

Conference Report

Bangkok: The End of Broken Promises? XV International AIDS Conference, 2004

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ABSTRACT. The global community has again failed to significantly confront the AIDS crisis. In the context of a worsening HIV pandemic, the conference highlighted the shortfall in funding, the soaring infection rate in Asia, the need to integrate prevention and treatment and the difficulties in coordinating a global response. To overcome AIDS, the global community must put aside ideology and honour its commitments.

Introduction

The most worrying concern to emerge from the Bangkok AIDS Conference was the further failure of the global community to significantly confront the AIDS crisis, prompting the blunt warning by Nelson Mandela's wife, Graça Machel, that 'Bangkok has to be the end of promises made, promises broken'.

The medical messages that came out of the conference were forlorn: no significant additions to the store of clinical knowledge, and the results from the next batch of vaccine evaluation trials 5 years away at the earliest. UN Secretary-General Kofi Annan touched on some of the key issues: the soaring infection rate in Asia; the need for more money; that women and young people are increasingly bearing the brunt of the pandemic; and the need for a full-scale, integrated infrastructure to provide both prevention and treatment.

The conference itself was overwhelming, intense and utterly exhausting: over 20,000 delegates occupying kilometres of corridors and halls, bombarded by thousands of presentations, workshops, seminars, posters and commercial displays. But the 'Access for All' theme was undermined by the hefty US\$1000 registration fee which denied access to many from developing nations who would have otherwise attended.

Hope was best embodied in the mix to be found in 'The Global Village' forum, which the general public was invited to attend free. Presidents, Thai sex workers, a gay men's collective and a Salvation Army band could be found sharing life and opinions in amongst a lively tapestry of hundreds of colourful food and craft stalls. This is surely what's needed across the wider world itself.

An overview

HIV is a preventable disease, which has become a runaway pandemic. Prevention efforts can only be described as anaemic. The world's HIV-positive people now number 38 million, over 2 million of them children. The number of new infections in 2003, almost 5 million, was the largest 1-year increase on record. Most of those infected 10 years ago are dying now because of the inequitable global distribution of anti-retrovirals.

Women and youth are bearing the brunt of the pandemic. In Sub-Saharan Africa, 57% of infected adults are women, and females make up a staggering 75% of infections in the 15–24 age group. Globally, the 15–24 age cohort accounts for almost half of all new infections.¹ Gender inequality is the main culprit, denying many woman and girls education, empowerment and control over their own bodies. They are now reaping the dreadful results of 10 years of inaction since these issues were prioritised at the International Conference on Population and Development in Cairo.

Asia — the future epicentre of the pandemic?

With 1 in 4 of the world's infections, Asia is now said to be poised to overtake Africa as the epicentre of the pandemic by 2010. India and China are both set to explode. India has already more than 5 million infected and China around 1 million.

Despite the diversity of epidemics in Asian countries, there is a common pattern of spread through identifiable risky behaviours which, though common, are not practiced by the majority of the population. The epidemic is sparked by injecting drug users and men who have sex with men.

HIV then spreads among commercial sex workers and their clients, finally becoming more common among pregnant women.² This pattern provides a focus for targeted prevention programmes that have been proven to reverse the tide.

Thailand is one such example, deeming it an appropriate venue to host the global meeting. By the early 1990s, there was a 30% infection rate in sex workers, which the government confronted with its widely praised '100% condom programme', targetting sex workers and their clients. That programme halved the sex workers' clientele and removed taboos around condom use, ensuring free and widespread distribution.

The results were spectacular, with an estimated 5 million infections averted. Condom use soared to over 95% and the annual HIV infection rate dropped by 80% from 143,000 in 1991 to 29,000 in 2003. In sex workers, the HIV prevalence fell from 30% in the mid 1990s to 2.6% in 2002.³

But now, condom use in Thailand is decreasing, especially among youth and the partners of sex workers. Like many other Asian nations, Thailand is finding the main challenge coming from injecting drug use (IDU). Fifty-four percent of HIV transmission is attributable to IDU,⁴ and 50% of all injecting drug users are HIV positive.⁵ In Vietnam, these figures are 65 and 74% respectively.

In opening the AIDS Conference, Thailand's Prime Minister, Thaksin Shinawatra, surprised everyone by promising a comprehensive programme to tackle the epidemic at a national as well as a regional level.

He admitted it was wrong to treat drug users as criminals and that they would now be regarded as patients who need support and treatment, backflipping on his government's hard-line stance in which 50,000 suspected drug users have allegedly been imprisoned.⁶ The harm reduction strategy would enlist government and non-government agencies as well as the Thai Drug Users' Network.

Thaksin also pledged to expand anti-retroviral treatment (ART), to reduce HIV-related stigma and discrimination by funding vocational training programmes, and to care for and educate AIDS orphans.

Importantly, Thailand has decided to help its neighbours, especially by the distribution of generic ART drugs produced at cost by the pharmaceutical company owned by the Ministry of Public Health. A small and developing nation pulling itself out of a recession, Thailand also boldly pledged US\$5 million to the Global Fund to fight AIDS, TB and malaria.

In a stroke, Thailand's Prime Minister positioned himself and his country as the model that others in the region, including Australia, must follow.

Can Thaksin's promises be relied upon? Having been announced on a world stage, Thais must ensure that they are honoured. Already, Senator Mechai Viravaidya, one of the architects of the '100% condom' policy, has promised to organise monthly public meetings to do so.

Perhaps Sonia Ghandi's closing ceremony comments auger well for India and Asia. 'I . . . categorically assert the determination and ability of the government and the people of India to meet this daunting challenge . . . effectively. We in India have much to learn from [Thailand] in many areas, not the least being in HIV/AIDS management itself.'

Integrating prevention and treatment

The WHO/UNAIDS '3 by 5 Initiative' aims to have 3 million people in low to middle income communities on ART by 2005, but presently, more than half way through 2004, only 400,000 are getting that treatment. Aptly, conference activists circulated a badge reading, 'Access for All — Denied!'

The cost of treating 3 million HIV-positive people with ART now is estimated at US\$3 billion. UNAIDS estimated funding for HIV totalled \$4.7 billion last year and it will need an extra \$6 billion next year. By 2007, the total amount needed every year for AIDS alone will be \$20 billion.

Some suggest that not all resource-poor countries should embark on a widespread ART programme. The director of the International Health Policy Program at the Thai Ministry of Public Health argued that ART programmes must be stratified according to health system capacity and financial resources, as ART provision takes up the lion's share of any AIDS programme budget.⁷ For example, if resources are adequate, but the health system capacity is weak, it is possible to 'mend the boat while sailing forwards': rehabilitating the health system while launching a small scale ART programme. However, in the common scenario of a weak health system and little money, these limited funds are better put into prevention only, with no ART programme. Although it sounds iniquitous, attempting to start ART in this situation runs the risk of seeing the whole budget swallowed up, while the epidemic spirals out of control.

Many delegates expected the theme 'Access for All' to downplay prevention in favour of expanded treatment. However, to their credit, the conference organisers and the vast majority of speakers, from Kofi Annan down, kept prevention high on the agenda, helped by a new report from the Global HIV Prevention Working Group: 'HIV Prevention in the Era of Expanded Treatment Access'. Fewer than one in five people at high risk of infection has access to proven HIV prevention interventions, since these programmes do not attract sufficient donor support.⁸ However, a 2002 study has reported that the 45 million new infections projected to occur between 2002 and 2010 could be slashed to just 16 million if existing prevention strategies were substantially expanded.⁹

The working group report argues that expanded treatment can improve prevention efforts and vice-versa. Without the prospect of HIV treatment, people lack the incentive to know their HIV status. So, when pilot ART programmes were introduced in Haiti, South Africa and Brazil, the number of

people attending voluntary counselling and testing soared. HIV-related stigma, which impedes so many prevention efforts, was also reduced.¹⁰ Interestingly, evidence is emerging that ART itself may reduce infectivity in correlation with a reduced viral load. However, this potential effect is reliant on strict adherence to treatment, and is overwhelmed if there is an increase in risky behaviour¹¹ (as we are seeing in many high-income countries) which may stem from the perception that with ART, fewer people being ill and fewer dying, HIV is less threatening.

One of the most interesting recommendations of the working group is the concept of 'Prevention for Positives'. The majority of prevention programmes have targeted HIV-negative people, not utilising the fact that each new HIV infection through sexual behaviour or injecting drug use requires the participation of one person who is HIV-positive and one who is HIV-negative. Acknowledging that during treatment, sexual desire may recover after a period of illness, one aim is to help HIV-positive people implement and sustain safer behaviours, as well as enlisting them as ideal advocates to deliver public prevention messages and services.¹²

A watershed event for microbicides?

Dr Zeda Rosenberg, the CEO of the International Partnership for Microbicides, declared that both vaccines and microbicides needed to be fully funded, rather than prioritising one above the other. She saw the Bangkok Conference as 'a watershed event' for microbicides especially given the urgent need for a female-controlled method of HIV prevention. These gels or creams applied to the vagina before sex could help prevent HIV transmission. The need is urgent because young, married women are now the most vulnerable group — they have limited say as to when or if they're to have sex, let alone use condoms or insist that their partners remain faithful.

A 60% efficacious microbicide introduced into 73 low-income countries and used by only 20% of women is estimated to be able to avert 2.5 million HIV infections over 3 years in women, men and infants.¹³

Research into microbicides is burgeoning once again, after the disastrous clinical trial of Nonoxynol-9 which increased the risk of HIV transmission due to vaginal inflammation.¹⁴ Rosenberg reported that there are 10 microbicides in pre-clinical tests, 16 in clinical trials, and by the end of this year 6 will be in efficacy trials. If one of these products proves successful, the earliest it could be commercially available is in ~5 years.

Even this best-case scenario is a long time to wait, which tragically will be counted in new infections and deaths.

Coordinating the response

Avoiding the duplication of efforts from hundreds of organisations is not being done well, if at all. Peter

Piot, the head of UNAIDS, put it bluntly: 'The lack of harmonisation kills people'. One speaker found it difficult to even obtain data from donor governments on their current AIDS funding and future spending. How could they be expected to collaborate? On the scientific front, such as vaccine and microbicide research, there are often a number of international collaborative initiatives working in parallel. Cooperation is antithetical to a world of intense scientific competition, but it is crucial to proceed in a faster and more rational way.

On a global scale, it is now recognised that the problems of HIV have to be defined within nations rather than having strategies imposed from the outside. Proposed as a solution in April this year, UNAIDS's 'The Three Ones' approach was widely endorsed in Bangkok. They are: One agreed HIV/AIDS Action Framework that drives alignment of all partners; One national AIDS authority; One agreed country-level monitoring and evaluation system.

At a clinical level, many speakers, including Nelson Mandela, supported the idea of an integrated, holistic approach to treating HIV, especially having regard to the fact that HIV is superimposed on pre-existing epidemics of TB, malaria and sexually transmitted infections, all fuelled by inadequate health care infrastructure.¹⁶ TB is the leading HIV co-infection worldwide at 11 million, causing up to 40% of AIDS deaths. Conversely, HIV increases the number of smear-negative pulmonary and extra-pulmonary TB infections. The co-infection increases TB mortality — similar to HIV co-infections with malaria, hepatitis B and C. Herpes simplex 2 virus increases the risk of HIV transmission 5-fold in per-contact risk due to genital ulcer disease.¹⁷ In general, the theory is that co-infection with other diseases may hasten AIDS progression by activating cellular immunity, which increases HIV activity and viral load, decreasing CD4 counts.¹⁸

Certainly in the era of expanded ART, a more integrated approach provides the maximum benefit. In one study, ART itself decreased the incidence of TB by 80–92%.¹⁹ On the other hand, prophylaxis with cotrimoxazole could reduce bacterial infections, pneumocystis carinii pneumonia, HIV mortality and disease progression.¹⁶ Existing TB programmes could be an entry point for as many as 400 000 additional HIV patients.²⁰

The canvas is gigantic: visualise tens of thousands of nurses, doctors and community health workers and massive infrastructure needs yet to be built, let alone paid for, and all this driven by the demand for the rapid progress of anti-retroviral treatment in developing nations.

A presentation from Stanford University highlighted the challenges developing countries will face with increasing HIV resistance.²¹ Depending on adherence to treatment regimens, it takes a few years before the HIV virus develops resistance to anti-retrovirals. To continue treatment, a salvage regimen must be substituted. In developed countries, genome

sequencing of the virus has helped select ART protocols by predicting likely drug sensitivities. The databases of sequencing which allows such interpretation have been based on the most prevalent HIV subtype in the USA, Australia and Europe: HIV-1 subtype B.

In the developing world, subtype B is rare. Non-B subtypes are concentrated in Africa, Asia and Eastern Europe, and given the extent of the epidemic in these regions, also make up the highest total number worldwide.

Interpreting drug sensitivities for Non-B subtypes is difficult, since they often have gene sequences not seen in subtype B, and are therefore not part of the West's current database armoury. Acquisition of data about the gene sequences of Non-B subtypes is a priority both for those working on ART rollout in developing countries and those experienced with susceptibility interpretation in the West.

There is a further problem. Viral resistance doesn't just occur in a patient treated with ART: it can be transmitted. In one USA study, in 10 cities, the incidence of resistant virus found in chronically infected, but newly diagnosed people was 8.3%. The numbers were highest in white, homosexual men, the group which had contact with those most likely to have been treated with ART.²² This will eventually have implications for getting the first-line treatment protocols right for newly diagnosed people in developing countries.

The WHO has set up a Global HIV Resistance Surveillance Network, a huge undertaking to collate and share the data as well as determine treatments and recommendations in the future.

As the presenter reminded us, when it comes to treating with ART, 'Plan for success, prepare for failure. Resistance will happen'.²¹

The Global Fund: great idea, woefully underfunded

The Global Fund to fight AIDS, TB and malaria has emerged as a crucial and innovative new funding distribution mechanism. It was praised as having 'an emergency spirit, recipient-owned programmes and participatory processes. And, as importantly, it is addressing problems it encounters'.²³ Country Coordinating Mechanisms (CCMs), encompassing a wide variety of governmental and non-governmental stakeholders, are responsible for applying for and implementing the programmes.

Although it is early days to be assessing outcomes, the initial results of the Global Fund are impressive. Its first report, 'A Force for Change: The Global Fund at 30 Months', states that since early 2002, it has committed US\$3 billion to 296, 2-year programmes in 130 countries over 4 rounds of grant proposals. An analysis of 25 programmes which have been in operation for 1 year found that they have reached an average of 80% of their targets. Twelve were on target or overperforming, while five were severely underperforming and will need significant improvement to secure funding beyond their first 2 years. The Fund has been

criticised for initial delays in approving proposals and the distribution of funds, but claims to have improved these processes significantly.

The Global Fund hosted its first Partnership Forum, a biennial feedback mechanism for CCMs and other NGOs, in the days preceding the AIDS conference. Two main recommendations emerged. First, donors should increase pledges in order to make Round 5 possible in early 2005 and high-income countries should follow the Equitable Contributions Framework, in which they would contribute what the Fund needs in proportion to GNP.²⁴ Second, the board was urged to ensure high standards relating to transparency, diversity, and conflict of interest of CCMs by upgrading these standards from 'recommendations' to 'requirements'.

However, financially, the Global Fund is at a critical juncture. It needs US\$3.5 billion for 2005 — only \$880 million has been pledged so far by donors. French President Jacques Chirac led a proposal that the Fund's needs be met one-third by the USA, one-third by the European Union, and one-third by the rest of the world, including private donors such as the Bill and Melinda Gates Foundation. Currently, more than one half of donations come from Europe.

If there is a shortfall in 2005, or if Round 5 is postponed or not launched at all, Joep Lange, outgoing president of the International AIDS Society, declared it would be 'catastrophic'. Richard Feachem, Executive Director of the Global Fund reminded delegates of its purpose: 'The Global Fund was created to fill that gap. That was the vision, the *raison d'être*. Those who doubt that should ask, 'If not the Global Fund, then which source? If not us, then who?'

Australia's Foreign Minister, Alexander Downer, who was in Bangkok at the time of the meeting, but did not put in an appearance, announced 'Meeting the Challenge: Australia's International HIV/AIDS Strategy'. Concentrating on bilateral programmes in the Asia-Pacific region, it pledged to extend the 6-year A\$250 million AIDS initiative announced in 2000 by an additional A\$350 million from now to 2010. This must be applauded.

In 2003, Downer declared: 'There can be little doubt today that global health is a foreign policy issue... the impact disease and other health problems have on global security and prosperity have been understood for a number of years... it must also be the concern of foreign ministries'.²⁵ However, in April 2004, Australia pledged just A\$25 million over 2 years to the Global Fund. According to the Equitable Contributions Framework, Australia's contribution to the Global Fund in proportion to its GNP should be A\$127 million over the 2 years 2004–05.²⁶

In recent years, Australia has been attempting to 'punch above its weight' in other foreign policy areas by substantial military involvement in East Timor, Afghanistan and Iraq. Here is an ideal opportunity to foster global security by

peaceful means. If the Global Fund dies from lack of funding Australia must bear some of the responsibility.

Conclusion

The time for debate, vacillation and compromise is over. Bangkok was pitched as being the conference of accountability. There must be no more arguing over 'Abstinence, Be faithful, Condoms' v. 'Condoms, Negotiation skills and Needle exchange' as if they are mutually exclusive. There must be no more 'prevention' programmes that refuse to use the word condom or distribute them, no more denying youth the sex education they need, no more denying intravenous drug users medical treatment, social support and clean needles.

We are taking great strides down the path of treatment, and unless proven prevention programmes are applied universally, treatment will be fighting a losing battle and will bankrupt those least able to pay for it.

It's not an ideological battleground anymore. In the last 20 years, HIV has spread unabated. At this crucial point, we must start planning for 40 or 50 years ahead. The Global Village, that was a centrepiece of the Bangkok Conference, is the model for our planet's future. We must throw away our national flags, our religious dogmas, our parochial funding agencies, and unite to address AIDS before it overwhelms the developing world.

In the end, the statement that struck me the most came from Sibu, a 20 year old leader of the South African organisation, 'LoveLife': 'If young people stand together and stop it, we won't have HIV. It will have nothing to do with the medication. It will have nothing to do with a cure. It will have everything to do with an attitude'.

Declaration of interest

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