions of the actual transmission mechanisms and populations are not addressed by such responses (du Guerny *et al.* 2003). Moreover, the fact that HIV transmission relates to human sexuality, sexual behaviour, and drug dependence means that its transmission is related to activities considered taboo in many societies or criminal in others. Consequently, decision-makers may be tempted to ignore these important HIV-related issues or they may choose not to deal with them at all.

Human rights can serve as the basis for HIV prevention

However, if decision-makers give primacy to human rights, the needs of all people will be considered and all people's rights respected; and as such, the principles of human rights will be pertinent for HIV prevention.

As previously described, development processes are not neutral with respect to HIV and AIDS. "Development" does not mean reducing the chances of HIV spreading. Forms of development that are not people-oriented or that sacrifice human development for economic gains actually increase people's vulnerability to HIV, particularly poor people's, and may even exacerbate HIV epidemics. Development programmes have stimulated the unprecedented movement of people and goods both domestically and internationally. The majority of such movement involves people seeking alternatives and opportunities to improve their livelihood or to escape chronic deprivation, sudden economic downturns, or natural disasters (Skeldon 2000). As people move away from their homes and culture, they have less access to supportive social networks and may be exposed to differential treatment and new temptations. Many of them do not have expectations of staying in the places to which they have moved. All these circumstances increase the vulnerability of people on the move and of the people living in areas in which the migrants have set up temporary residence. Thus, it is necessary to build the capability of these people to integrate and to protect their social values, their health, and their well-being. Building people's resilience is an essential task in the efforts to stem the spread of HIV and AIDS.

Two interrelated strategies are important in this regard: protection and empowerment. Protection shields people from dangers or protects them from HIV infection. In the context of HIV and AIDS, empowerment means creating an enabling environment in which people can enter into public dialogue and obtain the necessary information, and have the means and choices to make decisions about their lives and to protect themselves from HIV and AIDS. Both of these strategies are elements of human security, and democratic governance can act as a guarantor of that security,[1] which is itself a basic human right.

While the notion of governance comprises the complex principles, mechanisms, processes, systems, institutions, and practices through which citizens and groups articulate their interests, mediate their differences and exercise their legal rights and obligations, democratic governance principles take these attributes to a higher plain. Democratic governance is participatory, transparent and accountable, and it is effective in making the best use of resources. It is equitable and it promotes the rule of law (UNDP 1999). Three key players are involved in good governance: the state, civil society, and the private sector. The state uses the afore-mentioned mechanisms to pursue its legislative, political and economic goals just as civil society and the private sector use them to foster their interests. The state works through parliament, ministries and departments, and legal institutions; civil society and the private sector through NGOs, business councils and the like. Underlying the principles of democratic governance is a commitment to human rights.

While "perfect governance" remains an ideal, a quick review of the global situation indicates that the countries that have attained an advanced level of human development and have developed an effective democratic governance process are associated with lower HIV prevalence (du Guerny *et al.* 2002b).

Both scattergrams in Fig. 1 show a correlation at the global level between the Human Development Index (HDI) and the Gender-

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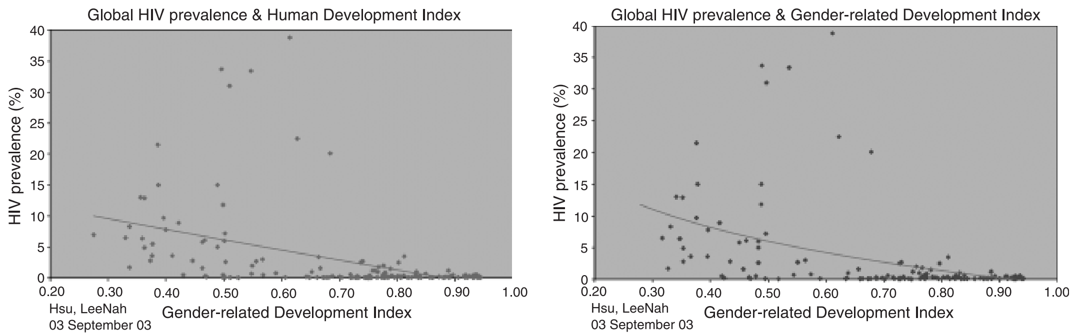

FIGURE 1. Correlations between the Human Development Index, Gender-related Development Index and HIV prevalence. *Source*: Graphics prepared by Lee Nah Hsu and Vincent Fung. Data taken from *UNAIDS Global HIV/AIDS Trend Report, 2002* and *UNDP Human Development Report, 2003 and Human Development Index, 2001.*

related Development Index (GDI), and HIV prevalence among countries. It appears that low levels of gender equity and low levels of human development achievement have some association with high HIV prevalence, with a few notable exceptions, as shown in Fig. 1. There are several countries where the GDI and HDI are low, and HIV prevalence is also low. Based on the data available, these are key outlier countries. Empirically, one finds that gender inequities in the levels of school enrolment and income, for example, create the type of social inequity that contributes to the vulnerability of females to HIV infection (see also Gordon *et al.* 2000). However, while the available data do not demonstrate any causal relationship, policymakers and programme planners need to understand why HIV infection has been so rapid in some countries, but has increased more slowly or has remained at lower levels in other countries. They need to see that HIV/AIDS requires responses much broader than health alone. Unless the social conditions that facilitate the spread of HIV and AIDS can be impacted, it will not be possible to slow down its transmission.

Just as perfect democratic governance does not exist anywhere in the world, perfect resource distribution, even in so-called developed countries, does not exist. Nevertheless, the way in which inequity in resource distribution plays out in the presence of HIV is reflected in the gaps in economic development between countries. Along the continuum from the poorest to the richest countries, the poor exert their efforts in trying to access resources and income; the rich use their income and resources to gain power and influence,[2] thereby enabling them to increase and safeguard their wealth.

By contrast, the democratic governance process addresses the issue of income and resource distribution. Thus, it deals with the background to HIV vulnerabilities that range from putting people in circumstances where they are exposed to infection, to pushing individuals to take risks that they would not have taken under normal circumstances, had the environment been more favourable to their livelihood (United Nations 2003).

Just as there are some common elements in what constitutes democratic governance, similarly, an analysis of the mechanisms for building HIV resilience reveals a number of common elements, as seen in the following country case studies. It is worth examining these before considering the general application of the principles they demonstrate.

The case of Brazil

In the early 1990s, the Brazilian Government recognized the threat posed by HIV and AIDS and devised a national AIDS strategy.[3] That comprehensive strategy called for the provision of free medication, initiation of a major mass-media campaign through prime-time television to disseminate HIV-preventive messages, and the distribution of condoms free of charge to sex workers.

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The government's decision was a brave one at a time when no other government was assuming the financial responsibility of covering the cost of medicine for HIV and AIDS. At that time, life-prolonging anti-retroviral (ARV) medicine had not yet been developed, so the treatment was mainly for opportunistic infections and other palliative support. Nonetheless, it was the view of the Ministry of Health that Brazilian citizens had the right to treatment for illness and it was the government's duty to provide free medication to its people.[4] Brazilian legislation now guarantees every AIDS patient access, free of direct costs, to all the medicine required for his or her treatment, including protease inhibitors, based on the treatment criteria and guidelines set by the Ministry of Health.

Today, the wisdom of the Brazilian leadership in responding as it did to the HIV and AIDS crisis is clearly visible from a business point of view in the costs averted because of this astute and people-centred national AIDS policy. The AIDS crisis forced the country to use creativity to overcome financial difficulties and the objections of various donors, and pursue initiatives that turned Brazil into a "public policy designer" to be emulated by other countries. It also made Brazil a leader, along with India, in the movement to challenge pharmaceutical patents in order to provide affordable medicines, particularly in the case of public health emergencies in the developing world. The country has gained additional social, economic, and political benefits in tackling HIV and AIDS with responsibility, competence and a humane response through solidarity in its planning.

Most importantly from the humane point of view, the Brazilian policy of providing easy access to anti-retroviral therapy (ART) has changed the morbidity and mortality rates of those infected with HIV. As a consequence, Brazil has gained from their increased social and economic outputs (Teixeira *et al*. 2003). The policy of providing ART has minimized the impact of the epidemic by virtually halving AIDS-related mortality from 12.2 deaths per 100,000 population in 1995 to 6.3 per 100,000 in 1999 (Teixeira *et al*. 2003). Such treatment averted more than 60,000 cases of AIDS, 90,000 deaths and 358,000 AIDS-related hospital admissions from 1996 to 2002 (Teixeira *et al*. 2003).

The people of Brazil were clearly put first by their government in respect of AIDS treatment.

The factors contributing to Brazil's effective HIV and AIDS responses are summarized below. Some of these will be elaborated with specific examples in the next case study.

- *Timing*: a concerted early governmental response.
- Strong and effective *participation* by *civil society*.
- *Multisectoral* mobilization.
- Balanced prevention and treatment approach.
- Systematic advocacy of *human rights* in all strategies and actions.
- *Transparency*, including access to information for the people.

The case of Thailand

The initiatives taken by the Thai Government reflect principles consistent with democratic governance.

In 1984, a prediction was made that 10% of the Thai population would die from AIDS by 2010; six years later (in 1990), Thailand had an HIV prevalence rate similar to that of South Africa. After public consideration and debate about the best approaches to take, the government mounted a massive national condom promotion campaign for sex workers in order to slow the trend. It also implemented many other measures to fight HIV and AIDS. Today, condom use protects more than 90% of registered sex workers. The overall responses in Thailand, including behavioural changes, have contributed to reducing new HIV infections from 143,000 in 1991 to 29,000 in 2001, with a projected further drop to 18,000 by 2005. According to the country's Ministry of Public Health, that response has averted an estimated 2 million new HIV infections since 1993, as shown in Fig. 2. Today, Thailand's profile is one of success compared with that of South Africa where the HIV prevalence is now among the world's highest.

What are the key mechanisms attributable to containing the HIV epidemic in Thailand? The following is an analysis of the various mechanisms the country used in order to build its HIV resilience.

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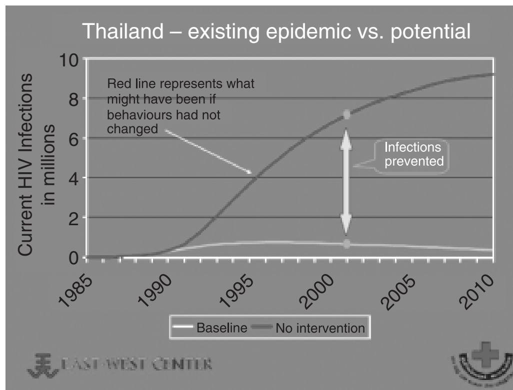

FIGURE 2. Existing versus potential HIV epidemic in Thailand. *Source*: Tim Brown, Director, East-West Center, University of Hawaii, United States, 2003.

Political leadership and strategic vision

In 1991 the then Prime Minister, Mr Anand Panyarachun, was concerned about the growing HIV rate in the country. On the advice of Mr Mechai Viravidya, the head of a family planning and AIDS NGO, and the so-called "condom king of Thailand", the National AIDS Prevention and Control Committee was established in the Office of the Prime Minister (see Panyarachun 2003). Since then, the Thai Government has increased its budgetary allocation for HIV prevention from $2.6 million in 1990 to $80 million in 1996. This trend of increasing budgetary allocations continued until the time of the devastating 1997 Asian financial crisis. The government feels that its support creates society-wide benefits in addition to helping people living with HIV/AIDS.

Transparency

Although HIV/AIDS was a difficult issue for the government to deal with, it acknowledged the practices that were fuelling the epidemic: sex work, injecting drug use, and the trafficking of children and women. Acknowledging the facts was the first step in finding ways to mitigate their HIV-related impact. The government's openness in dealing with the factors contributing to the people's HIV vulnerability created an enabling environment for HIV-prevention programmes to be implemented successfully. Promotion of condom use with free distribution to brothels and government clinics not only enabled increased condom use by a population at risk, but also resulted in an actual decrease in HIV prevalence among sex workers from 50% in 1991 to less than 10% in 2001, according to the Ministry of Public Health.

Multisectoral involvement through participation, access to information, and services

Thailand adopted a multi-level and multi-pronged strategy for HIV prevention. Not only was the government involved, but also more than 150 NGOs, private sector businesses and networks of people living with HIV and AIDS. Together they collaborated to promote the use of condoms and HIV-preventive education in ways easily acceptable to the general public and young people. The education and religious sectors worked closely with the people in communities to reduce risky behaviour and to improve people's understanding and compassion for people living with HIV and AIDS and their families. Civil society made critical contributions in mounting an expanded national response to HIV and AIDS ranging from HIV and AIDS awareness to care and support activities. The government's budgetary allocation to NGOs for HIV and AIDS responses in 1992 was $480,000; by 1996 it had reached $3.2 million. The mass-media sector supported nationwide awareness-raising campaigns on television and in newspapers, changing the focus from an orientation towards fear to one that provided information about how HIV is spread and what people could do to protect themselves. Teachers and parents, young people in schools and peer-educators in the workplace were mobilized to provide HIV-preventive education to co-workers in order to stop the spread of HIV. Thailand mobilized its provincial administration, health and criminal justice authorities, health workers, owners and managers of sex establishments, as well as sex workers and their clients. People's participation clearly contributed to Thailand's effective responses.

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A demonstration for better and cheaper treatment for AIDS outside an international AIDS conference held in Bangkok, July 2004. AFP

Protecting the rights of people living with HIV/AIDS

The Thai Government practises what it preaches by upholding the rights of people living with HIV and AIDS and protecting them against discrimination. It blocked a legislative proposal that would have restricted their rights, stopped prevention campaigns that stigmatized people living with HIV and AIDS and lifted a ban on the entry to Thailand of foreign nationals known to have HIV and AIDS.

Supporting people's livelihoods and enabling their access to treatment

Mr Mechai proposed establishing the Positive Partnerships Fund for people living with and affected by HIV and AIDS. This Fund enables such people to generate income by providing credit so they can earn enough money to buy their daily medicine (costing 40 baht or approximately $1US). The Fund has proven to be effective, with a repayment rate of 95%. It is an innovative approach at the individual level; it addresses people's basic needs and creates access to treatment. The government continues its prevention and treatment access efforts by providing ARVs to pregnant women in order to reduce the mother-to-child transmission of HIV. It further extends ARVs to post-partum HIV-positive mothers, which improves their chances for a more normal lifespan, thus indirectly prolonging the life and health of the newborn children.

Timing

The efforts by the Thai Government were made at a critical point in its HIV epidemic and thus contributed to keeping it in check. Unfortu-

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nately, however, the Thai Government has been slow in responding to the transmission of HIV through the injection of illicit drugs. The case of drug users is an example of the need for countries to cut through administrative boundaries to enhance multisectoral collaboration in responding to the HIV and AIDS crisis. It also reflects the need to be in touch with people's concerns by not allowing the bureaucratic structure to become an excuse or a barrier to protecting people's health and well-being.

This situation does not derive from bad will or lack of concern. In practice, the focus of democracies tends to be on the electoral process within a democratic structure. This results in compartmentalization of delegated authorities for different sectoral matters; thus, there could be a lack of coordinated response to drug users between law enforcement and health authorities with regard to HIV and AIDS. In addition, democracy, as practised by many politicians, tends to focus on shorter-term solutions owing to the great attention paid to the electoral cycle. Consequently, many politicians the world over tend to tackle issues in a way that will produce quick, visible solutions; they have little incentive to look for longer-term solutions.

HIV epidemics undermine democratic governance

When HIV prevalence is high[5] in a society, a loss of rank and file personnel will take place in vital sectors as diverse as the military, the civil service, the private sector, the educational system and agriculture. If the governance structure of social systems is disrupted, the potential exists for institutional collapse, which obviously undermines governance (de Waal 2002). Further, because there is as yet no cure for HIV infection, HIV-infected people and their families may lose their "sense of future" with the possibility of an impending death looming over them, influencing their decisions and outlook on life. This lack of a sense of future changes people's priority-setting and influences how they make choices about resource allocation and about their reactions or behaviour. If someone is infected with HIV and a social support system is not in place, he or she might not be able to think for the longer term but will focus on immediate needs only, perhaps thinking, "I am as good as dead anyway". In such circumstances, the constraints of law and order may seem less relevant to the person than would otherwise be the case (de Waal 2002).

The mechanisms for building HIV resilience enhance democratic governance process

There are several concrete examples of countries that have responded to HIV epidemics by building their resilience. The mechanisms they used to build HIV resilience have enhanced their democratic governance processes. An example is Uganda.

The case of Uganda

It is estimated that nearly 2 million Ugandans out of a total population of 22 million are infected with HIV; 67,000 of them are children. There have been approximately 500,000 deaths from AIDS, resulting in 1.7 million orphans. Between 1989 and 1993, the number of sexually active young adults appears to have dropped from 69% to 44% among males and from 74% to 54% among females (UNAIDS 2001).

Uganda's HIV and AIDS responses have come from multiple levels. Although it is one of the world's least developed countries, Uganda has a leader with vision who acted in a timely way to the early warnings of HIV problems facing the population. When a large proportion of Ugandan soldiers who had been sent to Cuba for training were found to have been infected with HIV, the Ugandan leader, realizing the threat that HIV could pose to the country's future, began campaigning for HIV prevention in the late 1980s. Uganda became the first country where a high-level commissioner for AIDS was appointed to develop a comprehensive national strategy and mobilize different sectors for action against HIV and AIDS.

The openness of the country's top leadership in discussing HIV and AIDS enabled the transparency necessary for communities to take action. Such openness provides a favourable environment in which civil society can respond. In fact, much of Uganda's efforts in responding

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to HIV and AIDS came from civil society, including the support of its Muslim religious organizations. The formation of self-support groups is important, particularly for the rural areas where the public sector health services were unable to cope with the ever-increasing burden of AIDS patients.

The movement to build HIV resilience by the people and for the people of Uganda involves partnership with international NGOs and other civil society organizations. Civil society's advocacy at the local and national levels to influence the HIV and AIDS responses reflects elements of the democratic governance process. The quality of service and the role of a constructive partnership with civil society have been positive forces in the country's social control and participation. Through their outreach activities, NGOs play a major role in advocating the rights as well as the responsibilities of people living with HIV or AIDS to speed up government processes, thereby complementing government efforts. Again, insistence on human rights produces positive results in stemming the advance of HIV and AIDS.

The importance of building regional HIV resilience

As activities increasingly take place on a global scale, people are becoming increasingly interdependent. They move more than ever before, and goods are being traded among countries on an unprecedented scale. The disparities in the levels of economic development among neighbouring countries and between urban and rural areas form the "push and pull" factors affecting population movements domestically and internationally. For example, some of the countries and areas that surround the landlocked Lao People's Democratic Republic have high HIV prevalence, namely, Cambodia, Myanmar, and Thailand as well as the Yunnan Province of China. The HIV prevalence in the Lao provinces bordering Myanmar and Thailand is significantly higher than the national average. Yet, this is only part of the picture. The Lao People's Democratic Republic is the hub of regional population movement in the Greater Mekong Sub region (GMS) (du Guerny *et al*. 2000). The strategies that country adopts in responding to HIV can therefore have an important impact on the course of the epidemic inside the country as well as in the GMS.

The UNDP South East Asia HIV and Development Programme, which was established in 1999, forged collaboration with member countries in the Association of South East Asian Nations (ASEAN) in order to build regional HIV resilience. The first step was to ask the participating countries on what issue they wanted the Programme to focus. Each country identified its priorities. After assessing all the priorities, a common regional issue was identified: the linkage between population movement and HIV.

Instead of holding a ceremony to launch the regional Programme, the countries asked UNDP to support them in ascertaining the situation of population mobility and HIV among ASEAN members: Brunei Darussalam, Cambodia, Indonesia, the Lao People's Democratic Republic, Malaysia, Myanmar, the Philippines, Singapore, Thailand, and Vietnam. To ensure "ownership" and to capture concerns about the source, transit points and host communities of mobile populations, a mapping methodology was developed to assess HIV vulnerabilities along the key transit routes (both land and sea). After each country had done its own mapping, the results were combined to give a regional picture (du Guerny *et al*. 2000; Hsu *et al*. 2001).

The mapping exercise did more than show the routes people used in order to move about. It was the beginning of a democratic governance process for the ASEAN region. The key was that people from communities along the main transit routes were the ones who collected, analyzed, and interpreted the data and quickly came up with proposals for action. Central, provincial, and district governments sent staff to participate in the mapping exercise with the local communities. Initially, debates were conducted and recommendations made at the local level. Representatives from each province then transmitted the results to the central level and finally consensus on the findings was reached that reflected the concerns of all the levels.

The solutions thus identified were "owned" by the local communities, that is, by the residents and the local governing officials. The likelihood of the proposed actions being carried out was therefore increased. The results were also more

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sustainable. As the process was initiated locally and involved multiple sectors, there were fewer sectoral barriers and this facilitated multisectoral collaborative responses, e.g., medical officers being able to work with brothels to ensure that sex workers received regular check-ups (du Guerny and Hsu 2003).

Another initiative was started in Cambodia in a partnership between UNDP and FAO in 2000. The aim of this experiment, called the Farmers' Life School, was to help the poorest farmers to design their own way of building HIV resilience. The farmers, previously poverty-stricken and having virtually no alternatives to getting deeper into debt and selling their daughters, created "schools" through which they gained the sense of a better future for themselves and their children (du Guerny *et al*. 2002a). The Farmers' Life School transposes the farmers' analytic thinking about their crops in relation to climate, soil conditions and pests to analysis of the relationship of HIV to their lives. They can thus figure out what they can act on to reduce their vulnerability to HIV and build their resilience.

Today, the Farmers' Life School is being expanded beyond Asia to Africa. In addition to adapting the School to the situation in Zimbabwe, a Junior Farmers' Life School is being pioneered by FAO in Mozambique where, because there are so many absent or missing parents, many youngsters have to take over farming tasks. Thanks to the School, they are now building a life with a future.

Good governance practices at the regional level are also evolving, which is important in view of the scale of mobility in Asia. In 1999, an effort was initiated by the United Nations system to bring together national AIDS authorities, which are represented in the ASEAN Task Force on AIDS, with key regional NGOs in order to find a way to respond to population movement related to HIV vulnerabilities in the region. The ASEAN Task Force on AIDS, with assistance from the United Nations system, recognized the importance of people's participation in developing effective responses that would be supported by their constituents. A consultative process began whereby in each country, NGOs and groups of people living with HIV or AIDS participated in the deliberations on and the drafting of the Declaration on HIV and AIDS, which was adopted by the Heads of State at the ASEAN Summit in 2001 (du Guerny and Hsu 2002). In this way, ASEAN is an intergovernmental structure functioning as a governmental network regionally.

The emerging regional democratic governance process has had a gradual trickle-down effect to the country level, where it has begun to stimulate the evolution of the democratic governance process at the national and subnational levels. The process has been having an impact on the formulation of HIV policies and strategies, as well as responsive programmes that reflect the needs of the people: in this case, those vulnerable to infection as well as people living with HIV/AIDS. Yet again, the process shows that the essential factor is the recognition by all actors of human rights.

Early warning rapid response system

Despite the importance of democratic governance, the funding decisions of donors concerning the AIDS pandemic seldom consider governance. Learning from the association between rapid economic development and the simultaneous spread of HIV in the region, the countries of South East Asia began a joint effort in 2000 to develop a solution that would be their own: the Early Warning Rapid Response System. In brief, the system examines the development paradigm, focusing on the various aspects that influence background factors conducive to increasing or reducing HIV vulnerabilities. This emerging development paradigm complements, rather than replaces, the health-centred approach.

Furthermore, the system attempts to find ways to capture early information on changes in socio-economic factors that make particular groups and locations vulnerable to HIV. By gathering and analyzing such information and giving appropriate warnings to relevant sectors and groups of people, the system is aimed at triggering rapid responses through development strategies, with the goal of reducing vulnerabilities and building resilience.

The system enables national AIDS programmes, governments, the private sector, civil society, including NGOs and people in communities, to collaborate in taking action to avert or reduce the impact of stressors on people's HIV

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vulnerabilities (Guest *et al*. 2000, 2003; Hsu *et al*. 2004). The emphasis is on action. It is essential to mobilize social action and to invest in supportive social arrangements, including providing access to information, in order to remove the root causes of ill-health, to warn people in advance of what could go wrong (as in the example at the beginning of this article) and mitigate negative socio-economic and health impacts once a crisis does occur.

The purpose of such a mechanism is to stimulate people's creative thinking because each group of people and each sector, community, country, and region must design its own responses, reflecting the insights and considerations of its respective culture, history and local circumstances, using the Early Warning Rapid Response System model as a framework.

It should be noted that the system could also be useful in countries with a high prevalence of HIV and AIDS because a national epidemic comprises a number of different epidemics, which are constantly changing. In such cases, the system can be used to monitor changes in the underlying dynamics and complement the health surveillance system from the early warning side in addition to triggering responsive actions.

The system must operate in the context of the democratic governance process, because the central or top level of a society must learn from the local levels the specificities of a situation. However, because people at the top are outsiders to a grass roots community, their understanding of local circumstances would obviously be limited. Only local people who live through an adverse situation daily have the insights that are needed by people at the central or top level in order to launch an effective response. Combining the central and local two-way flows of communication and collaboration is an effective way to ensure appropriate and effective implementation of plans and programme actions.

It should be emphasized that the Early Warning Rapid Response System is not the same as a regular health-based warning system. It requires triggers of warning based on information from development sectors. The necessity and relevant contribution of the global surveillance and alert system established by the World Health Organization (WHO) for health emergencies were demonstrated in the case of the SARS outbreak. With regard to SARS, responses were multisectoral: immigration, foreign affairs, the transport industry and economic sectors in addition to the health sector were mobilized. The effect was dramatic. The epidemic was contained in a relatively short amount of time.

What was possible for SARS should also be possible for HIV and AIDS; however, the two syndromes cannot be compared as equals. The issue that makes them different is the timeliness of responses. The impact of SARS was immediate. Its rapid spread and high morbidity and mortality rates, which were manifested relatively soon after infection, triggered people and institutions to recognize that the crisis posed a serious and immediate threat to health. Institutions and people can be mobilized to take action urgently in response to an immediate crisis. By contrast, the impact of HIV and AIDS is long-term. While HIV, like SARS, may spread rapidly, it can take years before the symptoms of infection become manifest. As a result, institutions and people cannot be mobilized so easily to take action in response to a crisis that will occur sometime in the ''distant'' future.

Critics have proposed reframing responses to the HIV and AIDS crisis with a full disaster-management response. If HIV and AIDS are officially recognized as a disaster, the thinking goes, appropriate policy actions will be needed as well as the organization of an appropriate management system to tackle the disaster. However, one needs to recognize the two-fold flaw in such a disaster-response management framework: (1) the development of AIDS involves a long-term process and it has a long-term impact – disaster-management systems are normally designed for short, time-limited and geographically limited events under the assumption that the disaster will not last for decades, thus damage can be limited – and (2) the assumption that external assistance is available.

One of the greatest difficulties with the development process and AIDS is the time lag involved. The impact of AIDS is diffuse and thus not immediately observable. The long time it takes before an AIDS crisis is manifest to people and institutions tends to dilute the accountability of the various players. Leaders and institutions tend not to pay attention to warnings about a future crisis or not to respond to such a

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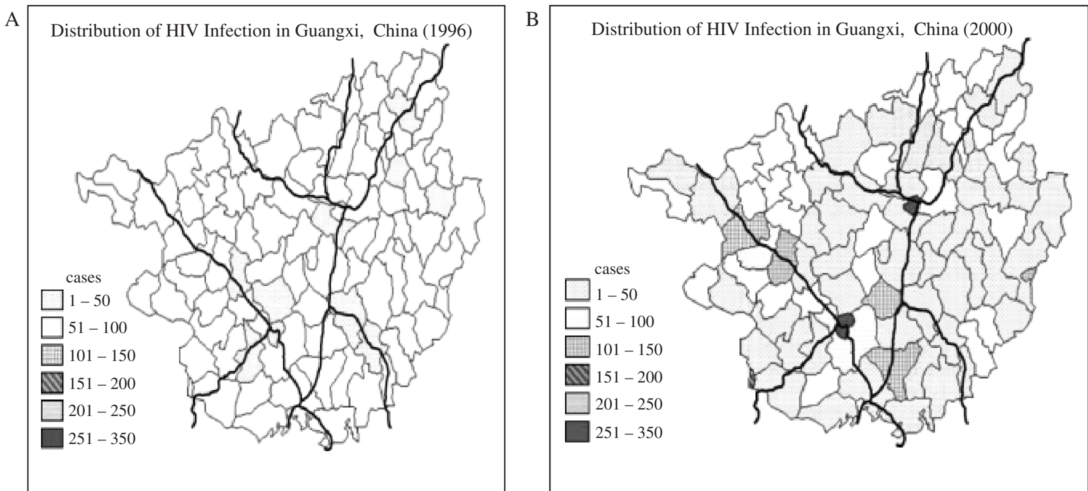

FIGURE 3. Road construction linked to HIV vulnerabilities. *Source*: Guangxi Center for HIV/AIDS Prevention and Control, 2003.

crisis until it is too late. Furthermore, people tend always to have more urgent, immediate problems facing them daily. They do not push their leaders early on to take action that will mitigate the potential impacts of HIV and AIDS, i.e., the trade-off between an immediate sacrifice for a future good versus a present good.

HIV and AIDS demand responsiveness in the democratic governance process. This is why the Early Warning Rapid Response System was developed.

Examples of applying the system

Road construction link to HIV vulnerability

In 1996, Yunnan Province had the highest HIV prevalence in China. Figure 3A shows the HIV prevalence distribution in Guangxi (a province to the east of Yunnan) in that year, which marked the beginning of a road infrastructure-improvement and construction process. The black lines indicate the road network. However, by 2000, when many sections of the key road network were being completed, from the centre of the province outward towards its borders, one can see that HIV was spreading throughout the province, along this network of roads, as shown in Fig. 3B.

This provides a powerful example of the potential impact that development activities may have on the spread of an HIV epidemic. One of the many functions of the Early Warning Rapid Response System is to bring together, early on, the economic development and planning sectors in the process of developing HIV resilience. Several years before construction actually takes place, the planning sector draws up infrastructure plans; then, several years pass while the roads are being built. However, getting such planning information from the planning sector to the communities that will be affected by the road construction projects enables people at the local level to benefit from the foreknowledge – the ‘‘early warning’’ part of the system. By being warned early on, people have the time necessary to analyse the potential implications: both the opportunities and the potential stresses. People’s analysis would enable them to determine whether it is necessary to take action in order to mitigate potential HIV vulnerabilities on the one hand, and to plan their actions in order to grasp the opportunities that are opening up to them, on the other. This is the ‘‘response’’ part of the system. At the heart of the system is the human right of access to information that can mean the difference between life and death.

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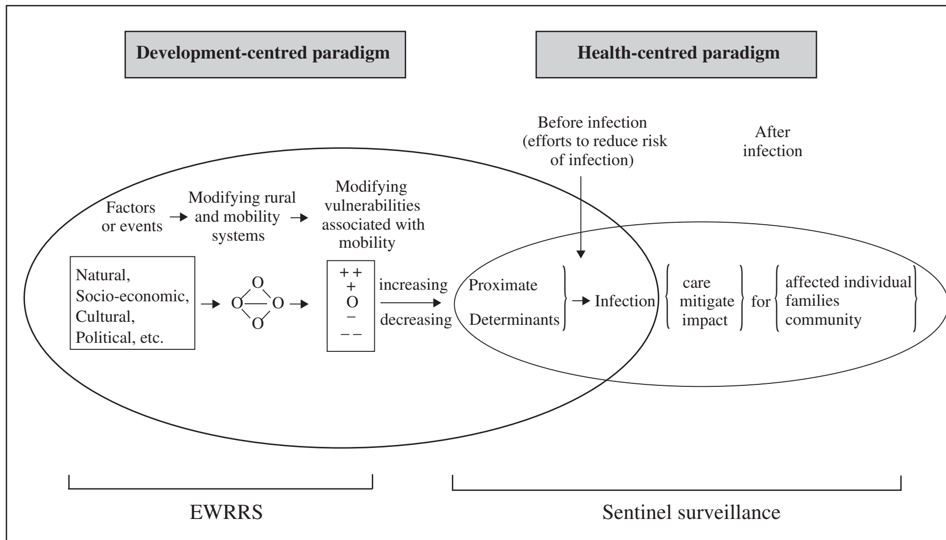

FIGURE 4. Mobility and risk of HIV infection with corresponding focus of surveillance and response systems. *Source*: Prepared by Jacques du Guerny and Lee-Nah Hsu, 2000.

Application of the system by ASEAN

An example of mobilization by the ASEAN region, based on the Early Warning Rapid Response System concept, is described below. Currently, ASEAN member countries are working to complete the construction or upgrading of the regional ASEAN Highway Network. ASEAN member countries now have heightened awareness of the fact that where roads are built, linking points of high and low HIV prevalence, the spread of HIV correspondingly increases along those newly established routes (Hsu 2001). As a result of advocacy by the United Nations system, the ASEAN countries adopted a recommendation known as the Chiang Rai Recommendation, whereby infrastructure construction project contractors are required to include HIV-prevention programmes for their workers and the surrounding communities in their plans as a pre-condition for bidding (du Guerny and Hsu 2002). To further strengthen the implementation of the Chiang Rai Recommendation, these countries also agreed the Bangkok Recommendation in 2003 whereby the infrastructure construction contractors have the options of either conducting an HIV impact assessment and designing an HIV prevention programme for the construction team and surrounding communities, or allocating 1% of the total construction budget for an HIV prevention programme.

The ASEAN case illustrates how the Early Warning Rapid Response System for building HIV resilience examines the development paradigm, focusing on the root causes that influence background conditions conducive to increasing or reducing HIV vulnerabilities. It is most important to keep in mind that people's responses to prevention efforts are not just the result of awareness creation; the contextual mediators of risky behaviour must also be addressed as must the ability of people to obtain the information and the means to protect themselves. The development paradigm is therefore complementary to the health paradigm; the inter-relatedness of the two paradigms is shown in Fig. 4.

A democratic governance system cannot be implemented overnight. Each country has to proceed at its own pace because each has a different way of working and none is starting at the same point, culturally or historically. However, a regional culture of democratic governance can speed up implementation of democratic govern-

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ance processes in the countries of a region through peer pressure and mutual learning exchange.

The practice of democratic governance has limits when dealing with HIV and AIDS: the short-term framework of politicians, based on election cycles and the compartmentalization of responses for quick, visible results to appease constituents, runs contrary to the mechanisms for building HIV resilience. The latter require long-term perspectives with timely responses and multisectoral actions. Further, to build HIV resilience through the lens of democratic governance is not cost-free. Although the process does not need new, additional resources, it does involve re-orienting the allocation of existing resources. Donors need also to support regional responses, which provide an essential dimension to national programmes in attempting to halt the spread of HIV internationally. Because HIV recognizes no borders as it spreads, it is critical to provide technical and financial resources to build regional HIV resilience in areas affected by the virus. Further, donor countries should be proactive and expand their aid framework for HIV and AIDS beyond the current focus on health or medical concerns towards a development framework through which support could be given for responses by various development sectors, including agriculture, construction, transport and defence, among others, in addition to the education and health sectors.

Because HIV and AIDS are threatening the future of humanity, action at various levels could help to reverse the devolution process by incorporating democratic governance principles in HIV and AIDS responses. The Early Warning Rapid Response System could be refined and expanded from local communities to provinces as well as to the national and regional levels. It is critical to ensure the application of democratic governance principles and multisectoral collaboration in the early detection of events that could signal conditions favourable to the spread of HIV and AIDS. In particular, ways should be found to reduce institutional inertia and political interest group barriers, thus ensuring that warnings would result in timely responses.

Development is sustainable only when the people affected by it participate in the process and when human elements are taken into consideration. Human development implies giving choices equally to people living with HIV and AIDS, so that they could have the means to live as long and as free of symptoms as possible. It also means that both men and women should have access to HIV and AIDS prevention information and treatment.

The long-term socio-economic effects of the HIV and AIDS pandemic are immense: the world's worst global pandemic in 600 years is in some places threatening the sovereignty of countries and in others unravelling decades of progress made in poverty reduction. Wherever it exists, it is reversing improvements in people's living standards, life expectancy, and security.

In the face of the further devastation that is projected to result from AIDS, can anyone afford to be complacent? Can anyone let go of the hard-won economic and human development achievements of the past two decades? Can we shrug off the millions of people suffering and dying from AIDS? Not if we really believe in human rights, and not if we dare to apply the principles of democratic governance to enable people to build HIV-resilient societies. This long-term approach could make a critical contribution to reversing the relentlessly expanding trend of the HIV and AIDS pandemic. It demands consideration.

Notes

1. Democratic governance can help build human capital and social cohesion more effectively than other approaches. However, this does not mean that authoritarian approaches, whether religious or dictatorial, do not work. Effective leadership plays an essential role in ensuring security, as will be seen in subsequent country case studies. Also, in the more democratic societies, there is often greater public awareness of HIV and AIDS, which can result in greater pressure from the people for effective government responses to the epidemic, as well as grass-roots and collective action in areas too

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sensitive for governmental measures. Indeed, in such societies, HIV and AIDS can become an election issue, on which the people expect and demand action.

2. As Becker (1990) notes: "... the patterns of HIV infection across Africa strongly suggest that AIDS is a 'disease of development', in which colonially inherited patterns of labour utilization such as temporary labour migration coupled with high levels of poverty in rural and urban areas and economic stagnation, all of which put women into temporary relationships with men; in which economic support is bartered for sexual favours [thereby] exacerbating the situation. In short, both early capitalist development and the stagnation of the past 15 years have contributed to a social structure in many areas ideal for the spread of HIV".

3. The epidemic had been expected to become one of the world's worst. In 1994, the World Bank projected a population of 1.2 million Brazilians living with HIV and AIDS by 2000. In fact, the number infected by 2000 was less than half that projection. See Rosenberg (2001).

4. Author's personal communication with Ministry of Health, Brazil, in the early 1990s while working with the government on HIV and AIDS prevention and care.

5. Low $<1\%$, medium 1–10%, high $>10\%$. However, for countries with a large population size, such as India and China, less than 1% prevalence still entails millions of infected people. Percentages to gauge the low, medium and high prevalence of HIV needs to be used in the proper context.

References

Becker, C. M. 1990. "The demo-economic impact of the AIDS pandemic in sub-Saharan Africa", *World Development*, 18(12), 1605.

de Waal, A. 2002. Modeling the governance implications of the HIV/AIDS pandemic in Africa: first thoughts, June, from Justice Africa. http://www.justiceafrica.org/governance_implications.htm.

de Waal, A. The links between HIV/AIDS and democratic governance in Africa. A paper adapted from presentations at Justice Africa, 30 October, and the Oslo Governance Centre, 3 November.

du Guerny, J., Chamberlain, J. R., and Hsu, L. N. 2000. *From AIDS epidemics to an AIDS pandemic: is an HIV/AIDS hub building in South East Asia?* Bangkok: UNDP South East Asia HIV and Development Programme. http://www.hiv-development.org/publications/epidemics%20Pandemic.htm.

du Guerny, J., and Hsu, L. N. 2002. *Towards borderless strategies against HIV/AIDS*. Bangkok: UNDP South East Asia HIV and Development Programme. http://www.hiv-development.org/publications/borderless-strategies.htm.

du Guerny, J., Hsu, L. N., and Chhitna, S. 2002a. *The Development Strategy to Empower Rural Farmers and Prevent HIV* January. http://www.hiv-development.org/publications/HESA.htm.

du Guerny, J., Hsu, L. -N., Rodolph, M., Wei, L., and Shaoji, Z. *et al*. 2002b. *Introducing governance into HIV/AIDS programmes: People's Republic of China, Lao PDR and Viet Nam*. Bangkok: UNDP South East Asia HIV and Development Programme. http://www.hiv-development.org/publications/introducing-Governance.htm.

du Guerny, J., and Hsu, L. N. Crossing national and sectoral boundaries in HIV/AIDS strategies – experiences from South-East Asia. *In*: *Sexual Health Exchange 2002/3*. http://www.hiv-development.org/text/publications/Crossing_Boundaries.pdf.

du Guerny, J., Hsu, L. N., and Hong, C. 2003. *Population movement and HIV/AIDS: The case of Ruili, Yunnan, China*. Bangkok: UNDP South East Asia HIV and Development Programme. http://www.hiv-development.org/publications/Ruili_Model.htm.

Giang, L. M. 2004. The irony of agency in space: Displacement and vulnerability in two highways in Viet Nam. A paper presented at the CICRED/UNDP South East Asia HIV and Development Programme Workshop on Inter-relations between Development, Spatial Mobility and HIV/AIDS: Contribution to Policies and Programmes against HIV/AIDS, 1–3 September, Paris. *In: Development, spatial mobility and HIV/AIDS:* a joint publication of UNDP-SEAHIV and CICRED, December. http://www.hiv-development.org/publications/spatial_mobility.htm.

Gordon, D., *et al*. 2000. The global infectious disease threat and its implications for the United States, NIE 99-17-D, National Intelligence Council, Central Intelligence

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Agency, January. http://www.cia.gov/cia/publications/nie/report/nie99-17d.html accessed on 18 March 2002.

Guest, P., du Guerny, J., and Hsu, L. N. 2000. *Early warning rapid response system: HIV vulnerability caused by mobility related to development*. Bangkok: UNDP South East Asia HIV and Development Programme. http://www.hiv-development.org/publications/ewrs.htm.

Guest, P., du Guerny, J., and Hsu, L. N. 2003. *From early warning to development sector responses against HIV/AIDS epidemics: A summary of two early warning rapid response system workshops, 13–14 June 2002, Thailand and 16 October 2002, China*. Bangkok: UNDP South East Asia HIV and Development Programme. http://www.hiv-development.org/publications/ewdsr.htm.

Hsu, L. N. 2001. *Building an alliance with transport sector in HIV vulnerability reduction*. Bangkok: UNDP South East Asia HIV and Development Programme. http://www.hiv-development.org/publications/building.htm.

Hsu, L. N., Tia, P., and Phimphachanh, C. *et al*. 2001. *The impacts of mapping assessments on population movement and HIV vulnerability in South East Asia*. Bangkok: UNDP South East Asia HIV and Development Programme. http://www.hiv-evelopment.org/publications/mapping.htm.

Hsu, L. N., Du Guerny, J., and Guest, P. 2004. *A manual for early warning and rapid response systems for HIV/AIDS*. Bangkok: UNDP South East Asia HIV and Development Programme. http://www.hiv-development.org/publications/ewrrs_manual. htm.

Panyarachun, A. 2003. Leadership in fighting HIV/AIDS. Presentation at the South-East Asia Chiefs of Mission Conference on HIV/AIDS, Bangkok, Thailand, 30 June.

Rosenberg, T. 2001. Look at Brazil, *The New York Times*, 28 January.

Skeldon, R. 2000. *Population mobility and HIV vulnerability in South East Asia: An assessment and analysis*. Bangkok: UNDP South East Asia HIV and Development Programme. http://www.hiv-development.org/publications/strategy.htm.

Teixeira, P. R., Vitoria, M. A., and Barcarolo, J. 2003. The Brazilian experience in providing universal access to antiretroviral therapy. *In*: *Economics of AIDS and access to HIV/AIDS care in developing countries: Issues and challenges* (section 1, chapter 2) ANRS, 25 June, pp. 69–88.

UNAIDS, 2001. Reaching out, scaling up: Eight case studies of home and community care for and by people with HIV/AIDS. *In*: *UNAIDS Case Study*, September.

UNDP, 1999. Governance for sustainable development. *In*: UNDP Policy Document 1999. New York: United Nations Development Programme.

United Nations, 2003. Human security now. *In*: *Report of the Commission on Human Security* (chapter 3). United Nations Commission on Human Security. 1 May.

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