Southern Exposure

Thailand worked a near miracle in the ’90s with “100 percent Condom Use” among sex workers and other prevention campaigns that are the pride of Asia. But with advocates now tackling treatment access and taking on fearsome Big Pharma, the country’s status as AIDS role model for the developing world is in danger.

July 1, 2000 By Mukdawan Sakboon

Most Bangkokians would have stayed indoors last December 22. Thanks to a ridge of high pressure coming down from China, the whole kingdom of Thailand was unseasonably cool. But the temperature did little to dampen the determination of 120 demonstrators camped out inside the compound of the Ministry of Public Health in Nonthaburi Province. “Two or three people caught a cold, but we were not giving up just yet,” recalls Paisan Tanud, 35, chairperson of the Thai Network of People Living with HIV/AIDS. Although the turnout was modest by ACT UP-heyday standards in the West, the gathering was nothing less than historic for Thailand: Most of the protesters were HIV positive. “It was the first time we came out to voice our demands and our plight,” Tanud says. “It was a very important step for us, to draw national and international attention to Thais’ lack of access to HIV and AIDS drugs.”

The protest was peaceful and colorful, with demonstrators carrying banners and placards, and cheering speeches. But the issue at hand was truly a matter of life and death. While Thailand has made a generic version of AZT at a quarter of its brand-name price since 1993, Bristol-Myers Squibb (BMS) still controlled the manufacture and sale of ddI (Videx), which, at $4.40 a day, exceeded the Thai daily minimum wage. For Thai PWAs, the vast majority of whom are low-wage earners, the medicine situation is critical: Studies at Bangkok’s Bamrasnaradura Hospital, which treats the country’s largest number of AIDS patients, found that just 5 to 10 percent had access to any anti-HIV meds. Longtime activist Thai senator Jon Ungpakorn says that the number may in fact be much lower.

Development of the drug had been financed by the U.S. National Institutes of Health and licensed to BMS with a never-enforced clause requiring “reasonable pricing.” BMS had applied for a Thai patent as early as 1992, and Thailand’s Department of Intellectual Property (DIP) granted it in 1998. However, critics like Jiraporn Limpananond, a pharmacist and lecturer at Thailand’s prestigious Chulalongkorn University, challenged the validity of BMS’ patent. “One of the considerations under Thailand’s 1989 Patent Act is that the product should not have been available in the country before its patent was sought,” she argues. And in fact, ddI was available in Thailand before 1992.

HIVers and activists were demanding that the Thai government issue a compulsory license for ddI production. This legal mechanism, allowed by Thai law and longstanding worldwide trade agreements, permits countries to hand over production rights on an already-patented product to another company or agency, if that is deemed in the public interest or in order to reduce an unreasonable price. Minimal compensation must be provided to the patent holder, but this need not be prenegotiated.

In the case of Thailand and ddI, if the Government Pharmaceutical Organization (GPO) was allowed to produce the drug, it would cut the cost in half, says Krisana Kraisintu, M.D., head of research and development. Before BMS obtained the Thai patent, the GPO's plans to patent its own ddI were well underway. "We even bought 780 kilograms of antacid, to be used as a buffer in ddI," she recalls. But last November, when her office requested the DIP license, the agency told its governmental colleagues to initiate negotiations with BMS -- an intimidating prospect. Six high-level BMS executives flew in to meet her. "They warned me against producing ddI, saying that they would soon get the patent. I never knew that, because officials at the DIP had always assured me that no one else was asking to patent ddI. That lulled us into a false sense of comfort, only to find that we were deceived by our own." When BMS got its patent, Kraisintu says, "there was nothing we could do."

Casting a pall over all these patent machinations is the ongoing threat of U.S. government sanctions against Thailand (similar to those directed at two dozen other countries) if it acts in a manner that big drug companies deem unfavorable to their profit margins. Any such retaliation would be particularly damaging to an economy just beginning to get its legs, given that a quarter of Thai exports go to the United States. In 1992, under a threat by the U.S. trade representative to limit textile imports, Thailand passed its first law to recognize product patents, but added a provision establishing a review board to collect and analyze data on the cost of drug production. After constant U.S. pressure -- threatening drastically increased tariffs on Thai exports of wood products and jewelry -- and despite a protest by AIDS organizations outside the U.S. Embassy, the Thai parliament in 1998 disbanded the board and limited the right to issue compulsory licenses.

The recent ddI tug-of-war is just the latest in a series of skirmishes over the Thai government's efforts to produce generic AIDS drugs. For example, fluconazole (Diflucan), an effective treatment for deadly HIV-related cryptococcal meningitis and serious candidiasis, is patented in the developed world by the giant Pfizer Pharmaceutical, yet the company has no Thai patent. But in 1992, the Thai government granted all drug companies, including Pfizer, six years of exclusive marketing rights for all new products, even if not locally patented. Pfizer's $7-per-pill price for Diflucan was out of reach for nearly all Thai PWAs. In 1998, the government released fluconazole for generic production. Two local companies began selling the drug for between $.26 and $.93 per pill.

The frustratingly fitful advances that Thailand has made in seeking greater access to pricey AIDS drugs stand in stark contrast to the brilliant breakthroughs achieved in condom distribution and use, a program now touted as one of the world's most progressive.

CONDOM NATION

With her steady supply of free condoms, activist Sommart Troy was in 1987 a familiar and welcome face among the U.S. marines anchored at the seaside town of Pattaya for sand, sun and sex. Her message was clear, but the Thai government, which had sporadically been waging its own HIV prevention campaigns for two years, begged to differ. Having decreed 1987 “Visit Thailand Year” in order to entice visitors to a tropical nation fabled for its beaches and sex trade, officials viewed Troy as a meddling alarmist who was scaring off tourist dollars.

But two years later, her cries in the wilderness were vindicated. Surveys done by the Ministry of Public Health revealed a staggering prevalence of HIV among sex workers -- 15 percent nationwide and as high as 40 percent in some northern provinces.

Panic set in. The government proposed -- and then aborted -- an AIDS law that would have required, among other things, a compulsory blood test, quarantine of HIVers, “AIDS Free” cards for sex workers and an entry ban against HIVers. Not surprisingly, Thailand’s early HIV prevention programs played on ignorance and fear. TV and radio spots aired the government’s “AIDS kills but is preventable” slogan, while posters depicted AIDS as a “demon.” The Thai media contributed to the hysteria by “outing” celebrities and others who were not in fact infected.

But with the release of the doomsday infection rates, the government changed course. Each key ministry was given its own AIDS plan and budget, and all governors led AIDS programs in their respective provinces. In 1991, Prime Minister Anand Panyarachun agreed to chair the National AIDS Prevention and Control Committee, becoming one of the first heads of state to personally lead a nation’s fight against HIV. Still, HIV infection rates rose rapidly among pregnant women and military conscripts -- barometers of heterosexual prevalence. Thailand’s huge sex trade was one reason. Visits to sex workers are a common rite of passage for male high school and college students. (Thai men have a saying that wherever they go, they must have sex with the local women.) “These are major factors that needed to be taken into consideration when designing intervention,” says Chaiyos Kunanusont, M.D., director of the AIDS Division of the Ministry of Public Health.

By 1993, the national prevention budget stood at $447,000, up from the $257,000 of the year before, and the Thai media began to play a more helpful role in disseminating the government’s messages. This was particularly the case with Thailand’s now-famous push for “100 Percent Condom Use” in all brothels throughout the country, the brain-child of Wiwat Rojanapitayakorn, M.D., health chief of Ratchaburi province. Under the program, brothels and other sex establishments would accept only clients who would agree to use condoms. The provincial governor agreed to give the idea a try. Rojanapitayakorn succeeded in getting enough brothel owners to comply that the Ministry of Public Health decided to include condom distribution in the national AIDS agenda.

By 1996, Rojanapitayakorn, who now leads UNAIDS’ Asia Pacific Intercountry Team, had achieved a near miracle. Condom use in brothels rose to 93 percent (up from 87 percent in 1993) and STD

cases plummeted to a low of 50,000. New HIV infections also fell. Among sex workers, the HIV prevalence rate declined to 28 percent (down from 36 percent in 1994), and the infection rate among pregnant women dropped to 1.8 percent from a 1995 peak of 2.3 percent. There was also a steady decline in infections among military conscripts in the northern region, and visits to commercial sex workers were decreasing among men. Since then the “100 Percent Condom Use” initiative has been imported by Cambodia, the Philippines and China, with varying results.

FUTURE SHOCK

Still, many at the frontline of Thailand’s prevention efforts are reluctant to call their country a “success story.” “No, we should not be called a model for others to follow,” AIDS Division Director Kunanusont says. “Our house was set on fire, and we had to put it out.”

In Senator Ungpakorn’s view, Thailand’s much-vaunted prevention campaigns are far from flawless. The fear-mongering, stigma-triggering programs put “too much focus on sex workers while ignoring other groups, making a horror out of AIDS and making HIVers a target of discrimination.” He also says Thailand’s efforts have failed to reach laborers, youth, housewives and prisoners.

Chansuda S., a Bangkok-based contact for the International Community of Women Living with HIV/AIDS (ICW), says the government’s campaigns gave people “an old image of AIDS as death and evil. They see it as something that happens to sex workers and other ’bad’ people -- they do not consider themselves at risk.”

Activists and authorities alike are increasingly worried that the government is prematurely resting on its laurels -- especially in light of budget cuts resulting from the recent Asian economic crisis. The AIDS Division’s Kunanusont warns against a “second wave” of infections, pointing to a recent rise in infection rates among pregnant women. The news is bad for others, too: The once-declining prevalence is now as high as 40 percent for IV-drug users; among sex workers, 30 percent. The rate of infection among young Thais is also alarming, says Paul Cawthorne, Thailand coordinator for the Nobel Prize-winning Doctors Without Borders. And by year’s end, Thailand’s AIDS orphans are estimated to number as high as a half-million.

Sadly, even Thailand’s star as a “condom nation” is falling. Now, Chansuda reports, HIV-positive women are saying that “they did not get condoms, because hospital officials said the government has cut the budget for condoms, and there are no more left.” Surang Chanyaem, head of Empower, an advocacy organization for sex workers, says that there are “no more condoms at sex venues, and several NGOs had to pool money to buy condoms for the sex workers.” Considering that each sex worker has three to five clients per shift, Chanyaem wonders how NGOs can sustain the effort.

In addition, Thailand has yet to confront confidentiality issues. HIV-positive pregnant women and children, marked by conspicuous “HIV positive” stamps on their health-record cards, are often forced to go from hospital to hospital in search of services.

Rampant anti-PWA discrimination and lack of treatment remain Thailand's major challenges. Despite the recent appointment of people with HIV to national committees, Paisan Tanud of the Thai Network of People Living with HIV/AIDS says that PWA input has a long way to go. "We cannot propose our own agenda or our own representatives," he says. "Our role is still just that of observer."

However, Paul Toh -- who founded APN+, an intercountry network of Asians with HIV, and who has been HIV positive himself for 11 years -- is more upbeat. He says that PWA networks in Thailand are some of the strongest in the developing world, providing support and wielding bargaining power to get the government's attention.

THAILAND

Total population
59,159,000

Number of people with HIV
UNAIDS 784,000
Official gov't NA

Number of people with AIDS
UNAIDS 260,000
Official gov't 70,013

Number of openly positive NA

Transmission Mode
6% **Homo**
68% **Hetero**
23% **IDU**
3% **Blood products**
A prevention success story, this comparatively prosperous nation's "100 Percent Condom Use" policy in brothels checked exploding infection rates in the '90s. Thailand launched the developing world's first HIV vaccine trial in March 1999.

DRUG WARS

Indeed, after last December's well-publicized demonstration for generic ddI, Public Health Minister Korn Dabaransi promised to respond by the protesters' January 17 deadline -- and did. He said that

Thai officials couldn't strike an agreement with Bristol-Myers Squibb, and therefore they would not issue a compulsory license for ddI's pill form. However, the GPO would be allowed to produce a generic *powdered* form of ddI. Thai officials said privately that U.S. trade pressures lay behind the decision. The next day, 150 activists -- with the support of Doctors Without Borders -- gathered outside the U.S. Embassy, calling for the pressure to be withdrawn, echoing similar demands made a week earlier at a Washington, DC, meeting between an ACT UP-initiated coalition and U.S. trade officials. On January 27, a top U.S. trade rep sent a letter to Thai activist Tanud declaring that U.S. officials would not object to any compulsory licensing that complied with international law -- a significant victory for HIVers that extended the precedent won last year with South Africa.

Meanwhile, BMS has kept a low profile, refusing to comment to Thai media. Some observers say that the company's close ties with the Public Health Ministry -- its main customer in Thailand -- means that generic production ultimately will have little or no effect on profits. Perhaps it's not surprising, then, that the GPO's Kraisintu, who reports that she has received big orders for powdered ddI from private hospitals, says that not a single order has been placed by the Ministry of Public Health. And the battle may soon escalate, as Doctors Without Borders has requisitioned not only generic ddI but another BMS antiretroviral, d4T (Zerit), which is not patent-protected in Thailand. According to a Thai press report, BMS is threatening to sue the GPO if it fills the order for the generic d4T, which would be 80 percent cheaper than its own product. (A BMS spokesperson says she has no knowledge of the threat.)

Neither AZT nor ddI monotherapy is advised for HIVers in Western countries, but for the vast majority of Thai PWAs, such as Poy, a 29-year-old hairdresser and mother of a 6-year-old, who asked only to be identified by her first name, below-standard treatment is her only hope. "I'm doing just fine, but I don't know what it would be like if I couldn't get the drugs," she says. Every day, Poy takes nine pills, totaling $157 per month. Poy, who earns only $131 a month, holds a government-issued low-income health-care card that, theoretically, entitles her to free medical services. But she and many other card-holders often find that the reality is much harsher. "Hospital officials say that HIV medication is not included in the national list of essential drugs to be provided free of charge," she says. "We patients have to buy the drugs ourselves."

The only other way for Poy to get medicine would be to use the government hospital's assistance program, which offers discounts for poor patients. But even with this reduction, the drugs would be out of Poy's reach. "Some hospitals ask me to pay half of the drug's cost, which I cannot afford to pay." Nor would she be able to get the meds by participating in the government's research program, which requires a minimum CD4 count of 200. Her latest checkup showed a count of 96.

Poy falls silent for a moment when asked about the future. "I dare not get my hopes up for anything," she says finally. "What I want is just to be able to live for another day, to take care of my daughter." She also wants her government to be the tiger on the treatment front that it was about prevention. "Even though I may not live long enough to use the cheaper drugs," she says, "at least others will have a chance."

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