TAC Electronic Newsletter

By *moderator*
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Appeal for funding

TAC launched a public appeal for funding on World Aids Day 2005 as part of our hope to get more individuals involved in taking ownership of the state of our lives, our communities and our future. We have been encouraged by the generous response we have received. Since our appeal, we?ve managed to raise over R270,000 from individual donations. Thank you! We've received particularly generous donations from students from New York University, Dr. Francois Venter and Wolfgang Tillmans. Your support is deeply appreciated.

However, we need much more to keep up our campaign to alleviate the HIV epidemic. In 2005 about 300,000 people in South Africa died of AIDS (source ASSA). That comes to about 800 people a day. Even more people were newly infected with HIV. South Africa continues to have the largest number of people living with HIV and AIDS in the world, with an estimated 5 million people living with the disease (Sources: ASSA, HSRC).

In 2006 our work will continue to focus on getting more people access to treatment, especially in South Africa?s poorest provinces of Limpopo, Mpumalanga and the Eastern Cape. TAC will also continue to speak out against pseudo-science and HIV denialism and will continue to strengthen our treatment literacy programme. We will also introduce a stronger focus on community driven prevention strategies and the empowerment and leadership of women and people living with HIV/AIDS.

If TAC does not urgently raise more funds we will have to scale back on our activities. TAC's greatest need is for committed long term support, through monthly giving. Regular donations will give us the capacity to achieve all of the above. We appeal to you to stand up for our lives by taking out a stop order (monthly or annually) or making a once-off donation. Visit our website and click on Donate Now for details on how to donate.

Help us raise R10m by March 2006! Make a contribution to South Africa?s future!

[END OF APPEAL FOR FUNDING]

How support from friends and his mother helped Moses Setseu

By James Dlamini

Moses Jacob Setseu (31) lives in Sebokeng. A few years ago he became very ill and decided to go for an HIV test. It came back positive. He considers himself lucky because he he went for voluntary counseling and testing (VCT) with his mother. It was a very painful experience for both of them because at first his mother didn?t react well to the news. She said some nasty things and swore at him. But after that he got a lot of support from her. Moses considers her to be like an angel to him.

? I feel very blessed to have her in my life? says Moses who is single. They didn?t do it alone though. They received a lot of support and information from the support group he used to attend: Bambanani (which means ?stick together?). Moses has since joined the Tshegetsanang (?support each other?) support group which he calls his home.

? I started to live openly with my HIV status in 2001, I disclosed my status at a school in Sharpeville. It was not easy but I thank Chris Mooi a counselor at Sebokeng hospital.? said Moses.

Moses, who now works as a counselor at Zone 14 Sebokeng clinic, says that the clinic staff is supportive of him. When he started measuring his CD4 count in 2003 it was 97 and antiretrovirals were not yet available, but Moses says the support, love and caring of support group members and his mother kept him going until he got the treatment. He also says being a member of TAC and being part of the struggle for treatment helped him.

When Moses started taking antiretrovirals his CD4 count was 74. After eight months it went up to 182. ?Antiretrovirals have changed my life a lot and they have given me the hope to live.?

[END OF COMMUNITY STORY]

A brief analysis of the Clinton Foundation Agreement

On 12 January 2006, the Clinton Foundation (former US-President Bill Clinton's foundation) announced that it had reached an agreement with a number of companies, resulting in lower HIV-test prices and lower prices for two antiretrovirals for fifty developing world governments. TAC welcomes the announcement. We note the following:

- A number of companies have agreed to supply HIV rapid tests (most of which determine if a person is HIV-positive with a very high degree of accuracy within about 20 minutes) to developing countries for between $0.45 to $0.65 per test (i.e. less than R4).

- A number of generic drug companies (including Cipla, Aspen, Strides and Ranbaxy) have agreed to sell efavirenz for $240 per patient per year (+/- R130 per month). This is the most important aspect of the deal. Efavirenz (currently approximately R200 per month), which has a good side-effect profile, is used as part of the first-line antiretroviral regimen by more than two thirds of patients on treatment in the public sector in South Africa. However, the offer will most likely have no effect in South Africa for some time. Only MSD's efavirenz is currently registered in South Africa and MSD has so far only granted a license to Aspen and the now defunct Thembalami Pharmaceuticals. TAC is putting pressure on MSD to grant licenses to other potential efavirenz manufacturers, including Ranbaxy and Adcock-Ingram (the two companies that formed the joint venture Thembalami) and Cipla-Medpro.

- Cipla has agreed to offer abacavir for $447 per year (about R240 per month which is still expensive compared to other antiretrovirals in the same class) which although welcome is of limited benefit. Abacavir is a specialist antiretroviral medicine with a complex side-effect profile. It is seldom used in the public health system.

- The difference in the price of efavirenz will help the South African government to replace stavudine, which

has a poor side-effect profile, with a better but more expensive medicine such as tenofovir once it becomes registered.

The Clinton Foundation has overstated by claiming they have reduced the cost of second-line treatments. Efavirenz is a first-line treatment. Abacavir can be used second-line, but it is not standard. There is much work left to be done to reduce the prices and ensure sustainable supplies of second-line medicines such as lopinavir/ritonair (marketed by Abbott as Kaletra) and the newer and better antiretrovirals that have recently come to market such as tenofovir.

We urge the Clinton Foundation to continue its good work and proceed with negotiations to lower the cost and ensure sustainable supplies of these medicines. We also ask the foundation to monitor the implementation of this latest agreement. We urge the South African National Department of Health to put pressure on MSD to grant more licences for efavirenz, and trust that the Medicines Control Council will fast-track the registration of generic versions of this medicine (as the law allows it to do). We call on the generic producers of efavirenz to ensure their production and bio-equivalence testing of efavirenz is implemented to the highest standards.

[END OF ANALYSIS OF CLINTON AGREEMENT]

Second installment of our new regular feature: How we know that antiretroviral treatment works - research from Africa

We run this feature to promote public understanding of the science of HIV and its treatment. The HIV epidemic has shown us how knowledge of medicine makes a substantial difference to people's ability to control their own health. Accurate information enables communities to take decisions which improve public health.

We also wish to demonstrate that science has for a long time been a global enteprise and critical scientific research on HIV and antiretrovirals has been conducted in African and other developing countries.

Lamivudine: A medicine tested globally, including South Africa

Lamivudine (better known as 3TC) is part of the government first-line antiretroviral treatment regimen in South Africa. It is associated with fewer side-effects than most other antiretrovirals. It is also one of the older antiretrovirals (registered by the FDA in the US in 1995). The major clinical trial that demonstrated lamivudine's clinical efficacy was known as CAESAR. It was a multi-centre study with one of the sites being in South Africa and the others being in Canada, Australia and Europe. The trial showed that lamivudine in conjunction with AZT slowed progression to AIDS or death compared to AZT plus placebo. It was one of the studies that demonstrated that combination antiretroviral treatment was superior to monotherapy (and that triple-therapy was superior to dual-therapy). The same trial demonstrated that lamivudine was effective at treating patients infected with both HIV and Hepatitis B (see Journal of Infectious Diseases 1999;180:607-613).

Here is the abstract from the report of the CAESAR trial published in the Lancet in 1997.

Lancet. 1997 May 17;349(9063):1413-21.

Randomised trial of addition of lamivudine or lamivudine plus loviride to zidovudine-containing regimens for patients with HIV-1 infection: the CAESAR trial.

Cooper, D.A.; Katlama, C.; Montaner, J.; et al.

BACKGROUND: Previous studies have shown that combination therapy with lamivudine plus zidovudine causes pronounced and sustained increases in CD4 counts and reductions in viral load in individuals infected with HIV-1. We assessed the clinical benefit of the addition of lamivudine to zidovudine-based regimens in patients infected with HIV-1 who had CD4 counts of 25-250/microL.

METHODS: Eligible patients receiving zidovudine monotherapy or zidovudine plus zalcitabine or didanosine combination therapy were assigned 52 weeks of treatment with the addition of placebo, lamivudine (150 mg twice a day), or lamivudine (150 mg twice a day) plus loviride (100 mg three times a day). Patients were unaware of type of treatment allocated. The primary endpoint was progression to a new protocol-defined AIDS event or death.

FINDINGS: The study was terminated following the second interim analysis because of a highly significant reduction in progression to AIDS or death in the patients treated with lamivudine rather than placebo. In the final analysis of 1840 patients, progression had occurred in 95 (20%) of 471 placebo-treated patients, 86 (9%) of 907 lamivudine-treated patients, and 42 (9%) of 462 patients who received lamivudine plus loviride ($p < 0.0001$, relative hazard 0.42 [95% CI 0.32-0.57]). A significant survival benefit was also seen ($p = 0.0007$, relative hazard 0.40 [0.23-0.69]). Significantly fewer patients in the lamivudine group than in the placebo group required hospital admission, unscheduled visits, or prescribed medications for HIV-related events. There were no differences in the frequency or severity of clinical or laboratory toxicities between the treatment groups.

INTERPRETATION: The addition of lamivudine to zidovudine-containing treatment regimens significantly slowed the progression of HIV disease and improved survival. However, it is unlikely that this combination alone would be sufficient to achieve long-term complete suppression of viral replication in all patients.

[END OF HIV SCIENCE EXAMPLE]

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