

**RE-APPLYING THE AUSTRALIAN
RESPONSE TO AIDS**

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I INTRODUCTION

After the dust had settled following the outbreak of HIV/AIDS in the 1980s, it became clear that Australia had managed to escape the phenomenal levels of HIV infection, social tension and discrimination experienced in comparable developed countries.

Australia's unique response to HIV/AIDS meant that the peak number of HIV diagnoses in Australia peaked in 1984,¹ while countries with a contrasting approach such as the United States saw a continual increase throughout the 1980s. By the end of the 1980s, around 10,000 Australians had been diagnosed with HIV, compared to around 650,000–900,000 Americans.² Today, the figures still show the prevalence of HIV in Australia is about one sixth of that in the US, and one third of that of Canada and France.³ The figures are much worse in developing countries, and stigma and discrimination are also highly problematic. It is not clear how effective Australia's response to AIDS in the 1980s would be when applied to a developing country, or how such an approach might be made to work in such a different social and economic setting. In this paper, I will discuss the details of the Australian approach, why it helped, how it transpired, and how it could be applied in a radically different context, specifically in Papua New Guinea. Specifically I will look at the roles of community mobilisation and the primary protection of human rights.

At the heart of the matter is the concern for the state of physical, mental and social well-being, and the implied right to have a safe and satisfying sexual life.⁴ A response to HIV/AIDS that considers these rights as non-negotiable is eventually more effective not just in stemming the spread of the virus, but also in protecting the rights of people living with HIV or AIDS, their families and friends, and all members of high risk groups.

¹Commonwealth of Australia, *National HIV/AIDS Strategy Revitalising Australias Response 2005-2008* (2005), 4.

²J Karon et al., 'Prevalence of HIV infection in the United States, 1984 to 1992' (1996) 2762 *the journal of the American Medical Association* 126.

³Commonwealth of Australia, *National HIV/AIDS Strategy Revitalising Australias Response 2005-2008* (2005), 4.

⁴United Nations, *Report of the International Conference on Population and Development* (1995).

II THE AUSTRALIAN RESPONSE TO AIDS

A particularly stark feature of the emergence of HIV/AIDS in the 1980s was the distinct mood of fear and uncertainty surrounding then what was a fundamentally unknown and unpredictable change. Nobody knew what caused this disease, how it was transmitted or how it could be prevented. Because of the perceived isolation of the disease among primarily homosexual men and drug users, there was a significant temptation to isolate the high-risk groups from the mainstream community and hope for the best. That was what happened in most of the world, that is not what happened in Australia.

A *What Happened in Australia*

By the time AIDS hit the streets of Sydney and Melbourne in the early 1980s, Australia had already developed a genuine social awareness and understanding of issues of human rights.⁵ The social movements in the 1960s, the lessening influence of the church, and the growing recognition of human rights and increased political mobilisation led to the introduction of anti-discrimination law and a move towards decriminalisation of homosexual behaviour in the 1970s,⁶ and throughout the 1980s.⁷ These general movements in the direction of securing universal human rights, predisposed Australian society and its representative Government in a small way to a protective response to AIDS, rather than a regulatory response.

Another helpful prelude was the recent election of a new Government led by the Australian Labor Party. The new Government was already philosophically aligned to centralised political initiatives and a nationally coordinated, preventative and community-based approach to health.⁸

And so it was, that when it became apparent that an epidemic was looming, the Federal Government worked together with the States and Territories⁹

⁵William Bowtell, 'Australias Response to HIV/AIDS 1982-2005' (2005) *Lowy Institute for International Policy*.

⁶Melissa Bull, Susan Pinto, and Paul Wilson, *Homosexual Law Reform in Australia* (1991), 2.

⁷*Ibid*, 2.

⁸William Bowtell, 'Australias Response to HIV/AIDS 1982-2005' (2005) *Lowy Institute for International Policy*.

⁹Who are solely responsible for regulating health in Australia's federal system.

and community groups in developing a nationwide strategy.¹⁰ In the end, it was the mobilisation of the affected groups themselves, in particular homosexual men, that dramatically reduced the rate of new infections.

B *How it Happened*

The coordinated effort was conducted primarily using task-forces and interest groups. The basic concerns of interested groups, ranging from the gay community to the Australian Medical Association were heard and efforts were made to ensure that discrimination, stigma and social conflict were kept to a minimum. The Government indirectly funded culturally relevant advertising and sought innovative ways to deliver effective social education. In the late 1980s, the public education efforts, which had previously focused on high risk groups, redirected itself at the general population. The National Advisory Council on AIDS published and distributed educational booklets, including the *Health Report to the Nation* and *AIDS: The Facts Everyone Should Know* in 1987, and of course the provocative ‘Grim Reaper’ ads. These internationally acclaimed ads brought about a widespread and remarkable change the attitudes of the Australian public,¹¹

Safeguards on the national blood supply were set comparatively early, following the death of four babies in Queensland, who contracted HIV through infected blood transfusions. The States agree to require signed declaration forms from blood donors, and all blood is screened for HIV.¹² Despite continued pressure from doctors, compulsory testing of patients was never introduced, respecting a fundamental right to privacy and showing a deeper commitment to reducing stigma and encouraging voluntary testing. But to address the doctors’ concerns, infection control guidelines for AIDS protection were introduced, with an assertion that ‘there is no reason for health personnel to refuse to treat HIV infected patients.’¹³

In 1988, 6 panels were formed to discuss potential strategies on AIDS-related topics.¹⁴ The panels recommended, among other things, the decriminalisation of homosexuality, prostitution and possession of personal amounts of

¹⁰Gaye Lansdell, ‘What have we achieved? Reviewing AIDS-related law and policy in Australia.’ (1990) 183 *Anglo-American Law Review* 201, 205.

¹¹Ibid, 206.

¹²Ibid, 205.

¹³Ibid, 206.

¹⁴Ibid, 206.

drugs.¹⁵ More widespread education and access to condoms and sterile needles was also recommended. Interestingly, the panels supported an exclusion of HIV+ migrants, and compulsory testing of prisoners, migrants and intravenous drug users.¹⁶

This led to the publication of the Australian Government's first National HIV/AIDS Strategy in 1989.¹⁷

C *Overcoming Political Forces*

The potential for politics to contaminate public health policy is real. Although it was remarkable how much support the Government was able to win in a relatively short time, there were many critics and much media backlash of some of the more controversial aspects of the Government's policies. One such issue was that of the supply of sterile needles to intravenous drug users.¹⁸ Despite being one of the most dramatically successful program in the response to AIDS,¹⁹ there were (and still are) many that believe this is counter-productive to the general response to drug problems in society. In essence, the supply of needles is simply a *harm reduction* effort that should be combined with *supply reduction* and *demand reduction* efforts.²⁰ In fact, it is necessary, as there will always be users who are not able to change their habits, and has been shown to play a helpful role in a response to drug problems. A general understanding of the wider social benefits in reducing AIDS prevalence in injecting drug users very quickly prioritises the need for clean needles over other considerations.

A second contentious issue was that of compulsory testing. A advocate for compulsory testing puts the needs of the society over the rights of high risk groups and people living with HIV. The need to reduce stigma and discrim-

¹⁵Gaye Lansdell, 'What have we achieved? Reviewing AIDS-related law and policy in Australia.' (1990) 183 *Anglo-American Law Review* 201, 206.

¹⁶*Ibid*, 206.

¹⁷Commonwealth of Australia, *National HIV/AIDS Strategy* (1989); See Commonwealth of Australia, *National HIV/AIDS Strategy Revitalising Australias Response 2005-2008* (2005), 9.

¹⁸Gaye Lansdell, 'What have we achieved? Reviewing AIDS-related law and policy in Australia.' (1990) 183 *Anglo-American Law Review* 201, 207.

¹⁹Commonwealth of Australia, *National HIV/AIDS Strategy Revitalising Australias Response 2005-2008* (2005), 4.

²⁰James Magee, *HIV Prevention, Harm Reduction and Injecting Drug Use* (2008) AVERT <<http://www.avert.org/injecting.htm>> at 30 May 2008.

ination is more important, and will still achieve the same effect if stigma and barriers to voluntary testing are eliminated. This was recognised by the Government, which decided to highly recommend voluntary, confidential testing with informed consent and counselling before and after the test.²¹ It was agreed that testing did not in itself represent a solution to the AIDS crisis.²²

Probably one of the most important features of the political landscape for this issue at the time, was that it enjoyed bipartisan support. It could have been particularly distracting for the response to AIDS if some of these contentious issues became political issues, putting political gain ahead of the effectiveness of the AIDS response.

D *Stigma and Compromises*

It is helpful at this point to consider where AIDS stigma comes from, and why it was, and still is, particularly strong in Australian dominant culture. In the confusing and uncertain years as AIDS first came to the public spotlight, it developed some particularly negative images that are still noticeable today. Some of the more abstract negative conceptions of HIV/AIDS include:²³

- as punishment (for immoral behaviour)
- as a crime (in relation to innocent and guilty victims)
- as war (in relation to a virus which need to be fought)
- as horror (in which infected people are demonised and feared)
- as otherness (in which the disease is an affliction of those set apart)

The UNAIDS resource for reducing sigma lists the following causes of stigma:²⁴

²¹Gaye Lansdell, 'What have we achieved? Reviewing AIDS-related law and policy in Australia.' (1990) 183 *Anglo-American Law Review* 201, 208.

²²Ibid, 208, citing D Evans, *Antibody Testing* (1988) Commonwealth Serum Laboratories

²³*Stigma, discrimination and attitudes to HIV and AIDS* (2008) AVERT <<http://www.avert.org/aidsstigma.htm>> at 30 May 2008.

²⁴Joint United Nations Programme on HIV/AIDS, *Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes* (2007).

- Lack of awareness and knowledge of stigma and discrimination and their harmful effects
- Fear of acquiring HIV through everyday contact with infected people
- Linking people with behaviour that is considered improper and immoral

Generally, it appears to be lack of knowledge that drives stigma, but stigma has always been common companion for diseases and epidemics in general.²⁵

The outcomes in terms of managing the prevalence of AIDS can be disastrous. Firstly, it can also discourage preventative action, such as using condoms, because it might give the impression that the person already has AIDS. Secondly, stigma can prevent people at high risk of infection from testing themselves, and thus do not receive treatment and may continue to engage in risky behaviour. Thirdly, stigma can prevent people from seeking treatment, as public knowledge of their condition will have a negative effect on them, and their families. Similarly, there is of course also discrimination that arises out of stigma and problems with under-reporting which can hamper coordinated responses to an epidemic.

Despite the mostly positive approach, the Australian Governments were not able to completely ignore public and media sentiment, and on a number of occasions gave in and enacted regulatory legislation, which was criticised for encouraging AIDS-related stigma.

Transmission of AIDS with knowledge of infection was criminalised in New South Wales, Queensland, South Australia and Victoria, which was seen as a political move that ignored unanimous advice recommending against such an approach.²⁶ This led to Altman describing the mood in Australia as a 'modern-day witch-hunt'.²⁷ In Western Australia, there was a requirement that an HIV infected person inform the driver of any public bus of their condition, and New South Wales required sexual partners to be informed of their HIV+ partner's status.²⁸ Somewhat more shocking was the Queens-

²⁵Michael Kirby, 'AIDS and the law.' (1993) 191 *Commonwealth Law Bulletin* 350–366 January, 351.

²⁶Gaye Lansdell, 'What have we achieved? Reviewing AIDS-related law and policy in Australia.' (1990) 183 *Anglo-American Law Review* 201, 212.

²⁷Ibid, 212 citing D Altman, *AIDS in the Minds of America* (1986), 186.

²⁸Michael Kirby, 'AIDS and the law.' (1993) 191 *Commonwealth Law Bulletin* 350–366 January, 361.

land requirement that blood donors were required to declare homosexuality, not past risky behaviour.²⁹ There does not appear to be any evidence that criminal laws prohibiting HIV transmission are actually effective at preventing HIV transmission.³⁰

Further regulation was enacted, including compulsory testing and segregation in prisons, which could be seen as beneficial for the rights of the prisoners, except that some states did not offer adequate confidentiality protection.³¹

The reactive law criminalising transmission are characterised by Michael Kirby as ‘Highly Inefficient Laws’,³² and contribute instead to stigma and discrimination of people living with AIDS. Certainly, the public pressure that lead to their introduction is evidence of the underlying fear and misinformation surrounding AIDS. In such an environment, confidentiality becomes extremely important and cannot be sacrificed until stigma itself is eradicated.

Certainly, any human rights based approach cannot allow such concessions to be made to the frightened media and general public, at the expense of the rights of people living with HIV/AIDS and at the risk of stigmatisation. It is important for legislators to realise that public health interests do not conflict with human rights,³³ and to ensure that the community is consulted at all stages of a response to HIV/AIDS.³⁴

E *Community mobilisation*

The Australian public were spared from an uncontrollable AIDS epidemic by the very people that were originally blamed for the disease: The homosexual community. It is true to say that to effectively combat AIDS, you have to change people’s private actions. The law has always had very little influence

²⁹ *Transplantation and Anatomy Act Amendment Act (No. 2) 1984* (Qld)

³⁰ Leslie Wolf and Richard Vezina, *Is There a Role for Criminal Law in HIV Prevention?* (2005), 2.

³¹ Gaye Lansdell, ‘What have we achieved? Reviewing AIDS-related law and policy in Australia.’ (1990) 183 *Anglo-American Law Review* 201, 212.

³² Michael Kirby, ‘AIDS and the law.’ (1993) 191 *Commonwealth Law Bulletin* 350–366 January, 353.

³³ United Nations, *HIV/AIDS and Human Rights: International Guidelines* (1998), 10.

³⁴ *Ibid*, 11.

in the bedroom, and widespread social behaviour change has proven to be the single biggest help in reducing the prevalence of HIV/AIDS.

Community mobilisation is a very effective tool in bringing about this required social behaviour change.³⁵ With the involvement of community members (people who have something in common) in the decision-making and action, other people from within the community also become involved and more effective use of human, material and financial resources is eventually achieved.³⁶ This approach is also particularly conducive to a response that is consistent with the protection of human rights, especially those of the community members, as was demonstrated by Australia's involvement of the drug using community.

Australia's success story even addressed general sexual and reproductive health goals, with a 'sex positive' education campaign that may not have eventuated with the involvement of the community.³⁷ Education by peers, using the community's language and images was a more pragmatic approach than an external body would be willing to use. The continuous involvement of people living with AIDS is another vital aspect of any community based approach.

The two key reasons for the success of community mobilisation in Australia were the Government's strong commitment and the experience of the gay community in forming and maintaining political organisations, as it had developed in previous encounters with law reform.³⁸

III PAPUA NEW GUINEA

Despite its close proximity, Papua New Guinea has a very different AIDS problem to Australia. It affects different groups, has a different predominant form of transmission, and faces a completely different set of challenges including economic poverty, education and religious influences.

But despite these differences, there are some fundamental similarities between AIDS in Australia and AIDS in Papua New Guinea, and the success-

³⁵ *Partners in prevention: International case studies of effective health promotion practice in HIV/AIDS* (1998), 5.

³⁶ *Ibid*, 5.

³⁷ Lou McCallum, *Experience From Australia* (1998), 13.

³⁸ *Ibid*, 12.

ful response in Australia with respect to AIDS prevalence and protection of human rights can also be applied in Papua New Guinea, albeit with a no doubt differently natured outcome.

A *The HIV/AIDS Problem in Papua New Guinea*

It is estimated that the current prevalence of HIV in Papua New Guinea is somewhere between 1 and 2.5%.³⁹ Without intervention, HIV prevalence could reach 12.5% by 2025.⁴⁰

In Australia and other developed nations, AIDS disproportionately affects high risk groups (men who have sex with men and drug users), mostly in the cities and HIV transmission is generally through male sex and intravenous drug use. In Papua New Guinea, like other developing nations, AIDS affects the general population, disproportionately affecting the poor in rural areas and the main form of HIV transmission is heterosexual sex.⁴¹

Eighty per cent of the Papua New Guinea population live in rural and remote areas, where AIDS has an astonishing 3% prevalence.⁴² Young people (aged 15–24) also experience a 3% prevalence of AIDS.

Surveys of adult working males show prevalent risky behaviour, including casual sexual partners, inconsistent condom use, anal sex and forced sex.⁴³ A survey of out-of school youth reported high incidence of anal sex (50% in males) and transactional sex (around half males, married females and two-thirds of unmarried females in last year).⁴⁴ The incidence of condom use is concerning: 70% for unmarried male youths, but 29% of unmarried female youths, who happen to be a group reporting more transactional sex.⁴⁵ Approximately half of the sex workers had been tested for AIDS, a staggering 80% of the women reporting a positive result.⁴⁶

³⁹AusAID, *Responding to HIV/AIDS in Papua New Guinea* (2006), 6.

⁴⁰AusAID, *Impacts of HIV/AIDS 20052025 in Papua New Guinea, Indonesia and East Timor* (2006), 8.

⁴¹Joint United Nations Programme on HIV/AIDS, *AIDS epidemic update* (2007), 36.

⁴²Ibid, 24.

⁴³PNG National AIDS Council Secretariat, *UNGASS 2008 Country Progress Report - Papua New Guinea* (2008), 25.

⁴⁴Ibid, 26.

⁴⁵Ibid, 26.

⁴⁶Ibid, 27.

Women in Papua New Guinea are particularly vulnerable to HIV/AIDS. They are disproportionately affected by poverty and problems with access to treatment.⁴⁷ Their socio-economic status forces many women into transactional sex and they are often victims of violence and rape. Young women, without children are unable to refuse sex,⁴⁸ and few women feel they are in a position to demand condom use.

B *What has to happen*

The high rate of HIV transmission is most likely caused by a number of factors. These include the high rate of casual and extramarital sex, lack of consistent condom use and the prevalence of violence. In terms of human rights with respect to reproductive health, it would be desirable to increase the consistent use of condoms, especially for extramarital sex, and to eliminate violence. Doing so would be conducive to the physical and mental well-being and the right to a safe sexual life.

There is no obvious need to reduce the high rate of casual and extramarital sex, as there is nothing medically wrong about this behaviour, and the right to a satisfying sexual life is also an important part of reproductive health.⁴⁹ There is also evidence to suggest that it is beneficial to the social well-being of the men.⁵⁰ It would still be important to ensure that such behaviour is accompanied with a knowledge and understanding of the inherent risks, however whether or not it should be encouraged or discouraged is a moral question (one heavily associated with religion), so long as the right to a satisfying sexual life is maintained. The mental and social well-being of the women must not be forgotten in such a policy, despite the fact that it may be difficult to assess this.

So if the goal is to increase condom use and reduce violence, it should be obvious that social behaviour needs to change. Here is where the parallel to Australia's position in the 1980s (and still today) can be seen. Without condom use, it seems, all societies are and have been vulnerable to HIV

⁴⁷AusAID, *Responding to HIV/AIDS in Papua New Guinea* (2006), 20.

⁴⁸Holly Wardlow, 'Mens Extramarital Sexuality in Rural Papua New Guinea' (2007) 976 *American journal of public health* 1006, 1011.

⁴⁹United Nations, *Report of the International Conference on Population and Development* (1995).

⁵⁰Holly Wardlow, 'Mens Extramarital Sexuality in Rural Papua New Guinea' (2007) 976 *American journal of public health* 1006, 1012.

infection, and all successful responses to HIV/AIDS have involved changing social behaviour and people's use of condoms.

Another important change needs to be the reduction of HIV/AIDS stigma and discrimination, for the sake of the mental and social well-being of those affected. HIV Stigma is particularly strong in Papua New Guinea, affecting both the person living with HIV/AIDS and their family. The Government of Papua New Guinea established rights for people living with HIV/AIDS in the *HIV/AIDS Management and Prevention Act 2003*, but killings and other human rights violations have nevertheless been reported.⁵¹ Another benefit of such a change would be increased willingness to test and with more testing people with HIV are less likely to continue risky behaviour.⁵²

Finally, access to antiretroviral drugs needs to be increased for treatment and also to prevent mother to child transmission.⁵³

C *How this might happen*

1 *Social behaviour change*

Much like in Australia, there is a need for people to change their sexual behaviour and habits, in particular, increasing consistent condom use. It is well recognised that laws cannot regulate what people do in the bedroom,⁵⁴ and Critical Race Theorists would argue that laws cannot instigate social change at all, instead they can at best follow and describe social norms.

Australia achieved its change in social behaviour through a well-organised campaign with the involvement of highly motivated communities. The advertising was communicated in the language and social context of the communities it was targeting, and the involvement of the individual members themselves put social pressure on people to change their behaviour. This initially worked well because only a small group was affected (men who has sex

⁵¹AusAID, *Responding to HIV/AIDS in Papua New Guinea* (2006), 12.

⁵²It is estimated that 60% of people living with HIV (28,000 people at the end of 2006) do not know their status: PNG National AIDS Council Secretariat, *UNGASS 2008 Country Progress Report - Papua New Guinea* (2008), 11.

⁵³AusAID, *Impacts of HIV/AIDS 2005-2025 in Papua New Guinea, Indonesia and East Timor* (2006), 7.

⁵⁴Michael Kirby, 'AIDS and the law.' (1993) 191 *Commonwealth Law Bulletin* 350-366 January, 352.

with men, sex workers). When the risk spread to the broader community, the social change experience was arguably less effective.

Much sexual behaviour in men in Papua New Guinea appears to be defined by social expectations.⁵⁵ Identifying what influences these men, and how they might be persuaded to promote safe sexual practice would be difficult to assess without extensive community involvement. Above all, misconceptions and conflicting concerns of the individuals must be identified and considered.

Secondly, any advertising material must be delivered in a culturally sensitive fashion, that is, in the local language and in a form accessible to illiterate.⁵⁶

2 *Education*

Another reason for the effectiveness of social change in Australia was the high level of education and understanding of the core issues. Basic medical understanding and years of media attention prepared the Australian communities to be more receptive to the required social change. This means, that any effort in community mobilisation needs to be founded, accompanied by and even preceded by effective education campaigns.

In Australia, this education was pre-existing. It took place in schooling, the media, regular visits to qualified doctors and through open discussion with friends and family. Unfortunately, this is not the case in Papua New Guinea. This barrier certainly makes any effort to change social behaviour more difficult, but may only have the effect of delaying the required changes.

Having said that, recent campaigns in Papua New Guinea have provided widespread AIDS awareness, but it was not accompanied by social change.⁵⁷

3 *Access to treatment*

Women and men in rural Papua New Guinea have extremely poor access to health services and treatment for AIDS and sexually transmitted infections. The treatment of infections is a helpful way of reducing the risk of HIV

⁵⁵Holly Wardlow, 'Mens Extramarital Sexuality in Rural Papua New Guinea' (2007) 976 *American journal of public health* 1006.

⁵⁶AusAID, *Responding to HIV/AIDS in Papua New Guinea* (2006), 21.

⁵⁷David Plummer et al., *Evaluation of the PNG National HIV/AIDS Support Project* (2005), xiv.

transmission, as is the treatment of HIV/AIDS itself. Of course, access to treatment helps protect people from the symptoms that make it desirable to avoid AIDS in the first place. Modern antiretroviral medication is generally expensive because of patents held by private companies who are looking to maximise their profits. Even basic health care offers at the very least important information to patients, which may help motivate the person living with HIV/AIDS, their friends and their family to change their own practices and convince others to do the same.

D *Overcoming difficulties*

Papua New Guinea faces a number of problems and conflicts, many of which were not an issue when Australia adopted its approach in the 1980s. They are very much likely to affect the effectiveness of the Australian approach.

1 *The Distributed population*

Unlike the population affected by AIDS in Australia, the vast majority of people infected with HIV in Papua New Guinea are in remote, rural areas. Furthermore, access to mass media such as television, print and the internet⁵⁸ is considerably less. This all makes the community mobilisation approach extremely difficult, as the effort must be repeated for every disconnected community in Papua New Guinea. As with the education problems, the effect may only be to slow down social change, but without considerable resources, it could be quite difficult to overcome this problem.

2 *Missionaries*

Papua New Guinea has long been under the influence of religious missionaries. This has been a mixed blessing for the response to HIV/AIDS, as church-based health services have been extremely helpful, but missionisation is also responsible for fostering a resistance to condom use.⁵⁹ Government and aid have been reliant on church groups to continue to provide

⁵⁸Australia in the 1980s did it without internet, but it would have been a helpful tool.

⁵⁹Holly Wardlow, 'Mens Extramarital Sexuality in Rural Papua New Guinea' (2007) 976 *American journal of public health* 1006, 1012.

the medical help they need,⁶⁰ but doing so compromises the effort to increase condom usage. The widespread cultural acceptance of extramarital sex and the current economic desperation women puts enormous strain on the religious response to AIDS, which promotes solely abstinence and marital fidelity, and discourages condom use. Individual missionaries are often willing to promote condom use, but unable to do so publicly and explicitly.

3 *Politics*

Australia enjoyed remarkable cooperation between the Federal Government and the States, and from both sides of politics on the issue of AIDS in the 1980s. This appears to have been considerably important to its success in such short time frame. However, non-local politics enjoys far less importance and influence in the daily lives of the people in Papua New Guinea, than it does in Australia.

But a complete failure by the Government itself to respond appropriately to HIV/AIDS does have a significant effect. The Papua New Guinea Government did not until recently consider HIV/AIDS to be a core concern, with only 10% of HIV/AIDS response funding coming from the Government of Papua New Guinea.⁶¹ An unwillingness to implement a human rights based approach is difficult to overcome. This can also have a number of subtle effects; for example, there is a distinct lack of people living with AIDS involved in the Government's decision-making process.⁶²

4 *Economic independence*

Foreign aid helps to overcome these economic issues, but it is usually restricted to reducing the eventual economic impact, especially on aid-giving countries. This is not irreconcilable with the protection of human rights, but it does limit its effectiveness. The reliance on existing missionary work also

⁶⁰See eg AusAID, *Responding to HIV/AIDS in Papua New Guinea* (2006) at 7, 8, 9, 11, 13, 16 and 17.

⁶¹David Plummer et al., *Evaluation of the PNG National HIV/AIDS Support Project* (2005), xiii.

⁶²'The absence of people living with HIV in Papua New Guinea's AIDS response is one of its greatest weaknesses' Maura Mean of the NGO *Igat Hope: Joint United Nations Programme on HIV/AIDS*, 'Papua New Guinea strengthens its national AIDS response' (2006) *UNAIDS Feature Stories*

means that foreign aid is limited, so long as the efforts of the missionaries are incorporated into the foreign aid approach.

The fundamental problem with aid-based solutions is that they are most often subject to the interests of others, despite being for the most part helpful. The lack of true economic independence may be a barrier to implementing an exclusively human rights based approach Papua New Guinea. This conflict is seen in the church's aid being subject to a focus on abstinence and the Australian government's focus on the problem to the extent that it is beneficial to Australia.

IV CONCLUSION

Australia's success in the 1980s in its response to HIV/AIDS was due to a very effective campaign resulting in behavioural change. This worked, because it was built on a strong foundation of the public's understanding of health issues and affected groups of people who already openly discussed sex issues. Alongside this was a remarkably successful needle exchange program, which dramatically enabled drug users to avoid unsafe practices.

Papua New Guinea is not so fortunate and will not experience such a quick and dramatic change in the prevalence of HIV and AIDS. But given the prevalence of preventable transmission, much can be done using the same techniques to achieve the required behavioural changes. It seems until recently, little has been done to encourage the change and effectively reduce stigma and discrimination. This may change, as aid efforts are currently emphasising this approach, but problems particularly with remoteness and the influence of the church will make these efforts slow and arduous.

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