Funding Crisis and Trade Agreements Threaten Asia’s AIDS Response

The TREAT Asia Report Interview: Shiba Phurailatpam

Shiba Phurailatpam is the director of the Asia Pacific Network of People Living with HIV/AIDS (APN+). Founded in 1994 by HIV-positive individuals from eight countries, APN+ was established to serve as a collective voice for people living with HIV (PLHIV) in the region. Before joining APN+, Mr. Phurailatpam worked with the UN Development Program and ActionAid International and spent many years fighting for the rights of PLHIV in India.

TREAT Asia Report. What progress has been made in addressing the HIV/AIDS epidemic in Asia and what major challenges are expected for PLHIV in Asia in the future?

Shiba Phurailatpam: Since the 2001 UNGASS Declaration on HIV and AIDS, governments in Asia have built their HIV programs, often at the urging of vocal, empowered communities of PLHIV demanding their rights and accountability from their governments. The Global Fund

A Jewel in amfAR’s Crown

amfAR CEO Praises TREAT Asia at 11th Annual Network Meeting

The eleventh annual TREAT Asia Network Meeting brought together leading scientists, clinicians, and advocates from across the region to reflect on the past year’s work and strategize about next steps in the network’s fight against AIDS in Asia. Taking place in Chiang Mai, Thailand, from 9–13 November, the meeting included workshops on the adult and pediatric HIV observational research databases as well as studies to evaluate HIV drug resistance.

TREAT Asia Director Dr. Annette Sohn provided a summary of the program’s progress in 2011. “Our network right now is the largest it has been in the history of the program, with 21 adult sites, 22 pediatric sites, and 17 laboratory sites,” she reported.

Dr. Adeeba Kamarulzaman from Malaysia at the 2011 TREAT Asia Network Meeting

CONTINUED ON PAGE 6

CONTINUED ON PAGE 3
Running Out of Treatment Options

The medicines we use for first-line antiretroviral therapy (ART) in low-income countries are now as inexpensive as $66 per patient per year for the more toxic d4T-based regimens and $179 per year for the less toxic and once-daily tenofovir and efavirenz regimen (msfaccess.org). However, when these medicines no longer work to control the virus due to drug resistance, patients need to take second-line regimens that cost around $440 per year. Should that fail, third-line regimens may cost as much as $2,700 per year. While very few of the almost seven million people on ART are currently using second-line regimens, drug resistance is practically inevitable. This means that one day, people will need those third-line regimens.

For a small but growing number of children in Thailand, that day is today. HIV-NAT is leading a national study of pediatric third-line ART in eight centers. Of the 44 children enrolled, nine (20 percent) are already failing third-line regimens. For these nine children, there is nothing left in the Thai Red Cross AIDS Research Centre pharmacy that will work to suppress their HIV.

We are not prepared for this—for telling patients that we have run out of ways to keep them alive. What can we say to families who have worked so hard to pick up their medicines on time, to give their children bad-tasting powders and pills every day, all while struggling with stigma and discrimination? Unless we can create broader access to newer antiretroviral drugs, the answer to that may be nothing.

Annette Sohn, M.D.
Dr. Sohn also noted that a key accomplishment in 2011 was the five-year renewal of funding from the U.S. National Institutes of Health (NIH) to support TREAT Asia’s role as the regional representative to the International Epidemiologic Databases to Evaluate AIDS (IeDEA). Dr. Gerald Sharp of the NIH later presented an overview of IeDEA and discussed the potential for global linkages between TREAT Asia and other IeDEA regions.

Throughout the meeting, participants heard research and education updates from across the region, such as presentations on acute HIV infection in Thailand from Dr. Jintanat Ananworanich, sensitivity training for providers working with men who have sex with men (MSM) in Indonesia from Dr. Evy Yunihastuti, and a study of tuberculosis in Taiwan from Dr. Arthur Chen.

Additionally, amfAR’s Vice President and Director of Public Policy Chris Collins joined the meeting to present on global HIV/AIDS policy issues. He identified access to medicines, harm reduction, and country ownership as potential policy concerns in the Asia-Pacific region.

A recurring theme during the meeting was the desire to turn the network’s research findings into a solid evidence base that might be used to influence funding patterns, HIV-related policy, and standards of clinical care in the region. Looking forward, meeting participants identified future priorities for the network, including addressing questions of how best to quantify its impact and strategically communicate its findings to target audiences.

Speaking at the meeting, amfAR CEO Kevin Robert Frost said, “I am happy that amfAR can continue to see TREAT Asia as a real jewel in the crown of our programs.”

TREAT Asia is pleased to introduce Giten Khwairakpam, who joins the program as Project Manager for Community and Policy. Mr. Khwairakpam obtained his Master’s degree in Social Work from the Tata Institute of Social Sciences in Mumbai and has worked with a number of non-governmental and community-based organizations on local and regional levels, including Catholic Relief Services, Health and Development Networks, and the Asian Network of People who Use Drugs. Most recently, he was the Regional Program Coordinator of the Coalition of Asia-Pacific Regional Networks on HIV/AIDS (7 Sisters), where he worked with organizations representing key HIV-affected populations.

TREAT Asia plans to work closely with amfAR’s Public Policy Office on regional issues related to access to medicines, support for harm reduction, and MSM-related HIV prevention and treatment priorities. Strengthening the policy component of TREAT Asia’s community program has become a priority as the network seeks to bridge gaps between the HIV research field and care and treatment policies within the Asia-Pacific region. We look forward to working with Mr. Khwairakpam in this endeavor.
Lipodystrophy is a side effect associated with some antiretroviral drugs that leads to atrophy and/or abnormal accumulations of fat in the body. The drug most associated with this side effect is stavudine, also known as d4T. Substituting other antiretroviral drugs for d4T can prevent worsening of the lipodystrophy and allow the body to recover.

Physicians in Chiang Mai, Thailand, have been carefully studying lipodystrophy in children at their pediatric HIV clinic since 2002. They first reported that 65 percent of their patients developed some form of lipodystrophy after 144 weeks of antiretroviral therapy.1 A recently published follow-up study monitoring 45 of these children showed that by 48 weeks after switching from d4T to zidovudine, 59 percent of children with fat atrophy and 40 percent of children with abnormal fat accumulation had recovered.2 However, 18 percent of the children still had lipodystrophy after 96 weeks. Although the study cohort was small, this is the most closely monitored group of children with lipodystrophy described in published reports from Asia. It is encouraging that lipodystrophy in children can improve after switching from d4T to other drugs like zidovudine, abacavir, or tenofovir. The first step in this recovery is to get children off d4T. Currently, about 30 percent of children followed in the TREAT Asia Pediatric HIV Observational Database are still on d4T. Although in 2010, the World Health Organization recommended that d4T use be progressively reduced in adults, it did not recommend the same

Still Presenting Late for Care

It has become increasingly clear that antiretroviral therapy (ART) should be started before CD4 counts have dropped to low levels in order to optimize clinical benefits and recovery of the immune system. In 2010, the World Health Organization adjusted its treatment guidelines to recommend that, even in the absence of symptoms, HIV-infected people should be started on ART if their CD4 levels drop below 350 cells/mm³. However, studies from both developed and developing countries show that many people infected with HIV do not start ART until their CD4 counts have dropped far below this threshold.

Researchers in China recently examined trends in the levels of CD4 counts of patients starting ART under China’s National Free ART Program.1 They analyzed data from 49,321 patients who started ART between July 2006 and December 2009. Even though the CD4 count before starting ART increased over this period, 30 percent of the patients still accessed ART at a very late stage in 2009, with CD4 levels below 50 cells/mm³. At the beginning of the study period, from July to December 2006, the median CD4 count before starting ART was 100 cells/mm³. Between July and December 2009, this number increased significantly, notably as a result of an increase in the proportion of patients started on ART at CD4 levels between 200 and 350 cells/mm³, but the baseline median CD4 count before starting ART remained as low as 150 cells/mm³.

The study team observed that factors associated with starting ART after CD4 counts had fallen to low levels included being male, single, having been infected through heterosexual contact, and having been recently diagnosed with HIV. In contrast, patients infected through intravenous drug
step for children. These research studies have demonstrated that Thai children can safely be switched from d4T and provide a model for the rest of the region to follow. ■

use or homosexual contact tended to have started ART at higher CD4 levels. It was noted that the average time between diagnosis of HIV infection and starting ART did not change significantly between 2006 and 2009. These findings illustrate that despite some improvements in earlier initiation of ART in China, the majority of patients continue to access ART late, when their CD4 levels have already fallen to low or very low levels. In addition, people with HIV are diagnosed long after most of them become infected with the virus. Greater efforts in China and across the region should focus on strengthening HIV testing services in order to facilitate earlier ART initiation, thereby maximizing its health benefits to patients. ■


Online Survey Examines HIV Status Disclosure Among MSM in Asia

HIV rates among men who have sex with men (MSM) in Asia, which are as high as 30 percent in Bangkok, Thailand, have led to the prioritization of MSM as a target group for prevention and treatment interventions. One prevention approach—known as “Prevention with positives”—helps HIV-positive individuals reduce the risk of transmission to their HIV-negative partners, including by disclosing their HIV infection status. Researchers used an online survey to assess HIV disclosure in the MSM community in Asia.1

The “Asian Internet MSM Sex Survey” was conducted between January and February of 2010 and offered in nine Asian languages as well as English. Of the 13,883 people who completed the survey, 416 self-identified as HIV-positive MSM and were included in the analysis. Sixty-eight percent of these HIV-positive MSM reported having unprotected anal sex in the past six months. However, 67 percent did not disclose their HIV status to any of their partners, and only seven percent disclosed to all partners. Participants who did not disclose their status were more likely to have partners who also did not disclose their own status, have only casual partners, use drugs before sex on a weekly basis, have been diagnosed between one and five years before, and not know their current HIV viral load. Notably, less than half of the survey participants who identified as HIV-negative had ever had an HIV test.

The researchers commented that stigma and discrimination are critical barriers to disclosure. Structural policies such as criminalization of HIV transmission or exposure, lack of employment protections, and personal fears of rejection or social isolation can all contribute to non-disclosure. Although these results may not apply to MSM who would not participate in an online survey or are within different social and demographic groups from the study participants, the study emphasizes the need for greater support for prevention activities that engage HIV-positive MSM and link them to care and treatment. HIV-negative partners should also be encouraged to receive HIV testing and disclose their own status to promote shared sexual responsibility. ■

and the availability of affordable generic medicines have played the most important role in treatment scale-up across the region.

The record for our region has been patchy though. Rates of treatment are still low with only about 36 percent of those requiring treatment getting it. Marginalized communities are still fighting criminalization in many countries. And the funding crisis and uncertain future of access to generic medicines are creating significant barriers as our countries work to build on past successes and finally get ahead of the epidemic.

**TA Report:** In November, the Global Fund announced the cancellation of funding Round 11, delaying new grants until at least 2014. What are the consequences of this decision in the region?

**Phurailatpam:** The November announcement came as a shock for many groups in the region and around the world.

The consequences are serious for the region. PLHIV in several countries are at the point of requiring second-line treatment, and governments must scale-up their programs. Marginalized groups like drug users, sex workers, and men who have sex with men (MSM) are particularly vulnerable, as governments are still reluctant to fund programs supporting these groups.

For China, the situation is especially grim as the decision also states that high-middle-income countries will not be eligible even for their second phase grant renewals. China was expecting nearly $880 million in these renewals. It is encouraging that the Chinese government has announced that it will fill the gap itself, but there is concern that funding priorities in the country may change without the influence of an independent, neutral funding source like the Global Fund to enforce a strong anti-corruption mechanism and focus support on evidence-based practices that place community groups at the heart of programs.

**TA Report:** As governments face growing budget constraints, global health funding is becoming scarcer. How will this shifting donor landscape affect Asia specifically?

**Phurailatpam:** For some time now, donors have been cutting or restructuring aid to several developing countries. Even so-called streamlining of aid can have a negative impact, particularly on community-based programs.

In August 2011, a community-based organization in Nepal was forced to reduce the number of beds in its care centers from 250 to 50 as a result of DFID’s [the U.K.’s Department for International Development] decision to harmonize its bilateral aid with that of other donors who decided to support the Nepal Health Sector Plan II, which did not incorporate community-based service providers.

With the shifting donor landscape already threatening the continuation of community-led programs, the lack of funds will only make matters worse.

**TA Report:** President Obama recently announced that his administration will deliver ARVs to six million people around the world by the end of 2013. What do you hope these new commitments will mean for Asia?

**Phurailatpam:** While the announcement that the Obama administration would be ambitious in its plans to deliver treatment comes at a crucial period when donors are retreating, it also must be seen in the context of the U.S. government’s trade policies.

The Trans Pacific Partnership Agreement (TPPA) is a free trade agreement (FTA) being pushed by the U.S. on several countries in the region, including Malaysia and Vietnam. It includes several aggressive provisions on intellectual property that will undermine access to generic medicines. Previous U.S. FTAs have led to significant increases in prices of medicines in developing countries, and for Malaysia and Vietnam, the TPPA would create a serious barrier to their ability to import generic ARVs or manufacture these medicines themselves.
Additionally, Europe is pushing an FTA with India that threatens its production and supply of generic ARVs. PEPFAR, the primary program through which the U.S. delivers treatment in Africa, is heavily reliant on generic ARVs produced in India. Therefore, for President Obama’s promise to become reality, India must continue producing generic ARVs.

**TA Report:** How might recent scientific advances in HIV prevention be translated into policy, and ultimately practice, in Asia?

Phurailatpam: The evidence is growing that PLHIV on treatment, particularly on early treatment, are less likely to transmit the virus. This means that our governments must abandon the false dichotomy in their policies of treatment versus prevention.

Faced with tight budgets, governments invariably adopt more extensive prevention programs, even though it is clear that treatment, care, and support are critical in HIV prevention. Now science has given us the evidence for this. Governments in Asia must determine how many more people need treatment and devise all possible mechanisms to ensure sustained access to affordable treatment.

Currently, however, the funding crisis and pressure to sign trade agreements are pushing governments to make poor treatment decisions like sticking to older, more toxic forms of HIV treatment and hesitating to examine earlier and better treatment options. In all this, the dramatic progress of the past decade is at risk, not just in Asia but across the globe.

**TA Report:** Are there other obstacles that stand in the way of improving drug access in the region and what strategies exist to overcome them?

Phurailatpam: Several governments in the region have had HIV treatment programs for several years and now have significant numbers of PLHIV requiring improved first-line or second-line treatment. The provisions in the FTAs proposed by both the E.U. and the U.S. will seriously undermine access to medicines for PLHIV and other diseases across the region.

Governments that have attempted to use health safeguards in their application of international trade rules are being sued by multinational pharmaceutical companies. From Pfizer in the Philippines to Novartis in India, companies are using legal and financial muscle to prevent countries from ensuring access to generic medicines for their people. And even institutions set up with health objectives, like the Medicines Patent Pool, have issued licenses that exclude Malaysia, Indonesia, and China from access to generic tenofovir.

A strong people’s movement has built up across the region to counteract these actions. From protests in Nepal to the brave actions of South Korean activists who faced unwarranted police brutality at the ICAAP [International Congress on AIDS in Asia and the Pacific] in Busan, PLHIV are demonstrating loudly against the actions of developed countries and multinational companies.

From the UN to the Global Fund, the advice to governments is clear—do not sign any trade agreements that undermine access to medicines and use all legal measures to ensure generic production and supply.

**TA Report:** Finally, what do you see as the major policy priorities for the HIV/AIDS community in Asia?

Phurailatpam: Discrimination is still a critical concern, and few governments in the region have provided legal protections for PLHIV. Laws in several countries continue to criminalize drug users, sex workers, transgender people, and MSM. Women living with HIV continue their struggle for equal rights, including sexual and reproductive rights.

As discussed above, the treatment scenario remains grim with governments being pressured to trade away the lives of their people. Our policy priorities are to address these challenges at local, national, regional, and international levels. We need policies that prevent drugs from just lying on the pharmacies’ shelves and instead get them to the people who need them.
Workshops on ART Failure, Lipodystrophy, and Treatment as Prevention Planned for 2012

TREAT Asia’s education program provides specially tailored workshops to healthcare professionals and community members across the region. In 2011, more than a dozen trainings were provided on a wide range of topics, from antiretroviral therapy (ART) failure and drug resistance to research ethics and scientific writing.

Improvements in treatment literacy and clinical care are evidence of the impact of TREAT Asia’s education activities. At the 2011 TREAT Asia Network Meeting, for example, John Tucker of New Hope for Cambodian Children reported that he successfully transitioned a group of children off the antiretroviral stavudine (d4T) just weeks after attending a TREAT Asia meeting where he learned how that particular drug causes lipodystrophy (see “Recovering from Lipodystrophy after Stopping d4T in Children” on page 4).

In 2012, Education Project Manager Aoy Boonsuk expects to add to the trainings TREAT Asia will provide to healthcare providers in the region. She is already busy organizing workshops on the diagnosis and management of pediatric ART failure and lipodystrophy in Cambodia and China.

In addition, TREAT Asia is planning three workshops on the “test and treat” approach for preventing HIV transmission and increasing uptake of HIV testing and treatment services among men who have sex with men (MSM) in Thailand. The workshops — which are scheduled to be held in Bangkok, Lampang, and Ubonratchathani — would be organized in parallel with a pilot study providing ART to MSM with newly diagnosed HIV, led by the Thai Red Cross AIDS Research Centre.