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AIDS

Normalization in the North, Tragedy in the South?

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Aids: Then and Now

Normalization in the North, Tragedy in the South?

At the beginning of the 80s, the health authorities in the USA were mystified: In large cities there was a rising number of rare forms of pneumonia or cancer which normally only occur in people with an immune deficiency. However, the people affected seemed to be completely healthy beforehand.[1] Within the shortest time, they developed grave symptoms, emaciated and died.

Since almost exclusively homosexual men are concerned, the deadly disease is termed Gay Related Immune Deficiency (GRID). But soon it becomes apparent that people with blood coagulation disorders, recipients of blood transfusions and drug addicts are also among the patients. For that reason, this mysterious disease is termed with the new name AIDS, Acquired immunodeficiency syndrome in 1982.

At the same time, the dramatic danger for public health is recognized in Germany: The Robert-Koch-Institute begins to keep a register and the Federal Center for Health Education sends out a first information brochure as a mail circular. In 1983 French researchers isolate a priorly unknown retrovirus. The pathogen of Aids, the human immunodeficiency virus (HIV) had now been found. However, it was to take years until the terrifying disease could be fought with an effective drug: In 1987, AZT (Retrovir) is approved as the first drug against Aids.

Information instead of scaremongering: Brochure of the Federal Ministry for Youth, Family and Health 1985

Hysterics in Germany

In the USA, the government under Ronald Reagan is trying to sweep the problem under the carpet although there are already thousands who are infected. Outsiders consider Aids to be a dingy disease. It was only when Rock Hudson, a world star, makes his HIV-infection public in 1985, the public perception changes.

A radical change of the public opinion from fear and rejection to compassion and commitment takes place.[2]

How different in Germany: Here, a wave of hysteria threatens which the tabloid Bildzeitung fuels with headlines such as "Homo plague is now threatening everyone!" The number of new infections increases rapidly – between 1984 and 1987 it doubles annually. Rigid strategies of fighting aids are discussed. Peter Gauweiler, CSU-politician and Bavarian state secretary, introduces a dreaded "package of measures" in Bavaria. Infected persons should be reported, isolated and, if necessary, locked away. Anyone who is suspected of belonging to a risk group is forced to be tested.[3]

Massive Prevention

Luckily, the attempt fails to transfer the Bavarian model to the rest of the Federal Republic of Germany. Instead, the then Minister for Health Rita Süssmuth (CDU) prevails with a liberal prevention policy which sets new standards.[4,5] 135 million DeutschMark are provided for fighting Aids in 1987, which is almost eight times as much as in the preceding year. 50 million are intended to the sole use of educational campaigns.[6] The Federal Center for Health Education campaigns with their famous slogan "Don't give AIDS a Chance." for dealing with condoms in a relaxed manner. The success is enormous: The Aids figures drop drastically and level off to approx. 2000 newly infected persons in 1993. In the Western world - and last but not least as a result of the availability of effective drugs - Aids changed into a chronic disease which can largely be controlled. Rolf Rosenbrock calls this the „normalization of Aids".[7]

Aids drama South of the Sahara

The situation in other parts of the world is quite different: Today about 33 million people worldwide live with Aids, two million of them are children.[8] The pandemic is particularly severe in African countries south of the Sahara. About 23 million people there are HIV-infected. More than three quarters of all Aids-related deaths occur in this region and nowhere else is such a large proportion of the adult population infected. In Swaziland, it is every fourth adult between 15 and 49 years.[9] And significantly more women than men are infected. Every second pregnant woman (20-34 years) who visited a birth clinic in Swaziland 2006 was HIV-positive. Sexual education campaigns seem to have hardly any effect: Although the knowledge about Aids is relatively large, this does not seem to change sexual behavior.[10]

The situation in the neighboring South Africa is similarly dramatic: There is no other country with more HIV-infected people. And again, it is the women who are particularly affected: Of the 15-24 year-old patients, 90 percent are female. Since 1990, Aids has lowered life expectancy by 13 years to presently 50 years.[11,12]

Postcards of the Federal Centre for Health Education. It is not morals that is focused on; instead, people with their sexuality are included in prevention... *photos: BZgA*

For years the South African Treatment Action Campaign (TAC) fought for affordable Aids-therapies. When the government finally decided to lower the prices for Aids-drugs by compulsory licenses [13], 40 international pharmaceutical companies filed suit at the court of justice in Pretoria. The legal proceedings took years and prevented the treatment of thousands of people.

photo: SACTWU und SWEAT

Drug-related Infection

Whereas Asia and Eastern Europe initially seemed to have been spared HIV, the numbers of infection rose rapidly in the nineties. The main path of infection was the joint use of syringes. After the breakdown of the Soviet Union, the number of drug addicts rose massively and correspondingly that of the HIV-infections. Ukraine was the worst hit. One percent of the population there is infected. Even today, an infection in the drug scene characterizes the image of HIV in Eastern Europe, although already 60 percent of the new infections occur by sexual contact.[14] It is similarly true for China, where about half of the 700,000 infected people caught the virus by contaminated syringes during drug abuse.[15] However, Aids seems to spread in India predominantly because of unprotected sexual intercourse – with the exception of the Northeast of the country, where the use of non-sterile syringes among drug addicts plays a key role. The rate of infection in rural areas is partly even higher than in the cities. 70 percent of the participants in a survey in North-Karnataka had never before e.g. seen a condom.[16]

The Red Ribbon was created in the USA in the eighties and has become known worldwide as a symbol of solidarity in the nineties.

No Law against Discrimination

According to UNAIDS, the funds allocated for national Aids programs have multiplied six-fold in the period of 2001 to 2008. At the end of 2007, three million Aids-patients were treated worldwide, ten times as much as in 2001. But it is only two thirds of those who need a therapy. It is above all children whose prospects to an effective therapy are bad.[17]

People with HIV fight for their rights worldwide. With top priority: The right to a life-prolonging therapy.

photos: Christian Wagner-Ahlfs

In many countries, Aids is a taboo. One third of all nations do not have laws protecting HIV-infected people from discrimination. There is no legal protection of risk groups such as homosexuals, drug addicts or prostitutes.[18] Without a fundamental understanding of cultural factors and social and economic conditions favoring the spread of the HI-virus, prevention campaigns and also treatment concepts will not be effective. Therapy and prevention have to go hand in hand to overcome Aids worldwide.

1 On 5th June, Michael Gottlieb describes in Morbidity and Mortality Weekly Report, a weekly bulletin of the US-health authority Centers for Disease Control and Prevention (CDC), the increasing number of an unusual form of pneumonia, which is caused by the fungi Pneumocystis jirovecii. The disease attacks almost exclusively patients with severe immunodeficiency; however, it had been diagnosed in five priorly healthy homosexual men in Los Angeles.
2 Andrea and Justin Westhoff: AIDS! Wie die Öffentlichkeit lernte, damit umzugehen. (AIDS! How the public learnt to deal with it) Contribution in DeutschlandRadio Berlin, 1.12.03 www.dradio.de/dlr/sendungen/merkmal/216644/
3 Susanne Mayer: Keine Kur nach Gauweilers Rezepten. Aids-Debatte im Bundesrat. (No treatment according to Gauweilers prescription. Aids-debate in the Federal Council of Germany) Die Zeit, 2.10.1987, Nr. 41 www.zeit.de/1987/41/Keine-Kur-nach-Gauweilers-Rezepten
4 Cited accord. to Andrea and Justin Westhoff: AIDS! How the public learnt to deal with it. Contribution in DeutschlandRadio, 1.12.03, p. 3, Berlin, 1.12.03 www.dradio.de/dlr/sendungen/merkmal/216644/
5 Rosenbrock's book "Aids kann schneller besiegt werden" (Aids can be overcome much faster) dated November 1986 characterized HIV-Aids-prevention in Germany; it outlined the basic structure of what was soon to become the official Aids-policy in the Federal Republic of Germany.
6 Susanne Mayer: No treatment according to Gauweilers prescription. Aids-debate in the Federal Council of Germany. Die Zeit, 2.10.1987, No. 41 , p. 4 www.zeit.de/1987/41/Keine-Kur-nach-Gauweilers-Rezepten
7 Rosenbrock/Schaeffer (Publisher): Die Normalisierung von AIDS. (The normalization of AIDS) 2002
8 UNAIDS: 2008 Report on the global AIDS epidemic www.unaids.org/en/KnowledgeCentre/HIVData/Epidemiology/epidemiologySlidesAuto.asp
9 UNAIDS: 2007 Aids Epidemic update, Sub Sahara Africa, p.3- 4
10 UNAIDS: 2007 Aids Epidemic update, Sub Sahara Africa, p. 4
11 UNAIDS: 2007 Aids Epidemic update, Sub Sahara Africa, p.3- 4 and Helmo Preuss: Life expectancy down. 27.7.04 www.news24.com/News24/South_Africa/News/0,,2-7-1442_1563846,00.html
12 As regards the lowering of life expectancy caused by Aids in Southern Africa, see also: Celia W. Dugger: Devasted by Aids, Africa sees Life Expectancy Plunge. The New York Times, 16.7.2004 www.nytimes.com/2004/07/16/world/devastated-by-aids-africa-sees-life-expectancy-plunge.html
13 Compulsory licenses allow independent production or imitation of branded products or their import from countries not yet acknowledging patent protection. The Patentee receives royalties.
14 http://de.wikipedia.org/wiki/AIDS#AIDS_in_den_Nachfolgestaaten_der_Sowjetunion
15 UNAIDS: 2007 Aids Epidemic Update, Asia, p. 2-4
16 UNAIDS: 2007 Aids Epidemic Update, Asia, p. 6
17 2008 Report on the Global Aids Epidemic, Executive Summary, p. 17 www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp
18 2008 Report on the Global Aids Epidemic, Executive Summary, p. 12 www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp

To change Behavior, the Circumstances have to Change

HIV/Aids-Prevention Today

The ways of transmission of HIV are known. Likewise the measures for preventing transmission. Why is it then that worldwide more than 2.5 million people get newly infected with the virus each year? What about prevention? Armin Schafberger is consultant for medicine and health policy at the Deutsche AIDS Hilfe and has summarized the most important developments for us.

Prevention is not only aimed at individual behavior (behavioral prevention) but also at changing social structures and areas of life in such a way that people can protect themselves (situational prevention).

To Change the Situation

People consuming drugs intravenously, men having sex with men (MSM)[1], sex workers and people in prisons are particularly endangered to get infected with HIV. Any group that is socially weak, marginalized or discriminated principally find it difficult to protect themselves. Thus, the pathological fear of homosexuality thwarts a prevention during MSM in large parts of Eastern Europe. Those who are exposed to social violence will hardly "come out" and will not be reached. Prevention will not succeed here without anti-discrimination work. And that's not all: first anti-discrimination work has to show effect then prevention can also be effective. Some Latin American states, Mexico taking first place, provided a legal basis for the equal treatment of homosexuals and started anti-discrimination campaigns.

With syringe-exchange programs and substitution (Methadone) the rapid rise of the infection numbers in drug users could have been prevented in Eastern Europe and Southeast Asia. That was opposed by discrimination and the unrealistic demand for abstinence. In the Ukraine and other Eastern European countries, a re-thinking process has started – even if it is a little late –, whereas a wait-and-see attitude without action is still being taken in Russia. In Southeast Asia, the fight against drugs is confused with the fight against drug users. They are threatened by lengthy imprisonment or the death penalty. How can prevention be successful in such a situation? In industrial countries, there are also differences when dealing with drugs. In the USA it is more difficult for drug addicts to obtain clean syringes than in most European states. The number of new infections of drug users in the USA is higher.

The prevention of an HIV-transmission from mother to child depends almost exclusively on the situation. With medical measures it can be lowered from an average of 15-30% to below 1%. The fact that every year approx. 370,000 children are infected with HIV worldwide is caused by the problem the pregnant women lack access to information, HIV-tests and medication for lowering the virus load to below the detection limit before birth. There is no alternative to breastfeeding in many regions since there is insufficient access to clean water and baby food; without breastfeeding, the HIV-transmission risk would be lowered, but the mortality as a result of e.g. diarrhea increases massively.

Thus, numerous structural conditions are obstacles in the way of prevention or even add fuel to the fire. Prevention is therefore connected with anti-discrimination, de-stigmatizing and a social strengthening of the position of all those who are particularly endangered by or concerned with HIV. Successful prevention can and should not only refer to the individual; it should, at the same time, create the conditions that the individual can receive and translate the message of prevention.

To Change Behavior

HIV is predominantly transferred sexually. At first glance, it should be possible that people protect themselves. However, prevention starting at the behavior of the single person does not find it easier than prevention that is focused on the social situation. Anybody knows how difficult it is to put behavioral changes into action who has tried to quit smoking, finally do more sports, ... Why should it be different when sexuality is concerned? Sex has to do with lust, with love and rose-colored glasses, with the wish to become one, with losing control, with devotion, letting go, contact of skin and mucous membranes and desires. Rational messages and education are in fact the necessary basis for prevention, but they are aimed at the human cerebral cortex and are not sufficient in situations in which the cerebral cortex has to be switched off in favor of other areas of the brain. Prevention therefore has to address people at different levels. If should take the cultural context into consideration as well as the respective target group. It should be close to the world in which those people live and should not overstrain them with unrealistic objectives such as abstinence and faithfulness. Prevention may then also be funny: Nobody will forget that German TV advertisement of the Bundeszentrale für gesundheitliche Aufklärung (BZgA, German Federal Center for Health Education) which was broadcast in 1989 and in which a young man wants to bashfully buy condoms and the cashier loudly calls to the back of the supermarket: "Tina, how much are the condoms?" Today, after a quarter of a century of HIV-prevention, the purchase of condoms is no longer bashful – that is also a success of prevention.

Condoms offer the best protection. Still, there are factors such as the desire to have children, erectile dysfunctions etc., which limit the use of condoms. In long-term stable relationships, the use of condoms generally also decreases over time. Additional methods for preventing an HIV-transmission therefore make sense and are necessary. The subjects of research are microbicides, HIV-vaccination, pre-exposition-prophylaxis and anti-retroviral therapy as prevention. The only measure to be acknowledged by the World Health Organisation (WHO) is circumcision.[2]

Protection by Circumcision

For heterosexual men, circumcision of the foreskin reduces the risk of an HIV-infection by 60%.[3] A protective effect of the circumcision has long been suspected; since the year 2000, cohort studies provided sufficient proof.[4] Furthermore, circumcision reduces herpes and HPV (human papillomavirus) infections in heterosexual men.[5] Nevertheless, the WHO hesitated and waited for the conclusion of 3 randomized intervention trials [6,7,8] with thousands of adult men before adopting circumcision into the HIV-prevention program in 2007 in those areas where the HIV-prevalence among heterosexuals are high and the rate of circumcision is low.

"Tina, how much are the condoms?" – a legendary TV-spot helped to free condoms of their grubby image. *Pictures: Federal Center for Health Education*

However, what happens with the women? What happens if the men – falsely assuming that they were now sufficiently protected from HIV – increase their risk behavior? In those trials, the men were intensively advised on safer sex and

diminished their risk behavior. In the field, however, the advise will be reduced as a result of a lack of resources – in no case may it be absent.

The WHO recommends the circumcision of adult men since the effect of the prevention already starts after the six weeks of post-operative sexual abstinence.

In case of MSM, the effect of a circumcision on HIV-transmission has hardly been scientifically researched. The results currently available do not show an effect or contradict each other.

Microbicide – Protection for Women?

In some countries women and girls are particularly at risk and do not have any means of effectively preventing an HIV-transmission, with the exception of the female condom (the use of which still also necessitates the acceptance by the man). Research counts on microbicides, which are creams and ointments that are introduced into the vagina in order to prevent an HIV-transmission. However, two trials had to be terminated, since the substances did not reduce the risk of an HIV-transmission but even increased it – they probably even opened the door for the virus by irritating the vaginal mucous membrane. New substances of the 2nd microbizide generation are now being developed, but they will only be available in five to ten years at the earliest. Hopes are placed on the use of HIV-drugs which are released over a longer period of time e.g. by means of a vaginal ring. In contrast to the 1st generation of microbicides, which all failed during the developing stage, the new products[9] will be expensive since they contain anti-retroviral drugs. Whether they do have a protective effect will be seen.

Condoms Suit *photo: Christian Wagner-Ahlfs*

Therapy as Prevention

If HIV-positive patients have received anti-retroviral treatment, the virus load in the blood and also in the genital secretion (which are decisive for sexual transmission) as a rule decreases below the detection limit. Thus infectivity also decreases. On the level of public health, it is beyond dispute that the use of anti-retroviral therapy has a significant influence on the spreading of HIV and could restrict the epidemic decisively.[10] However, it is controversial whether HIV-positive patient receiving good treatment could do without condoms. The supporters (i.a. the Eidgenössische Kommission für Aidsfragen[11] (Swiss National AIDS Commission) and the Deutsche AIDS-Hilfe[12] affirm the question of omitting condoms for an exactly defined, relatively small group (stable couples) under exactly defined medical conditions. Critics (among others UNAIDS) are afraid of a softening of the condom message, an increase in the incidence of other sexually transmitted diseases and thus, in general, also an increase in the HIV-incidence (since the HIV-transmission risk increases with the presence of other diseases).

A Pill against Aids?

Will there be a pill against HIV one day? In randomized interventions studies[13] with thousands of persons with a high HIV risk, it is presently examined if an HIV-infection can be prevented by the precautionary intake of anti-retroviral substances. First results are expected after 2009/2010. In all trial designs referring to the so-called pre-exposure prophylaxis (PREP), it is a prophylaxis which has to be taken over many months. If the trials show high efficacy, the question of the costs of drugs will be extended from therapy to prevention. Critics of the PREP point out the ethically questionable situation wherein HIV-negative persons receive drugs although HIV-positive persons are not sufficiently treated with anti-retroviral drugs. Moreover, PREP could undermine the formation of resistance. Supporters argue that this method could offer an interesting option, e.g. for couples with a desire for children for the protection of the woman if the man does not yet receiveanti-retroviral treatment or has a detectable virus load.

Prevention of Aids

Today the stage Aids is avoidable at least for a long time.The prerequisites for avoiding the stage Aids are timely diagnostics, timely start of the therapy and competent medical care. In developing and threshold countries, the majority of the HIV-positive persons are not even diagnosed. And even in case of a timely start of treatment, the medical control methods as well as the necessary second- or third-line therapy are often not available for cost reasons. But even in industrial countries, Aids is by no means a thing of the past. In Germany, approx. 25-30% of the HIV-positive persons do not know about their infection and, of the newly diagnosed, approx. 30% are “late presenters” in Europe.[14] They have been tested too late and/or the therapy has been started too late. In the field of AIDS-prevention there is also much to be done yet.

(Armin Schafberger, Deutsche AIDS-Hilfe)

1 The term „men having sex with men“ includes men openly living as gays as well as those who would not call themselves gay since they are (have to be) afraid of discrimination or who would term themselves rather heterosexual – and only occasionally have sex with men. Admittedly, the term is quite a mouthful, however prevention politically correct.

2 WHO. New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications. www.who.int/hiv/mediacentre/MCrecommendations_en.pdf 28. März 2007

3 The foreskin of the penis offers an entry gate for the HIV-virus by immune cells which are located at the surface of the mucous membrane and which contain receptors for HIV into the cell.

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6 Auvert B, Taljaard D, Lagarde E, et al. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: the ANRS 1265 Trial. PLoS Med 2005;2(11):e298.

7 Bailey C, Moses S, Parker CB, et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomized controlled trial. Lancet 2007;369: 643-56.

8 Gray H, Kigozi G, Serwadda D, et al. Male circumcision for HIV prevention in young men in Rakai, Uganda: A randomized trial. Lancet 2007;369:657-66

9 An up-to-date summary on the current trials is provided by the Alliance for Microbicide Development: www.microbicide.org

10 Reuben M Granich, Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV-transmission: a mathematical model. Lancet 2009; 373: 48–57

11 Eidgenössische Kommission für Aidsfragen (2008) (Swiss National AIDS Commission). HIV-infected persons without other STD are not sexually infective under effective anti-retroviral therapy. Schweizerische Ärztezeitung (Swiss Medical Journal); 89: 5; 165-169

12 Deutsche AIDS-Hilfe e.V.: HIV-Therapie und Prävention-Positionspapier, April 2006 (HIV-therapy and prevention position paper). www.hivreport.de/media/de/2009_03_HIVReport.pdf

13 An up-to-date summary on the current trials and their results is provided by the website of the AIDS Vaccine Advocacy Coalition: http://prepwatch.org

14 ECDC European Centre for Disease Prevention and Control, Stockholm, Sweden, 2007. www.ecdc.europa.eu/en/files/pdf/Publications/20090122_Annual_HIV_Report.pdf

More information: www.aidshilfe.de

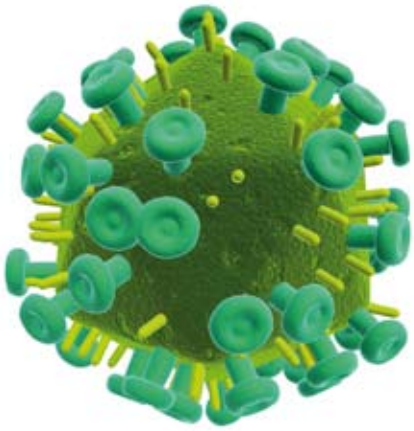
The Enemy Within

The Disease Aids and How it is Treated

The human immunodeficiency virus (HIV) predominantly attacks the cells of the human immune system. Although the body forms antibodies, it cannot defeat the virus. Only a life-long therapy keeps the disease in check.

The acute infection often remains undetected or runs like an influenca. Then there is a phase in which the patient does not notice the disease but can infect others (latent infection). During this time, the virus load in the body rises and the CD4 cells (cellular immune system cells) are decreasing. If the CD4 cells drop below a specific value (ca. 200/µl), the full symptoms of Aids develop. The body becomes defenseless. Tumors and associated diseases result, which would normally be fought off by a healthy immune system. Without treatment, these so-called opportunistic infections lead to a rapid and painful death.

Aids Diagnosis



The Center for Disease Control and Prevention divides HIV into three stages:[1] In stage A, the patients do not show any symptoms. In category B, there are symptoms which are not necessarily typical for Aids patients. In stage C, typical concomitant diseases occur, for example cancers such as the Karposi sarcoma or certain forms of pneumonia (e.g. the pneumocystis Carinii infection). In addition, the phases of the disease are defined by the respective number of CD4 cells and the virus load in the body. In industrial countries, this laboratory value determines the start of treatment: patients in stage A and B of the disease will be treated as soon as their CD4 cell count drops below a specific value and the virus load rises above a specific value. Once the treatment has been started, it has to be continued for life. In most poor countries, the virus load in the bodies of patients cannot be tested for financial reasons and the start of the therapy only depends on the number of CD4 cells or even only on clinical diagnosis. An affordable virus load diagnosis is urgently needed to improve the therapy of the poor.[2]

The Effect of the Aids Drugs

Since the middle of the nineties, there are effective HIV drugs also called antiretroviral therapy. A combination of at least three drugs can retard the full symptoms of Aids or even prevent them, improve the quality of life and significantly prolong life expectancy. However, after some time resistance to the drugs develop which necessitates a change to more advanced medication. In order for the medication to be effective for as long as possible, the drugs have to be taken reliably. Aids drugs lower the virus load, i.e. the amount of virus in the blood. But they cannot cure the disease. Even if the virus can no longer be detected in the blood, it does not disappear. However, infected persons with a low virus load are significantly less infective. Moreover, the drugs cause the number of CD4 cells to rise and the condition of the immune system to improve.

Aids drugs are quite well tolerated by most patients if they have the possibility to change from one combination therapy to another in case of

severe adverse effects. Acute adverse effects such as headache and vertigo usually recede after a few weeks. However, long-term side effects such as painful inflammation of nerves, diarrhea or lipid metabolic disorders are very irksome for the patient. The latter result in a redistribution of fatty tissue. It disappears in the face and attaches to the gut and back of the neck. Additional side effects are severe organic damage such as liver failure.

Complicated Therapy

At present there are about 30 drugs available with different modes of actions. They all act at the different stages of virus reproduction. The most important are NRTIs (nucleoside reverse transcriptase inhibitors), NNRTIs (non-nucleoside reverse transcriptase inhibitors) und PIs (protease inhibitors). As an initial therapy, two NRTIs are combined with an NNRTI or PI as a rule. This ensures that the virus can simultaneously be attacked from different sides and that the development of a resistance is thus delayed. Whereas in industrial countries each single patient is fine-tuned to an individual therapy, poor countries have to use standardized schemata. As a disadvantage, neither a resistance examination can be carried out nor the side effects can be avoided.

The most inexpensive combination (90 US $) in the developing countries consists of Lamivudine, Stavudine und Nevirapine. Since Stavudine has particularly severe side effects, the WHO recommends to replace it with Tenofovir.[3] However, in most countries this is protected by patents. The price for the combination therapy therefore rises to 350 US $ per year and patient. If the treatment is no longer effective, the therapy has to be changed. At least two first-line drugs are then replaced by PIs. Protease inhibitors, however, are protected by patents in most countries. With the replacement, the annual price of a therapy rises to at least 1000 € with the replacement.[4]

Children and Aids

The largest risk of infections for children exists during pregnancy, birth or breast-feeding (mother to child transmission). Whereas in Europe, less than one percent of the children of HIV-positive mothers get infected, the figure in poor countries lies between 15 and 45 percent, depending on the duration of breast-feeding.[5] On the other hand, for children that have not been breast-fed there is a much higher risk of dying from an infectious disease or diarrhea.

HIV-positive children in Africa often die before they school age. In rich countries, children can grow up with Aids. If the therapy is started at an early stage, they have a significantly improved life expectance.[6] The problem lies in the fact that there are no suitable administration forms for babies. Since HIV is rare in children living in rich countries, there is hardly any research for drugs which are suitable for children.

In rich countries, HIV-infected pregnant women receive a complete combination therapy at least during the last trimenon; after birth, the baby receives medicinal prophylaxis for one month. In many poorer countries, the pregnant woman only get one tablet of Nevirapine before the birth and the baby one dose after the birth. This controversial mono-therapy does, in fact, lower the risk of infection for those children by more than 40 percent, however, at the same time it advances resistances.[7] If children are infected despite Nevirapine, they often can no longer be treated with first-line drugs. It would therefore be important e.g. to manufacture Lopinavir /Ritonavir as a suspension which can also be swallowed by small children. The manufacturer Abbott has so far shown little interest. (CF)

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photo: Sebastian Kaulitzki/fotolia.com

Tuberculosis and Aids – a lethal combination

Half of all HIV-positive persons who get infected with tuberculosis develop TB in the course of their lives. In 2007, almost 1.5 million TB-patients were HIV-positive. This double infection is treacherous: Every year, 200,000 HIV-positive patients die of tuberculosis. Tuberculosis is the most common cause of death in Aids-patients.

"I am afraid to infect my family with tuberculoses but I have to care for my children." , says Monica who suffers from Aids and multi drug-resistant TB and shares one room with her five children in the slum of Mathare in Nairobi/ Kenya.[1] In a therapy facility of Doctors without Borders (MSF), she is being treated against Aids and TB. That means more than 20 pills a day and a painful injection in the morning. Nairobi City has an estimated HIV-rate of about 20 percent and is responsible for Kenia's proportion of TB-cases which is just as high. Three quarters of the patients live in slums, like Monica.

One third of the world population is infected with the tuberculosis bacterium. This also includes a good third of the worldwide 33 million HIV-infected persons.[2] In contrast to people with a good immune system, tuberculosis breaks out in HIV-infected persons with a significantly higher likelihood. The risk rises from 10% in the course of one's life to 10% in one year and to 50% in the course of a much shorter life. Once the disease has broken out, it often runs a severe and rapid course and can lead to death within a few weeks.[3]Aids weakens the immune system dramatically. Even if double-infected patients were successfully treated against TB, it is very likely that they suffer a new tuberculosis breakout after a new infection. An Aids-therapy reduces this risk since it stabilizes the immune defense and it is the only sustainable possibility of lowering the TB death rate for HIV-patients.

The WHO thus calls for all TB-infected persons to be tested for HIV and for all HIV-infected persons to be tested for TB. In 2007, as much as one million TB-patients, i.e. 7% of the 14 million TB-infected patients worldwide, were tested for HIV, but only 2.2% of the HIV-positive persons were tested for TB. The WHO recommend a preventive therapy of Isoniacide in their therapy guidelines for HIV-positive patients with a latent TB-infection. This gives protection from re-infection for some years and can cure an existing latent TB. However, in 2007 only 0.1% of HIV-positive patients received Isoniacide as preventive therapy. Such a therapy would have spared patients such as Monica much suffering.[4] (CF)

Risk Double Infection

- TB is difficult to diagnose in HIV-patients which often exhibit atypical forms of diseases.
- TB progresses more rapidly in HIV-positive persons.
- The likelihood of dying of an untreated tuberculosis is considerably higher for HIV-positive than for HIV-negative persons.
- TB breaks out earlier than other opportunistic infections.
- TB is the only opportunistic infection with which HIV-negative persons can be infected.
- Even if AIDS-patients are treated against tuberculosis, the HIV-infection continues.
- In poor countries, only a third of the people are treated with life-prolonging HIV-drugs.

1 A slide show of the Doctors without borders (MSF), dated March 2007, impresses with the living conditions of Monica. She is being treated at the Blue House, a therapy facility of MSF. www.doctorswithoutborders.org/photogallery/gallery.cfm?id=2031&cat=audio-slideshow&ref=tag-index

2 Tuberculosis, WHO Fact Sheet, www.who.int/mediacentre/factsheets/fs104/en/index.html

3 TB and Aids, a lethal combination, Pharma-Brief Special, 2/2007, p. 12-14

4 TB/HIV Facts 2009, WHO Fact Sheet Geneva 2009, www.who.int/tb/challenges/hiv/factsheet_hivtb_2009.pdf

Challenges for Prevention and Therapy

Nowhere else is there such a high number of HIV-infected people as in South Africa. We talked to Tobias Luppe about the structural conditions which obstruct prevention work and therapy.

Tobias, in what kind of project did you work?
I worked for a prevention project of the Ndlovu group, a South African organization responsible for various health projects. 55 colleagues carry out projects at schools in the provinces of Lompopo and Mpumalanga.

How does such a project in a school work?
My colleagues perform a play and then we discuss it. We want to inform adolescents about HIV best before they begin their own first sexual activities. The topics are contraception, pregnancy but also the isolation of people having HIV. For girls the topic of sex with older men is important. That is widely spread. In exchange, the girls often get a credit for their mobile phones or money for the school uniform.

What are the central messages of your work?
First, of course, the information on HIV and Aids: how do you get infected, how can you protect yourself, how can you live with it. Most already know about condoms. The classic demonstration of how a condom is fitted on a wooden penis is no longer sufficient. Rather, the young people have to be personally strengthened to apply that knowledge.

So it is more a psychological counseling?
Yes. Two central messages are important: I am threatened by HIV. Many people suppress the fact that it is already every fifth person in South Africa who is HIV-positive. Second message: I can protect myself. That is a question of self-confidence. This confidence is often missing. This may be partly due to the fact that the classic core family with father, mother, child often does not exist anymore. The structure which in fact convey such social values has thus broken down. It is officially in the syllabus of the schools to strengthen social abilities: to make one's own decision, to fight against peer pressure. However, the schools alone can hardly achieve that: not enough teachers, classes that are too large, and often there are language barriers.

How did the breakdown of family structures come about?
An important reason is the system of migrant laborers in Southern Africa, which was even amplified by apartheid. Far away from their families, the men had to work in mines or on farms for most of the year. The women were forced to give away their children at a very early stage in order to be able to work in the cities. Not much has changed. In addition, we now have the problem of almost 2 million Aids orphans. It is not rare that thirteen-year-olds have to keep house and look after the smaller brothers and sisters. To personally strengthen the adolescents is an important part of prevention work.

Why is pregnancy an important topic in Aids prevention?
The best protection against an infection is still the condom. However, many girls do not want to use a condom, they want to become pregnant. Anyone who grows up in a township does not expect a rosy future. To get a child will give the girl a task. And the social status is also raised: the girls want

to marry and whoever has proven her fertility by a pregnancy, has much better chances to find a husband. Even if it sounds paradoxical: Money also plays a role. The government introduced a kind or social support for young mothers; they get about 1000 ZAR (approx. 80 Euro) per month. That is their sole income for many and for some young people an incentive for a pregnancy.

For adults, prevention used to be characterized by the ABC-concept: Abstain, Be Faithful and Condomize. Is that still valid?
Abstinence and condoms used to be praised. But the prevention work to date obviously failed: for each person accepted into a therapy, statistically three people get infected.

How do you reach adults?
The teams go to the migrant workers into mines and on farms. Events in the townships are also important. It is enough to erect two loudspeaker and play Kwaito, a popular music. At once people stream together, since there is not much going on otherwise. With plays and quiz shows, my colleagues can convey information; individual counseling, however, is also important.

Keyword abstinence: can this be conveyed?
No, just as little here as anywhere else. However, here the relationships function differently. In Germany you could talk of serial monogamy; people often have several partnerships in the course of their lives, but one after the other. In Southern Africa, people have several solid partnerships at the same time. Under these conditions, a sexually transmitted disease will naturally spread much faster. An important step in containing HIV thus has to be: to have fewer partners simultaneously. However, that is an enormous cultural change.

Do the people have good access to medical treatment?
In South Africa, 5.7 million people live with HIV. About 1.7 Million thereof need treatment. 0.5 million do get it. Although the South African government started an official treatment program as recently as 2004, it has meanwhile become the largest in the world. However, there is a lack of everything: not enough doctors, not enough hospitals, in rural areas, the infrastructure is a disaster. The diagnostic methods used in industrial countries, which optimize therapy, are not affordable here or not even available.

Tobias Luppe, political scientist, lived in southern Africa from 2007 to June 2009. He coordinated a project for HIV prevention there and researched the use of sports activities such as football in HIV prevention for young people. Starting on 1st August 2009 he will deal with questions of global health for Oxfam in Berlin.

How complicated is it to carry out a therapy?
In recent years, therapy has clearly been simplified. Today a standard treatment consists of two tablets. Trials showed that the patients' adherence to therapy in Southern Africa is not worse than in Europe. There are people everywhere, who interrupt therapy, e.g. due to the side effects. Many people also start their therapy too late and the infection is often already too advanced. In South Africa, an outdated treatment regimen with the drug d4T (Stavudine) is still applied. The optimum therapy with Tenofovir has fewer side effects, however, it is ten times as expensive. The price reductions which we had for older drugs, we now also need for the new improved drugs. Although many things have improved: the standard of the optimum therapy has not yet reached South Africa.

The interview was held by Christian Wagner-Ahlfs, BUKO Pharma-Kampagne.

photos: Lipsewers/WHO; Sebastian Bolesch

More information about Ndlovu Care Group (in German language)
http://hugo-tempelman-stiftung.de/

Played Down: Aids in India

First Aids Cases among the Indigenous Population / Discrimination Hampers Prevention

A rising number of TB-infections, a low level of education in sexual matters and a high number of HIV-infected people refusing treatment for fear of discrimination – all these are alarming signs as Indian experts say. The HIV/Aids numbers in India might be much higher than official data tell. Even among the native inhabitants, living far away from the big cities in jungle regions, first HIV-infections were found.

"We are sitting on a time bomb", explains Dr. Reji, co-founder of the Tribal Health Initiative. The little hospital of the initiative treats the indigenous population (Adivasi) in the Dharmapuri district in southern India. A few weeks ago, the first five HIV infections were diagnosed among the Adivasi.

Aids in Rural India

70 million Adivasi live in India, mostly in remote villages and jungle regions. As a result, many NGOs have been relatively relaxed with the topic of HIV. On the other hand, among the Adivasi communities there are, as a rule, more open moral concepts: sex before marriage and a certain amount of promiscuity are accepted in contrast to the rest of the Indian society. That fact that HIV has reached these communities is an alarming danger signal. The Tribal Health Initiative[1] invests a lot of energy in sex education and prevention. Condoms are for free, the hospital tests, free of charge, all pregnant women, patients suffering from TB and those people showing specific indications of Aids. Whether their efforts can stop the virus, however, is questionable. Furthermore, the problem of supplying Aids patients with ARVs still remains.

In India, the treatment with first-line drugs is free of charge, in some states, even second-line drugs are included in the treatment program of the governmental treatment centers. The figures showing how many HIV-positive people have access to those drugs essential for survival fluctuate. However, it is deemed to be quite certain that less than half of them are supplied with ARVs[2]. Dr. Reji explains: "We have an HIV-positive patient in a remote village. First he has to walk for twelve kilometers and then it takes him three hours by bus to Seelam, where the next government ART center is. If he goes there once a month, he will lose a working day each time and will have to pay 28 rupees for the bus. And on top of that, the whole village will learn that he is HIV-positive. I don't think that he let himself be treated. We are trying to become a treatment center ourselves since the patients trust us. However, it is uncertain if we succeed."

TB-infections are on the Rise

Jhoyiti, the director of MILANA, a local NGO, which supports HIV-infected women and children in Bangalore, harshly criticizes the new Aids figures: "That was a purely political decision with which the government wanted to prove that all Indians are monogamous. That is perfect nonsense!"

Non-governmental organizations, on the other hand, estimate that up to 20 million Indians are HIV-infected.[3] As proof they state that the number of tuberculosis infections rises in some regions. HIV drastically increases the risk of an outbreak of TB. Moreover, it was a clear indication that the virus increasingly spreads within the heterosexual population as well. It affects mostly women from the poorer classes who had generally been infected by their husbands.

HIV increasingly spreads within the rural population in India. Prevention in school could play an important part, but it is hardly possible due to sexual taboos. *photo: ACCORD*

Outlawing in Big Cities

For women in the Indian metropolitan areas, the situation caused by stigma and discrimination is particularly bad, even though the ART-centers are actually closer and could be reached much better. Parvathi is HIV-positive and has been taking the second-line drugs for a few months. She recounts: "My husband died from Aids two years ago. He did not want to be treated for fear that our neighbors, parents and his colleagues would learn of his infection since the ART-center is clearly recognizable as such. Only HIV-infected persons are treated there. That is bad since everyone knows: Anyone who goes there has the disease. When my husband died, I let myself and my children be tested. Two of the children are negative, one is positive. I went to MILANA. They helped me and my daughter to begin the therapy and my parents have accepted that. However, my parents-in-law threw me out of our house. I did not learn a profession, I was a housewife. Here, the second-line drugs are not yet free of charge. Each month I pray that my sponsor sends the money so that I can be further treated. What shall become of my children otherwise?"

MILANA offers prevention work against Aids. However, that is difficult. Many taboos have to be broken. At the state schools of the federal state Karnatake, sexual education at schools is, for example, completely prohibited. Gowri, who has been HIV-positive for five years, explains: "For us it is difficult to explain the facts of sexual life to our own children. So that the shame is not so intensive, we do it for each other. I explain it to Parvathi's children and she explains it to mine. That makes it somewhat easier." (CF)

1 More information under www.tribalhealth.org
2 Aids drugs are termed antit-retrovirale therapy (ART or ARV)
3 The organization does not have a homepage at present.

Stigma can be Deadly

Interview with Jyoti Kiran, MILANA/India

The Indian metropolis Bangalore lies in the federal state of Karnataka and has the fifth-highest HIV-rate in India.[1] Since 2004, the federal government provides infected people with HIV-drugs free of charge. However, the therapy drop-out rate is high. We talked to Jyoti Kiran about the reasons.

I can see more women here than men, why?
In India, the patriarchal system mostly silences women and children. We therefore try to help in particular women by ensuring that they are treated and get work. The women sow bags, shirts and other things that they sell.

How does MILANA work?
Our principle is mutual support. Those women who have been here for a longer time go to other HIV-positive people and offer their help. Together with the affected persons, they visit their families. Very often it is them who inform the relatives about the HIV-infection. Many of the women are no longer in contact with their own families and in particularly not with the families of their husbands. When the families learned that the wives were positive, they were thrown out. We then try to reconcile them.

Is help being accepted?
Last night we received a call. A man was suffering a lot from an infection of the urinary tract and high fever. Two of our women drove there immediately. The people concerned know that they can always call us. It does move something.

Do you also go into schools to give sexual education to young people?
Yes, but we can only go to private schools. In the state schools, sex education is forbidden. The parents believe that their children would be tainted and that sexual education contradicted Indian values. This conservative attitude is a big problem.

Do the people let themselves be treated?
Those who come to us – yes. But most of them do not do it publicly. One patient had been taking his medication, but now he does no longer take them. He told us that the people in his village started to talk because he goes to Bangalore every month. Although we have tried everything, he no longer comes. He told us that he would rather die honorably than reveal his secret. We have also talked to his wife and children. But they could not make him change his decision.

How many people are treated in Bangalore of those who would need treatment?
That is difficult to say since stigma and discrimination keep most affected people from taking the free medication. Many come from outside Bangalore so that they do not have to get the medication in their home districts where somebody might recognize them. It is a very slow process to fight stigma and discrimination. Governmental authorities, NGOs and organizations such as us will have to continue their work for a long time.

The interview was held by Christiane Fischer, BUKO Pharma-Kampagne.

1 www.avert.org/indiaaids.htm (10.6.2009)

This Indian organization MILANA offers support to women with HIV; a support that is often denied by their families. *photo: Christiane Fischer*

Figures and Assumptions

In 2006, UNAIDS revised the number of worldwide HIV-infections downward. New calculation methods rendered the then 40 million Aids-patients to 33. Data from six countries are responsible for 70% of the deviation. One of these countries is India. Instead of the formerly estimated 5.6 million, there officially only remain 2.5 million HIV-infected Indians.[1]

The new estimates for India are based on unreliable assumptions: The spreading of HIV in the general population (prevalence) is deducted from random samples of pregnant women who were examined in healthcare centers. However, since not all persons within the age group of 15- to 45-year-olds have had sexual contact, the determined value was corrected downward. This calculation method, however, only takes pregnant women into consideration, who take advantage of the preventive medical check-ups. All other women, however, may be significantly more at risk. It is furthermore problematic to deduct the prevalence among men from those results. The calculation method is certainly suitable for diseases occurring uniformly in all regions, population and age groups. In the case of HIV, however, this is not the case.

The spread of HIV in special risk groups is determined by separate random samples for example in centers for sexually transferable diseases (STI-centers) and connected with the random samples of the pregnant women within a mathematical model.[2] With the calculation methods currently available, reliable statements on the actual number of HIV-infected persons can hardly be made. The UNAIDS-figures for India should therefore be taken as a minimum value. At most, they are a vague approximation to the problem. (CF)

1 UNAIDS and WHO. AIDS epidemic update 07. Geneva 2007 http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf
2 Technical Report; India HIV Estimates 2006, National AIDS Control Organisation, Ministry of Health and Family Welfare Government of India, NACO 2007

Aids in the Ukraine: Not only the Fringe Groups are Affected

When the issue of Aids is broached, one mainly thinks of Africa. But it is also in Eastern Europe where the infection spreads massively. We had a conversation with Markus Leimbach, Renovabis.

What distinguishes the HIV-epidemic in Eastern Europe from the developments in other regions?
The infection has not yet spread as far as e.g. in Southern Africa. The disease is not so much spread by sexual contact as, above all, by drug abuse, by syringes.

So it is only a problem of social fringe groups?
No, it is not. Take the Ukraine: Many young people do not have a job, are completely without perspective. Among friends, young men inject cheap "local" drugs and get infected via jointly used syringes. Young women get in contact with the drug via older partners and then prostitute themselves in order to finance their addiction. Their clients come from all circles of society – the visit to a brothel during a business trip is for example widely spread. In addition to the sexual transmission of HIV, the transmission from mothers to their newborn babies is currently becoming more important. Many mothers without risk behavior only learn of their infection during pregnancy.

Does homosexuality play a role?
Homosexuality is a taboo in Eastern Europe; it is therefore not clear how high its proportion of the transmission is. In prisons, the sex between men is often forced. Anyone who admits to be gay, will slide down to the lowest position within the social order.

How should we imagine the situation in Ukrainian prisons?
The living conditions are disastrous. The people live in overcrowded communal cells. HIV is a big problem; infection is in particular caused by drug abuse or jointly used razor blades. (Resistant) tuberculosis spreads particularly fast in prisons. This infection frequently accompanies HIV and the close living conditions in prisons aid the transmission.

How does the government deal with this?
Up to now, the government has hardly done anything. In the prisons, the main measure is separation: Anyone who falls ill will be separated from the others.

Do people with HIV receive medical treatment?
Officially the government says that everyone receives a therapy. But the dark figure of people with HIV among the population should be high and they naturally do not receive therapy. A further problem exists for drug consumers. The use of drugs is illegal. For a long time, addicted people only received HIV treatment after drug withdrawal. Now there are the first programs of (Methadone) substitution predominantly for addicts with HIV.

Will the state take over the treatment?
In every Oblast (somewhat smaller that a Federal State of Germany) one (1!) Aids-center exists which is responsible for the treatment. For a long time, the government completely left the topic HIV to the NGOs. Accordingly, an international NGO was responsible for supplying medication via the Global Funds. However, the government is slowly getting active.

What is the role of the churches?
Church institutions are active on all levels. Parishes inform young people about HIV, other organizations take over the succor for and caring of the sick, and there is a rehab institution for drug addicts. Renovabis, for example, supports a project for training voluntaries in parishes as resident advisers for the persons affected.

Condoms as preventions – what is the position in this respect?
The position held by Renovabis is: To inform about condoms but not to specifically propagate them. In the Ukraine, the churches are partly extremely conservative and strongly emphasize the significance of abstinence. In the Greek Catholic and Roman Catholic church, emphasis is placed on supporting the people in everyday life. In recent years, the awareness for HIV has significantly changed in all parts of society and the need for action is recognized by everyone. In project cooperation, we follow the strategy that the topic condoms is not focused on too much.

Which are the tasks that the Expert Group Eastern Europe have set themselves in the Coalition for Action against Aids?

In fact, we are all practical people who are in charge of projects in Eastern Europe. There are several church and civil society institutions. We link our projects, search for gaps in which we can supplement each other, encourage exchange, develop joint positions and corresponding approaches of lobbying.

Does the Federal Government of Germany do anything as regards HIV in Eastern Europe?
Yes, the program is called „German-Ukrainian partnership initiative for the fight against HIV and AIDS". It is sponsored by the German Ministry of Health (BMG) and i.a. projects of German NGOs and their partners are supported. This is an important sponsorship of pilot projects and the German Ministry can exert a positive influence on their colleagues at the Ukrainian Ministry of Health. The consequences can be felt. However, we consider it a big disadvantage that the projects are only sponsored with small sums and for an extremely short time: for example, they always end on 31st December. Furthermore, administration and financial settlement is very time-consuming.

What are your wishes for improving your work?
I wish that the responsibilities within the Federal Government of Germany would become clearer and, at the same time, that the exchange between the Ministry of Health and the Development Ministry would become more intensive – while including the civil society!

The interview was held by Christian Wagner-Ahlfs, BUKO Pharma-Kampagne.

photo: Alta.C/fotolica.com; Markus Leimbach

Markus Leimbach works for the catholic Eastern Europe relieve organization Renovabis. He is responsible for the department Projects and Countries. Renovabis was founded as "Solidarity initiative of the German Catholics with the people in Central and Eastern Europe" in 1993. In the German Action against Aids, Markus Leimbach is the chairman of the expert group Eastern Europe.

More informationen
www.renovabis.de
www.aidskampagne.de

Cheap and Without Rubber

Forced Prostitution and Aids in Germany

In the middle of one of the richest industrial countries, a parallel world without rights and social securities has been established. We talked to Corinna Dammeyer, who works for Nadeschda, about forced prostitution and Aids in Germany.

Corinna, what is the task of Nadeschda?
Nadeschda looks after women who were trafficked to Germany and forced into prostitution. Our clients mainly originate from Eastern and Middle Europe and, on average, are between 18 and 25 years old. However, among them are also minors. Health plays an important part in our counseling - the physical as well as the mental health.

Is Aids a topic that you are concerned with?
As far as I know, there are no estimates as to how many of the forced prostitutes are HIV-positive. That what we see is only the tip of the iceberg. We are presently taking care of two women who are HIV-positive and receive Methadone substitution treatment. In these cases, the medical treatment takes a large part in our advisory activities.

What do you advise about?
Most women got to know insufficient health systems in their home countries. They need a lot of support to get used to our system. In case of a drug addicted prostitute from Russia, a blood dialysis was carried out in a hospital in St. Petersburg. This extremely expensive treatment had to be paid by the woman and her family. So the woman reacted very skeptical: What do I have to do or pay if I make use of the medical service?

Human trafficking with women and children is also common in industrial states. In the European Union alone, there are about 300,000 victims of traffickers. Often, the perpetrators get away with minor prison sentences.

How do the women come to you?
On the one hand, our outreach work leads us into brothels. We distribute e.g. handouts in eight languages which inform about the necessity of a health insurance. On the other hand, we are being informed if the police pick up women without papers in a raid.

How did your clients get infected with Aids?
One client got infected in Germany because she shared her injecting equipment with another woman. Others were infected in their home countries. Drug abuse and red light crimes go together like a pair of shoes. Forced

prostitutes are often exposed to extreme violence. Many of them see alcohol or drugs as their only escape.

Do the women know about the health risks – and especially as regards Aids?
The women have received hardly any health education at home. Many do not know how to use a condom, how they can protect their body and their health. Above all in Rumania or Bulgaria, sexuality is a big taboo. Parents do not talk about it and there is no sexual education in schools.

Do the women have access to medical care?
As soon as we counsel them, yes. Those women decided to give evidence in criminal proceedings against those human traffickers. For the duration of the proceedings, they receive social welfare benefits, have health insurance and all acute diseases can be treated. This also covers Aids. After the lawsuit, women from Non-EU states are requested to leave Germany.

What happens then?
In two cases of HIV-positive women, we were able to push through permanent residency since the women would not have received sufficient medical care in their home countries. In the case of a Russian woman, addicted to drugs, no Methadone substitution treatment would have been possible. The immigration office themselves conducted a research and had to confirm our information. In Russia, this woman would have reverted to drugs. Again she would have prostituted herself to finance the drugs and would have further spread the virus.

Do you encounter more positive women today as compared to when you started your work 12 years ago?
I cannot fix that to Aids, but generally the health of the women has deteriorated: sexually transmitted diseases, tuberculosis, hepatitis … Very often the women are malnourished in addition to the traumatization. As regards Aids, one could perhaps say: In earlier days, the women came and got infected here. Now, many of them come here, already infected, but they do not know about it and unintentionally infect others.

Corinna Dammeyer is a social worker and works for Nadeschda, a specialized women's advice center for victims of human trafficking. The organization is located in Herford and is responsible for all of Eastern Westphalia.

Do the clients know about the risk of an Aids infection?
The customers increasingly want sex without taboos for little money. And that means above all: without rubber. German women say that they will not do it without. But women forced to prostitution do what they are told. Even voluntary prostitutes are under enormous pressure: The prices have sunk, the supply has risen.

Which steps would be necessary to improve the women's health?
Women need to have equal access to education. And here in Germany, the health authorities would have to accept more responsibilities: For example, a regular examination for the prostitutes, anonymous and free of charge. However, there are big fears of contact on both sides. They say, for example: Such an offer existed for years but nobody came. The authorities would have to go into the milieu themselves, search out those women and build trust.

The interview was held by Claudia Jenkes, BUKO Pharma-Kampagne

photos: Yam/fotolia.com; Corinna Dammeyer

More information about the project (in German language only):
www.frauenhilfe-westfalen.de/menschenhandel.html

High Prices cost Lives

Patents and the Protection of Public Health

At first glance, it seems to be just to reward innovation with a patent. But what if the invention concerns vital goods such as drugs and medications?

Any invention which is novel, innovative and can be industrially applicable can be patented. The patent grants exclusive rights to the owner for a limited period of time. It grants a monopoly on production, utilization and sale of the innovation for a limited period of time and excludes others from the production, utilization, the sale or the option of importing a patented product. Any patentee can raise the price of their products and limit their amounts. Each patent application is granted by national patent offices and each patent is principally only valid within the authority of that state.[1]

A Monopoly raises the Price

International treaties require that national patent laws be harmonized. The World Trade Organization (WTO) plays a decisive part in this. The TRIPS Agreement (Trade Related Intellectual Property Rights) forces all WTO member states to include extensive patent protection on drugs in their national laws. That means that product patent protection of a minimum of 20 years has to be granted. This exclusive right prevents other manufacturers from imitating a drug and marketing it as a generic. Such competitive products would lower the price. Patent protection allows a temporary monopoly which enables the manufacturers to offer their branded articles at elevated prices.[2] In poor countries, drugs are thus becoming a kind of goods which is available only for few.

Safeguard for Human Rights

In order to guarantee a balance between trade laws and human rights on access to indispensible drugs, TRIPS contains important safeguard clauses intended to also protect public health. These safeguard clauses were confirmed by the Doha Declaration on TRIPS and on public health, which was agreed upon by the WTO ministers in November 2001. It says: "We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health."[3] The Doha Declaration acknowledges i.a. the rights of all WTO-member states to grant compulsory licenses – for example in the case of a national health emergency.

Government authorities can enforce a production permit by means of a compulsory license. The manufacturer receive a fixed license fee in exchange. Thus, a government could grant a compulsory license on an urgently needed second-line Aids-drug and then have it produced by a company. A case of health emergency is only one of many reasons for which a compulsory license can be claimed.[4]

What do Countries without a Pharmaceutical Industry do?

After the Doha Declaration, the following problem still existed: According to TRIPS, products under compulsory license can only be produced for the local market. So how should countries without a local and capable pharmaceutical industry be able to utilize compulsory licenses? A compromise to the export of products under compulsory license had to be found. On 30th August 2003 it was agreed that all WTO-members were entitled to grant compulsory licenses for export in order to export imitations of patented drugs into countries without sufficient production capacities. However, in reality this compromise is not practicable: The bureaucratic obstacles are that high that only a little shipment of AIDS-drugs has been shipped from Canada to Ruanda within six years. The receiving and the exporting country each have

to grant a compulsory license for each single drug – a cumbersome process. Only four countries have implemented their national laws in accordance with the compromise at all.[5]

Thus generic companies, as a rule, depend on the voluntary licenses of large pharmaceutical groups to be able to produce low-priced drugs for poor populations. Such voluntary licenses do indeed improve access to vital medication. However, they are not an enforceable right and thus no sustainable solution.

India – Chemist of the Poor

Threshold countries such as India had to amend their patent law in accordance with the TRIPS guidelines in 2005. The poorest countries still have time until 2016. India did not grant any product patents within the period of 1970 to 2004. Thus, Indian generic companies were able to grow into an efficient industry. Today, they have become the most important supplier of generics for the southern countries. India is therefore often called the chemist of the poor.[6]

The amendment of Indian patent law of 2005 uses the flexible aspects of TRIPS as much as possible:[7] Compulsory licenses for national use as well as export licenses are provided. (However, both provisions have not yet been used.) Indian patent law also wants to prevent "evergreening" of patents. Article 3 (d) excludes products from patent protection which are only a new form of an already known substance and do not have a novel therapeutic value. Oppositions of affected groups (post- and pre-grant opposition) against patent applications are provided. In this case, there has to be a hearing.

Right to oppose

The right to oppose is used by civil society groups such as the Lawyers Collective,[8] but also of generic companies such as Cipla, in order to fight patent applications for indispensible drugs. An example for this is the pre-grant opposition of both against Lopinavir/Ritonavir, which is the heat-stable form of an indispensible HIV drug of the second therapy line for which Abbott applied for a patent.[9] The drug is not endowed with therapeutic novelty as compared to the form that was unstable in heat.

Should patents be granted on indispensible ARVs, it is not clear how and whether the production of generics can be continued. The Indian companies would be dependent on voluntary licenses of the large pharmaceutical companies. These could then dictate the conditions of such voluntary licenses. However, the production of generics could also be stopped in favour of the original preparation. A price increase would be most probable. In the case of Lopinavir/Ritonavir, there would be cause to fear that if the Indian government did not grant a compulsory license, since Abbott does no grant voluntary licenses on principle. Whether India is prepared to take this step, however, is unclear. (CF)

1 http://en.wikipedia.org/wiki/Patent
2 Banta, D.H. (2001). Worldwide interest in global access to drugs. The Journal of the American Medical Association, 285 (22), 2844-2846.
3 Declaration On The TRIPS Agreement and Public Health, WTO, Wt/Min(01)/Dec/2 20 November 2001, Ministerial Conference Fourth Session Doha, 9 - 14 November 2001
4 Declaration On The Trips Agreement And Public Health, WTO, Wt/Min(01)/Dec/2 20 November 2001, Ministerial Conference Fourth Session Doha, 9 - 14 November 2001:
§5(b) Each Member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted.
§5(c) Each Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.
5 MSF Press Release, WTO sacrifices access to medicines before Hong Kong ministerial meeting, December 12,2005
6 Jean O. Lanjouw; The Introduction of Pharmaceutical Product Patents in India: "Heartless Exploitation of the Poor and Suffering?", NBER Working Paper No. 6366, Yale University and the NBER, p. 47-48
7 The Patents (Amendment) Bill 2005 passed by Indian Parliament, www.indianembassy.org/press_release/2005/Mar/12.htm
8 www.lawyerscollective.org
9 Abbott Patent 339/MUM/2006, Filing date: 26.8.2004

The Role of Aids Research

Research can make a significant contribution in fighting HIV and Aids. The problems to be solved in this respect are manifold: New drugs are needed since the viruses develop resistances against therapies after some time. It would also be desirable to have alternatives with fewer side effects or a vaccine to effectively prevent infection (page 26).

The basis for this research are reliable data on epidemiology, i.e. on the spread of the infection, or which subtypes of the HI-virus can be found where and with which factors their propagation is connected. Last but not least, the deciphering of a phenomenon could become a mile stone: time after time, people are being infected and still no viruses can be found in their bodies after some time. Why? That is a mystery.

A tangible result of research are new drugs. However, what is the use of research if the drugs are not affordable? On page 22 we summarize the state of the international discussion on the role of patents. The World Health Assembly adopted an action plan in May 2009, with which the development of new drugs shall be tailored to needs.[1] Important cornerstones are a critical view of the established patent system as well as the realization that other incentives for research are necessary. We introduce sustainable concepts of other and fairer research structures as well as the model Patent Pool (page 27). (CW)

1 Resolution WHA 62.16 of 22/5/2009
http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R16-en.pdf
and Resolution WHA 21.21 of 24/5/2008
http://apps.who.int/gb/ebwha/pdf_files/A61/A61_R21-en.pdf

There are other Ways! Alternatives to the Patent System

Patents do not suffice as an incentive for research in order to fulfill the health-related needs of people living in poor countries. That is the conclusion of an expert commission of the World Health Organization (WHO). New research models could offer an alternative. We will introduce the most important models.

Publicly financed Clinical Trials

Publicly financed research is already playing an important part in the development of new drugs and therapies. More than 50 percent of health-related research are publicly financed worldwide. So far the money is mainly used for basic research. The development of products which are close to the market – i.e. mainly clinical trials in humans – is left to the industry. However, there are many reasons for accepting clinical trials as a public task: the concealment of undesirable results of the trials for commercial reasons could be prevented, and an enormous amount of money could be saved if fewer but only high-quality trials were carried out. Financing would be conceivable via taxes, but also health insurance companies could participate (which would necessitate a legal amendment in Germany). The savings for the public health systems achieved by lower prices of the pharmaceuticals alone would more than compensate the costs of such a public system of trials. [1,2,3] Even the leading public research institutes have recently advocated a strengthening of the public trial culture.[4]

Prizes instead of Patent

The concept of a prize is mainly aimed at disconnecting the medicinal prices from the costs of their development. Whereas the current patent system is based on the assumption that high costs of research have to be refinanced by high product prices, a bonus disconnects the two.[5] Anybody who develops a new drug (or essential stepping stones on the way there) will be rewarded with a publicly financed prize. Thus, the claims of the developer are satisfied, the drug so to say becomes public property and can be manufactured as a low-priced generic drug right from the start. Pilot projects will be proposed e.g. for the diagnostics of tuberculosis and for Chagas medication.[6] Unfortunately, there is a lack of financing for testing the efficiency of this model.

Health Impact Fund

Another concept, the Health Impact Fund, also proposes the bonus system, however, it upholds the monopoly system. Accordingly, the pharmaceutical companies receive a bonus if they sell a new drug at production costs. The extent of the bonus shall be defined by the benefit for world health.[7] Thus an incentive would be created for companies to get more involved when diseases are concerned that have not been commercially interesting so far. As regards this model, the continuation of the concept of monopoly is above all criticized. The introduction of a remuneration according to benefit ("health impact") has to be regarded as positive.

Research Funds

A multinational pot of money from which research projects were financed would also be conceivable. A proposal developed by the pharmaceutical company Novartis provides that the fund remains the exclusive owner of the drugs but sells them at production costs.[8] Although this concept is reminiscent of non-profit research groups, the suspicion of a cross-subsidization of industrial research arises – this proposal in fact having been made by Novartis.

Which model will work best? Nobody can predict that. What is decisive is the courage and the political will for testing. (CW)

1 Dean Baker: The benefits and savings from publicly funded clinical trials of prescription drugs. International J. of Health Services, Volume 38, Nr. 4, Pages 731–750, 2008 www.cepr.net/documents/publications/clinicaltrials_2008_03.pdf
2 Pharma-Brief 3-4/2008 p. 5-8
3 Lewis T., Reichman J.H., So A. The case for government oversight and government funding of clinical trials. *Economists' Voice* (Berkeley E-Press). 4(1). January 2007
Reichman J.H. Rethinking the role of clinical trial data in international intel lectual property law: the case for a public goods approach. *Marquette Intellectual Property Law Review.* 13(1):1-68. Winter 2009
Jerome H. Reichman, Marquette Intellectual Property Law Review 2009, 13:1.
4 Investigator-Driven Clinical Trials. European Science Foundation 2009. http://www.esf.org/fileadmin/links/EMRC/FL_IDCT.pdf
5 The concept of the prize fund was essentially developed by James Love (www.keionline.org) and Tom Hub bard. See Love J, Hubbard T., The Big Idea: Prizes to Stimulate R&D for New Medicines. Chicago-Kent Law Review 2007.
6 WHO Intergovernmental Working Group on Public Health, Innovation and Intellectual Property: Public Hearing on R&D Financing. Joint submission of Bangladesh, Barbados, Bolivia and Suriname (April 2009)
www.who.int/entity/phi/Bangladesh_Barbados_Bolivia_Suriname_ChagasPrize.pdf
www.who.int/entity/phi/Bangladesh_Barbados_Bolivia_Suriname_TBPrize.pdf
7 Aidan Hollis, Thomas Pogge (2008): Health Impact Fund. www.yale.edu/macmillan/igh/
8 www.who.int/entity/phi/Novartis.pdf. The proposal mainly originated from the Novartis executive Paul Herrling. Paul Herrling, Making drugs accessible to poor populations: a funding model. Global Forum Update on Research for Health Vol. 5 (2008) S. 152-155 www.novartis.com/downloads/research/nitd/newsroom/news/makingdrugsaccessible.pdf

photo: P.Virot/WHO

Vaccination against Aids: No Success in Sight

A vaccine could offer an important contribution to the protection from infection, but work is on therapeutic vaccination as a treatment of already infected people is also on its way. However, it is not forseeable when an effective vaccination against Aids will exist.[1]

Worldwide intensive research is devoted to a vaccine. The various research groups have meanwhile been well linked, which allows a systematic comparison of different vaccination concepts. But most of supposed progress has always ended with a disappointment. In 2007, a harsh setback was the termination of a clinical trial by the manufacturer MSD, since more people got infected with the vaccination than without.[2] The failure of previous efforts is caused by many reasons, for example the distinct characteristic of the HI-virus to mutate.

In 2007, more than 900 million US-dollars were invested in the HIV-vaccine research worldwide, 82% thereof were public funds.[3] The most important sponsors are the USA, followed by some countries of the European Union. As a private sponsor, the Bill & Melinda Gates Foundation is in second place of the research supporters.

In Germany, 16 research locations (universities and other public institutes) take part in HIV-vaccine research. The scope of research activities reaches from researching the biological basis of the HIV-infection to testing potential vaccines in humans.

Since a future HIV-vaccine would have to be used above all in developing countries, it has to be tailored to the local needs. It must offer protection against the prevailing viruses and also be used in hot climates. And it should have to be produced at lowest possible costs. HIV-vaccines are therefore predominantly tested in developing countries. German research teams mainly work together in this with teams in China and Tanzania. (CW)

1 C. Wagner/Aktionsbündnis gegen Aids: Die aktuelle Situation der HIV-Impfstoff-Forschung (Tübingen 2005)
C.Wagner-Ahlfs: HIV-Impfstoff-Forschung. Update zur Lage in Deutschland 2008 www.aidskampagne.de
2 hivreport December 2007
3 HIV Vaccines and Microbicides Resource Tracking Working Group, August 2008
www.hivresourcetracking.org/content/RT_report_August2008.pdf
photo: Krischi/fotolia.com

To Benefit from Plenty: Patent Pool

If many patents get in each other's way during the new development of drugs and medicines, the handling can become difficult. Then, it may be advantageous to bundle the patents. The procedure known as patent pool is customary for some technologies and it could also solve many problems for HIV-drugs.

In a patent pool, patents are not cancelled, but the use of them is simplified. The property laws of the various patent owners (companies, universities etc.) are centrally managed and utilized non-exclusively for others. This is important if others are dependent on those patents and e.g. wish to acquire licenses. Drugs are protected by a large number of patents – like many products and technologies. Accordingly, license negotiations are often necessary with several patentees. That can be very complicated if, for example an HIV-drug is to be developed containing different active agents. These combination preparations (fixed-dose combinations) are useful for HIV-therapy. A patent pool could function here as a middle man, as a central authority which acts between patent holders and those seeking a license in accordance with a uniform scheme. Anyone who wants to develop a combination preparation does no longer have to go into lengthy negotiations with each single patentee but can clarify all at one go with the administration of the patent pool. This is determined by clear rules which are known beforehand and which simultaneously fix the license fees.

Such pools are mainly customary for electronic devices but they are also increasingly used in the field of biotechnology. In July 2008, the organization UNITAID decided to develop a mandatory patent pool for Aids-drugs. UNITAID is an organization which finances drugs for HIV projects in poor countries with the aid of an additional tax on flight tickets (i.a. France, Norway and Chile).

A patent pool can also be useful for drugs that are already on the market since it can facilitate technology transfer into poorer countries and thus the production of generics. That again lowers the prices of drugs and makes medication accessible for more people. The procedure also has clear advantages for the patentees: Their administrative effort with the licenses is reduced since all is handled centrally via the pool. That saves cost, is reliable and can also be well calculated.

What is problematic is the voluntariness of the pool. Indian manufacturers of generics fear that only unimportant patents will land in the pool. Whether the pool is realized largely depends on the power of persuasion of UNITAID. GlaxoSmithKline has already announced that they participate in a patent pool for neglected diseases.[1] Now GSK and likewise other companies are asked to get involved in an HIV-patent pool.[2] (CW)

1 Pharmaceuticals, patents, publicity…and philanthropy? Lancet 2009; 373: 693.
2 GSK: please extend patent pool to AIDS drugs. Lancet 2009; 373: 1339.
photo: UK Stop AIDS Campaign, Andrew Aitchison 2009

Brazil: Free-of-Charge Treatment for All

Brazil is seen as a success story in the fight against the spreading of HIV. We interviewed Andreas Wulf of medico international on the background.

How good is the medical care for people with HIV in Brazil?
The therapy is at a similar standard as in Europe. The reason for this is the government policy which provides "universal health care for everyone", which is why each and every HIV-infected person is entitled to treatment free of charge.

How was this success possible?
The Brazilian health system is the result of an intensive public debate which is closely connected with the democratic movements. The people stand up for their rights. In the field of HIV, the gay movement plays an important role. The commitment for social acceptance, coupled with the interest of the media, laid the foundation for prevention work in Brazil. It is characteristic that the target groups of prevention and treatment had been involved in the concepts right from the start.

However, the general conditions have changed recently. One says "Aids is getting older", the disease is no longer restricted to young gay men. More and more women are affected as well, the infection is becoming heterosexual. And the infections are no longer restricted to the Brazilian metropolitan areas, but extend to the rural areas. That presents the educational work with big challenges.

Andreas Wulf has been working as medical project coordinator at medico international for 11 years. He is also responsible for the international health policy networks, in which medico is also active (Health Action International, People's Health Movement).

Does medico support a Brazilian organization in their work?
Yes, we support projects of ABIA (Associação Brasiliera Interdisciplinar de AIDS), a NGOs working in the field of Aids- ABIA coordinates a network working on Aids and patents (Grupo de Trabalho de Propriedade Intelectual GTPI). For example, a workshop has recently been organized with which activists from all over Brazil were schooled on the background of patent law.

Why do Aids-activists work on the topic of patent law?
Patent law ensures high pharmaceutical prices. For that reason, the government has Aids-drugs which were developed before the year 1995 (that means that they are still being used for basic therapy today) be produced in the pharmaceutical company Farmanguinhos, which is publicly owned. However, that is more difficult for new drugs still protected by patents. The second-line drugs or the improved first line are therefore still very expensive in Brazil. In this respect, the government counts on negotiations with the patent owners to lower the prices. If the negotiations do not result in a satisfactory outcome, compulsory licenses can be imposed. Maintaining this threat, strengthens the negotiating power of the government. Until now, Brazil has imposed a compulsory license only once: for the drug Efavirenz. That was of important symbolic significance. Aids-activists make such topics public and exert pressure on the government.

Is there an example in this respect?
The patent on Tenofovir was not acknowledged in Brazil. The active ingredient had long been known, so there was no inventive novelty. It is the result of NGO-work that this is thoroughly examined. The NGO ABIA supported by us has recently also been registered in India as an NGO in order to file suit against patents in cooperation with Indian

organizations. That is true progress in particular when the NGOs start to overcome the traditional language barriers between the Anglophonic and the Latin-American world in their cooperation. ABIA also works closely together with South-African NGOs.

How does the Brazilian government plan to improve the situation?
In Brazil, generics have priorly been produced, the necessary active ingredients have been bought to 80% and mainly in China. The setup of a Brazilian production of active pharmaceutical ingredients, which is now intended, will strengthen the local industry and can make the supply with Aids-drugs cheaper.

The interview was held by Christian Wagner-Ahlfs, BUKO Pharma-Kampagne.

photo: medico

More information:
www.medico.de

Political Work meets with Success - Worldwide!

- Until 2001, an HIV-treatment cost more than 10,000 Euro per year and patient. Because of the courage and the pressure of civil social groups, the prices for the poor could be reduced to below 90 Euro. This price difference is a question of life and death.
- The South African government hardly reacted to the HIV-epidemic at home for many years. As a result of the untiring commitment of the Treatment Action Campaign and other local organizations, the problem could no longer be denied.
- Compulsory licenses are a protective clause provided by the international trade law. However, the pressure of the USA and the large pharmaceutical companies was so great that poor countries did not dare to claim their rights. Encouraged by the public discussion, Thailand and Brazil are the first countries to have granted compulsory licenses to indispensible medication.
- After the WTO ministerial conference failed in Seattle in 1999 because of the resistance of poor countries, the Doha Declaration for the Protection of Public Health was resolved on in Doha, two years later. If the industrial countries had not agreed, they would have risked a new failure of the WTO ministerial conference in Doha.
- Aids policy in Germany is based on the development of concepts in cooperation with affected people. The request of homosexuals for social acceptance was an essential driving force for this.
- Brazil grants all citizens free-of-charge access to diagnosis, prevention and therapy. Aids-related mortality has drastically sunk since. Even the rate of new infections declines.

Aids

Normalization in Germany, Tragedy in the South

Whereas HIV/Aids is regarded as a controllable chronic disease in the western world – not least because of the availability of effective medication -, the situation for large parts of the world's population is dramatic: In Africa, south of the Sahara, 23 million people are infected, among them about two million children. However, the infection figures are also on the rise in Eastern Europe.

This Pharma-Brief Special does not only give you recent figures and facts concerning the worldwide spread of HIV. It also summarizes the latest developments in the fields of HIV-prevention, therapy and research. Interviews with experts on the situations in India, South Africa, Germany and the Ukraine present first-hand information and illustrate the problems encountered in prevention work or as regards access to effective therapies.

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