



**ashm**  
Australasian Society for HIV Medicine Inc

## **Submission to AusAID's HIV/AIDS and Development Policy Review**

February 27, 2004

### **AUSTRALASIAN SOCIETY FOR HIV MEDICINE**

ASHM is a peak body of medical experts concerned with the care and treatment of HIV infected individuals. Over 20 years the organisation has built expertise in training and education, policy development and supporting health mechanisms for people living with HIV/AIDS. The organisation is concerned with administering these processes appropriately and ethically, focussing on primary care mechanisms. We believe that ASHM's expertise, developed and nurtured within the Australian health care system and with government funding, is being overlooked in the present AusAID system of contracts which currently excludes special expertise such as ASHM's. Yet the very skills required to support foreign aid are present and ready for collaborative use.

ASHM acknowledges the long-standing contribution of the Australia government, through AusAID, to combating the HIV epidemic within its international sphere of influence and acknowledges the achievements through this involvement. We look forward to enjoying constructive collaborative relationships with AusAID as it moves to include treatment in its programs.

ASHM believes that dealing rapidly and comprehensively with the HIV/AIDS epidemic in developing countries is closely linked to important health and development outcomes. The HIV epidemic has proven to have a significant and devastating impact on the social and economic resources in countries where the fundamentals of health care have not been addressed. Given that the epidemic is growing at a rapid rate in many countries in the Asia Pacific, addressing key issues as soon as possible can have a profound impact on future development. This is of particular importance today in Indonesia, PNG and India where epidemiological evidence suggests a rapidly expanding epidemic.

We believe that giving effective support to developing countries is not only in Australia's interests – in terms of promoting greater economic and political security in the region – but that it is also a moral obligation. Australia's international obligations in responding to the epidemic are also established through the United Nations Special Session on HIV/AIDS (UNGASS) *Declaration of Commitment on HIV/AIDS* (2001) and the Millennium Development Goals adopted by the UN in 2000.

ASHM's membership has voiced a collective wish to participate in the transfer to regional countries of the benefits of experience with HIV/AIDS treatment, management and care in Australia. The sectors that support HIV health care, management and education are acutely aware of the successes and lessons from the Australian response, and the need to contribute internationally. This is true on a clinical level, as well as many others. For instance, the developed world has come to understand the complex nature of many of the toxicities that are incurred with use of the current antiretroviral drugs (peripheral neuropathy and lipodystrophy and lipoatrophy) and Australia has led the way in this area. It is critical that clinicians and scientists be able to impart this knowledge to their colleagues in resource-poor countries in an attempt to prevent toxicities.

However, the mechanisms and sources of funding available for this transfer of experience are unclear or not present.

There are three main areas on which we want to comment at this stage.

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## 1. Training

As the peak organisation providing HIV prescriber training in Australia, one of our concerns is what happens once antiretroviral drugs for HIV/AIDS treatment are available in resource-poor countries. There is a need for the maximum support possible to manage the effective introduction of these treatments. Experience currently exists in Australia, and can be further developed, to contribute in this area.

Numerous treatment programs worldwide have shown that it is possible to navigate successfully through the problems posed by complex regimens and adherence in resource-poor settings. Once daily and single-dose regimens make this easier, although such drug combinations are often difficult to access in developing countries.

Experience shows that treatment programs in resource-poor settings require a comprehensive approach based on prevention linked to treatment, care and support.

- Prevention has been the major focus of many AusAID HIV/AIDS projects. With the advent of treatment in recipient countries, prevention remains an important goal and evidence shows that prevention efforts are in fact strengthened when linked to care and treatment programs. Prevention programs have been implemented with varying success in a number of African and southeast Asian countries. The role of health care workers in prevention should be reinforced.
- Adequate counselling is essential – concerning adherence to treatment regimens, resistance to antiretroviral drugs and drug reactions, etc.
- It is also essential to promote the provision and acceptance of basic care and support through hospitals, clinics, day care centres and home-based care, prevention and harm reduction messages, and community involvement.
- Ethical issues surrounding treatment and care are also essential to address – such as fear, discrimination, and confidentiality.
- All of this necessitates a team approach by healthcare workers in addressing the variety of needs of patients and their families, and maximising the scarce resources available to improve their quality of life.
- From a clinical perspective, promoting better HIV/AIDS treatment and care necessitates looking at issues of testing, laboratory work, treatment of opportunistic infections, as well as antiretroviral therapy and its related issues (resistance, side effects).

In the light of this, and with the increasing possibility of treatments being available, we believe that AusAID needs to think very carefully about the principles behind the training that is provided through its programs, and the policies on training that it promotes. We also believe that AusAID should reconsider how it engages Australian experience in responding to an epidemic as complex as HIV/AIDS.

HIV medicine as a specialty is not very old even in developed countries, and those moving into this area in the developing world face significantly more challenges. Providing one-off clinical short courses is unlikely to provide the technical skills and attitudinal change needed. Updating knowledge on a regular basis is also essential to ensure that practitioners are aware of new trends in treatment and any changes in the epidemic, such as the development of viral resistance to HIV/AIDS treatments. In a number of countries it may be just as useful, or more useful, to focus on on-the-job training, mentoring or rotation to increase skills and experience. We believe that training of healthcare workers needs to include an emphasis on prevention linked to care and treatment. It should include issues surrounding adherence, the necessity for a team approach, and sessions focussed on ethical issues. Training needs to include the active participation of people living with HIV/AIDS.

In terms of developing future training programs, there are numerous resources which can be drawn on internationally – including training manuals and policy documents being developed through the World Health Organisation's 3 x 5 initiative. At a minimum AusAID should facilitate the provision of such material which will aid countries in devising and implementing locally appropriate programs.

ASHM has produced a range of comprehensive resources on clinical management through funding from the Commonwealth Department of Health and Ageing, many of which could immediately or potentially be of use internationally. We receive constant requests for copies from those in the region. We are already re-packaging some of this material for the AusAID National HIV/AIDS Support Project in PNG. We are interested in looking at other ways of doing this for other countries.

One of the problems that ASHM has encountered in attempting to contribute more in this area is the difficulty of attracting a funding base. Traditionally, HIV/AIDS activities funded through the Department of Health and Ageing have had to be exclusively conducted within Australia – although as a result of the recent reviews of the national strategy there may now be more opportunities for support for international activities. In addition, the tendering process for AusAID projects severely limits the degree to which important sections of the Australian HIV/AIDS sector can be consistently and comprehensively involved.

Individuals or organisations from within the sector are approached to be part of one tender – and are thus tied into a competitive process. Unfortunately, those preparing tenders do not always have good knowledge of the sector, and appropriate individuals and organisations may be overlooked. Expertise is often structured into projects through longer-term positions, or via short-term consultants (employed on an individual basis). This negates utilising the repository of institutional knowledge that has been built up over the years of the response to the epidemic in Australia – including the formation of organisations for people living with HIV/AIDS, national research centres, and the peak professional organisation for clinicians (ASHM). We would like to see a restructuring of the tendering process to include more involvement of these organisations across the board.

ASHM supports the principle of local control over training programs being implemented. We also support maximising the benefit to other countries of Australian expertise in HIV/AIDS treatment and care. But we recognise that it is vital to be mindful of the chasm between the conditions under which treatment and care occurs in Australia, compared to developing countries. As such, the exchange which is possible by using Australian expertise in training programs is of potential benefit in terms of learning for both local participants and Australian participants. The latter has the potential flow-on benefit of building up Australian expertise in how to sensitively, appropriately and collaboratively assist the transfer the knowledge which has been built up over the last two decades. This is urgent given that many southeast Asian epidemics are now on the same trajectory as sub-Saharan epidemics were 15 years ago.

However, Australia has little experience in how to implement this through its aid program. An approach needs to be carefully developed in consultation with key stakeholders. We would support AusAID setting out principles on which training would be conducted, and on the basis of which Australian expertise would be used. We also believe that there is a need for careful monitoring and evaluation of all programs that are implemented, in order to maximise cross-fertilisation and the lessons learnt.

We feel that there needs to be more provision for the transfer of clinical knowledge. While many Australian-based clinicians will be unable to take up longer-term contracts, many are able and willing to undertake short-term placements – to conduct advisory, training or mentoring roles. ASHM has an extensive database and intimate knowledge of clinicians with overseas experience or interest in the area, and with experience in training. If given some institutional support, ASHM could further develop this resource and advise on appropriate clinicians and trainers for such work.

In addition, ASHM already has considerable resources in terms of clinical and training experience which may be of use in particular instances. Over recent years we have established an international sub-group of the ASHM board, and interest groups within our membership on international issues and PNG in particular. We have many members who already have extensive experience overseas, and others who are interested in participating.

Within our secretariat there is also significant experience. Our Education and International Programs Manager has 10 years experience in managing development projects in south-east Asia, was team leader for the AusAID Indonesia HIV/AIDS and STD Prevention and Care Project review of the Indonesian National AIDS Committee and National AIDS Committee Secretariat in 2002, and was lead consultant on the development of the Indonesian National HIV/AIDS Strategy 2003-2007. The Executive Officer visited PNG in 2003 for an ASHM project to strengthen the capacity of HIV/AIDS health care worker teams. Our Senior Education Projects Officer has a PhD in politics and international relations, and considerable experience in fieldwork research and community education programs in South Africa, Indonesia and Mauritius.

We have established an international stream at our annual conference, and have received AusAID funding for overseas delegates to attend this conference – and an associated short course in HIV medicine. Delegates also attended a laboratory seminar and a symposium on NeuroAIDS. Through the National Reference Laboratory our members are already involved in WHO-supported programs of quality assurance in

laboratories in the region and have significant experience to offer in this difficult (and sometimes neglected) area. The Asia Pacific NeuroAIDS Consortium is a collaboration which was initiated by ASHM members, and has continued over the last two years.

AusAID has supported participants from the region to attend our conference and associated seminars over the last two years. This has enriched these aspects of our work, and been beneficial for participants. However, there is currently no provision for institutional support for organisations such as ASHM to conduct these activities. With such support, we would be better able to carry these out in the future. In addition, if funding were made available, we could consider running short-term placements for clinicians from overseas. ASHM has just hosted such a placement for Dr. Evy Yuniastuti, as part of the David Barry Fellowship Scheme, managed by Family Health International.

One of the most important concerns we have with integrating treatments into AusAID's programs is that of sustainability. While projects are time-limited, there are frameworks that can be established to encourage this. For instance, one of the most important things that ASHM has to offer is ongoing collaboration between healthcare workers in the region via our annual conference, our resources and various formal and informal networks within our membership. We would like to be able to develop this further in future – as those who we have worked with so far have found this incredibly useful.

#### *Recommendations:*

1. That AusAID develop HIV/AIDS training guidelines to apply across its programs – based on WHO guidelines, including attitudinal and ethical issues, and adequate monitoring and evaluation frameworks.
2. That AusAID consider how to draw on the large amount of individual and institutional knowledge and experience in the HIV sector in Australia– for use in its projects across the board.
3. That AusAID facilitate short-term placements overseas for Australian clinicians to provide advice, training and mentoring.
4. That AusAID facilitate short-term placements in Australia for overseas clinicians to upgrade their skills and knowledge.
5. That AusAID (in collaboration with the Department of Health and Aged Care) consider providing some infrastructure funding to key organisations in the Australian HIV/AIDS sector for international activities. For example, ASHM could repackage educational materials for use overseas, increase our distribution of these materials, develop email networks, develop our website as a resource base for international programs, further develop our database of Australians in the sector with experience or interest in international activities, etc.
6. That AusAID facilitate the provision of WHO and other educational and training materials to its projects, including ensuring safe passage into country.
7. That AusAID (in collaboration with the Department of Health and Aged Care) consider funding training programs in Australia to build capacity to contribute internationally. This could include programs for healthcare workers who require basic HIV training, healthcare workers (with HIV experience) who require project management training, and clinicians who have not yet worked overseas.

## **2. Treatments**

Antiretroviral drug prices in developing countries have declined dramatically in recent years, and much of this is due to the availability of and competition with generics. In the light of this, we still have major concerns with the past and future impact of the TRIPS agreement on access to medicines.

While the agreement at Doha was important in reconfirming the ability of poor countries to make use of compulsory licensing, the actual benefits to such countries are in doubt. Subsequent negotiations and agreements within the WTO have introduced various cumbersome and restrictive conditions on issuing compulsory licenses to allow the import of generic medicines, which will most likely prevent or discourage countries from making use of these provisions. In any case, the impact of these conditions has not been fully tested, and we have concerns about plans to institutionalise them through a permanent amendment to TRIPS this year.

In addition, 2005 is the deadline for countries such as India to become TRIPS-compliant. The impact of this on the supply of generic medicines for other countries is potentially significant, even for those with domestic manufacturing capacity (as many are reliant on India for active constituents).

We believe that AusAID should fund treatment programs, but on the basis that all programs purchase and use the most affordable and sustainable drugs available that can be prescribed and used to follow as closely as possible the current international HIV treatment guidelines – including generic medicines. After coming under pressure, the Global Fund to Fight AIDS, Tuberculosis and Malaria now includes generic medicines in its programs. Australia should follow suit.

We believe that the Australian government should pursue all avenues possible in WTO negotiations to facilitate conditions which make it easier for countries to make use of compulsory licensing, and provide technical support at country level aimed at maximising their ability to manufacture or import cheaper generics. Meanwhile, the government should encourage the pharmaceutical companies to reduce prices further, and provide cheaper medicines to developing countries on the basis of differential pricing.

From the discussion above, it is clear that this issue concerns a number of different government departments. On this basis, we would be pleased to see a cross-sectoral working group established (Department of Immigration, Multiculturalism and Indigenous Affairs; Department of Health and Aged Care; AusAID; and Department of Foreign Affairs and Trade). However, we believe that it is imperative that such a body include community representation. The concept of partnership has been a cornerstone of the response to the complexities of HIV/AIDS in Australia – and there is even more reason for this in considering Australia's international response.

Another important part of the response in Australia has been government support for clinical, epidemiological and social research related to HIV/AIDS. Again, extending such research into the international arena runs into barriers of traditional aid and research funding models. The NH&MRC, for instance, only funds medical and public health research and training throughout Australia. AusAID has traditionally been little involved in research funding. Aside from the possibility that a growing epidemic in the region is likely to impact on Australia (through travel and immigration), there is a moral argument for Australia to contribute to the international research push to facilitate treatment access. Clinical priorities in this area include simpler drug regimens, and developing cheaper and simpler methods of diagnosis and monitoring. Social and behavioural research are also critical in developing and monitoring the success of various programs. The possibility of linking research efforts to AusAID projects is under-utilised. This undermines potential research outcomes and comprehensive evaluation of projects. The starting point for this should be closer involvement with and support of the established national centres in HIV research.

#### *Recommendations:*

1. That AusAID adapt international HIV/AIDS treatment guidelines to apply across its programs, which include an imperative to purchase and use the most affordable and sustainable drugs available – including generic medicines.
2. That the cross-sectoral working group (DIMIA, DoHA, AusAUD and DFAT) include community representation and consider the impact of trade negotiations on access to such medicines.
3. That clinical and social research efforts be incorporated into AusAID programs.

### **3. Global Fund**

Finally, we welcome Australia's contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria of AUD\$25 million over three years (AUD\$8.3 million per year). However, an economy the size of Australia should be contributing US\$25 million (AUD\$31 million) for 2004 *alone*.<sup>\*</sup> In addition, we believe that Australia's commitment to the fund should be on top of its existing aid commitment.

The Australian government has previously cited a "wait-and-see" approach and concerns that the fund would not prioritise the Asia Pacific region as reasons for not contributing. However, over three rounds and initial two-year phases for grants, the Global Fund has committed US\$ 391 million to the Asia Pacific Region. Over the full five-year terms of these countries' programs the Global Fund has committed US\$ 1 billion. About 20% of Global Fund resources go to the Asia-Pacific region. The fund has already contributed above and

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<sup>\*</sup> Based on the Equitable Contributions Framework. [www.aidspace.org](http://www.aidspace.org)

beyond the capacity of any one country's aid program. Beyond its perceived interests in the Asia Pacific region, Australia would be contributing to the global response to the epidemic by contributing to the fund.

The fund has provided much-needed hope to countries struggling to respond to the epidemic. It has proven to be an effective means of distributing funds to countries outside of bilateral aid programs. Even where initial applications are not successful, the process of submitting, revising and re-submitting proposals builds skills and capacity in many countries. The fund encourages international collaboration in setting up the in-country infrastructure needed to implement treatment programs. The fund is already allocating grants to supply antiretroviral drugs (in countries such as Thailand, for instance). While treatments will need to form part of Australia's future bilateral aid program, the fund is another mechanism for achieving this which already has experience in the area.

However, the fund relies on significant donations to give the process the best possible chance of succeeding. Major shortfalls in funding have consistently threatened the future prospects of the fund, and countries like Australia could play an important role in leading the process with significant and ongoing contributions.

*Recommendations:*

1. Australia should work collaboratively with infrastructures being set up through the Global Fund process, and fund bodies with appropriate expertise to participate in these.
2. Australia should contribute to the Global Fund in line with the proportion recommended for Australia by the Equitable Contributions Framework.
3. This contribution should be on top of the existing aid commitment – as a special response to its international obligations (as established by UNGASS and the adoption of the Millennium Development Goals).

**Conclusion**

ASHM welcomes the opportunity to participate in this review and would like to continue to be involved in ongoing consultation and implementation.

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