

MSF report
November 2008

A preventable fate: The failure of ART scale-up in Myanmar



Executive Summary

The situation for many people living with HIV in Myanmar is critical due to a severe lack of lifesaving antiretroviral treatment (ART). MSF currently provides ART to more than 11,000 people. That is the majority of all available treatment countrywide but only a small fraction of what is urgently needed. For five years MSF has continually developed its HIV/AIDS programme to respond to the extensive needs, whilst the response of both the Government of Myanmar and the international community has remained minimal. MSF should not bear the main responsibility for one of Asia's most serious HIV/AIDS epidemics. Pushed to its limit by the lack of other services providing ART, MSF has had to make the painful decision to restrict the number of new patients it can treat. With few options to refer new patients for treatment elsewhere, the situation is dire.

An estimated 242,000¹ people are currently infected with HIV in Myanmar. 76,000 of these people are in urgent need of ART, yet only 15%² of them receive it through the combined efforts of MSF, other international non-governmental organizations (NGOs) and the Government of Myanmar. For the remaining 65,000 people the private market offers little assistance as the most commonly used first-line treatment costs the equivalent of a month's average wage. The lack of accessible treatment resulted in 24,000³ AIDS related deaths in 2007 and a similar number of people are expected to suffer the same fate this year, unless HIV/AIDS services - most importantly the provision of ART - are urgently scaled-up.

The Government of Myanmar and the International Community need to mobilize quickly in order to address this situation. Currently, the Government spends a mere 0.3% of the gross domestic product on health, the lowest amount worldwide⁴, a small portion of which goes to HIV/AIDS. Likewise, overseas development aid for Myanmar is the second lowest per capita worldwide⁵ and few of the big international donors provide any resources to the country. Yet, 189 member states of the United Nations, including Myanmar, endorsed the Millennium Development Goals, including the aim to "Achieve universal access to treatment for HIV/AIDS for all those who need it, by 2010". As it stands, this remains a far cry from becoming a reality in Myanmar.

As an MSF ART patient in Myanmar stated, "All people must have a spirit of humanity in helping HIV patients regardless of nation, organization or government. We are all human beings so we must help each other". Unable to continue shouldering the primary

"I think that I am going to die. I cannot do anything to get better. Even if there is a treatment I am not able to afford it, as I do not have money. So I think that I will die from HIV"

28 year old male, Myanmar, 2008

1 This is based on an estimated HIV prevalence range in the adult population (15 to 49 years) of between 0.5-0.9%, with a mid point of 0.67%. According to UNAIDS, the 2007 estimates, which are a reduction in previous estimates where in 2004 the midpoint was 1.3% of adult population, are finer analysis of existing data using EPP software and not related to the impact of public health interventions.

2 UNAIDS Report for the Global AIDS epidemic 2008

3 UNAIDS Report for the Global AIDS epidemic 2008

4 United Nations Development Programme (UNDP) 2008

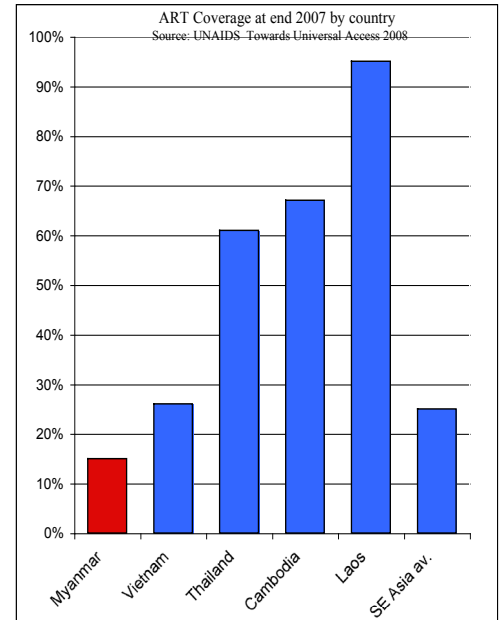
5 UNDP-comparing the bottom 50 countries in the Human Development Index

responsibility for responding to one of Asia's worst HIV crises, MSF insists that the Government of Myanmar and international organizations urgently and rapidly scale-up ART provision. A vast gulf exists between the needs related to HIV/AIDS and the services provided. Unless ART provision is rapidly scaled-up many more people will needlessly suffer and die.



HIV/AIDS in Myanmar at Crisis Point

Myanmar is experiencing one of Asia's most serious HIV epidemics, yet the available care and treatment meets only a fraction of the needs. As a result people are dying unnecessarily, people who are desperate to live and contribute to their family, community and country. An estimated 242,000⁶ people are thought to have HIV in Myanmar. Of these people, 76,000 are in urgent need of lifesaving antiretroviral therapy, yet only 15% of those in need of treatment receive it⁷. This is the lowest coverage rate in Asia after Pakistan and puts Myanmar in the bottom 10 countries globally for ART coverage⁸.



As it stands, MSF provides ART to more than 11,000 people, which makes up the majority of all available treatment countrywide. The Government of Myanmar and other non-governmental organizations (NGOs) provide ART to around 2,000 people. While there are a number of NGOs working in HIV/AIDS in the country, efforts are largely focused on the provision of care rather than treatment. Although well meant, care alone can only support people in dying, whereas ART can assist people to live. Having put significant resources into its Myanmar programme, MSF can no longer continue to scale-up ART provision, in the face of so little response by other actors. Therefore, it has had to make the painful decision to restrict the number of new patients it can treat. With few options to refer new patients for treatment elsewhere, the situation is dire.

For the 65,000 people unable to access free ART there are very few other options open to them. The cost per month of

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⁷ UNAIDS Report for the Global AIDS epidemic 2008

⁸ UNAIDS 2008 Progress Report 'Towards Universal Access'. The figure is based on countries that have over 5,000 people who require ART according to this report. The other 9 countries with the lowest ART coverage are: Chad, Eritrea, Iran, Liberia, Nepal, Niger, Pakistan, Sudan, Ukraine

“If I have the opportunity to get ART, I will make an offering. After I got healthy, I would work more and would try to get back some of my possessions. I will help my mother to live happily. After I got healthy, I would run my business like before.”

28 year old, Female, Myanmar, 2008

the most commonly used first-line ART in a private pharmacy in Myanmar is \$29⁹. This is far beyond the means of most people who on average live on \$1.2 per day¹⁰. Even if people can find a way to afford ART many often become indebted and are soon forced to stop. This leaves families not only with the trauma of losing a loved one, often the main income-provider for the family, but also with crippling debt. Alternatively, some patients are only able to source treatment irregularly, when finances allow or family and friends assist. This can lead to the rapid development of drug resistance.



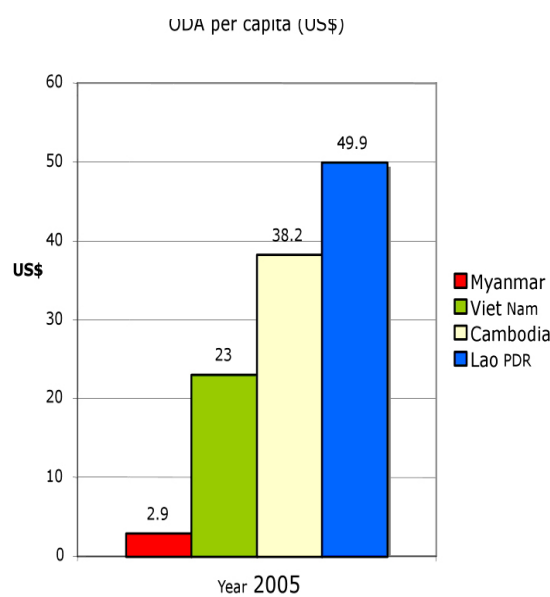
⁹ MSF data for 1 month supply of Lamivudine, Stavudine & Nevirapine in a private pharmacy in Yangon, October 2008 priced at Khat 35,000(1 USD=1,200 Khat). If patients have side effects to Nevirapine, which is common, and need to move to Efavirenz then the price triples to 100,000 Khat

¹⁰ Economist Intelligence Unit (EIU) estimate the GDP per capita of \$435 per year in Myanmar-2008

A lack of resources and commitment

On the one hand, Myanmar has a weak and under-funded state health-care system. The Government of Myanmar spends a mere 0.3% of its gross domestic product on health, the lowest amount worldwide¹¹. In 2007 the Government spent just USD\$ 0.7 per person on health,¹² with the 2008 annual HIV/AIDS budget estimated at just USD\$ 200,000 in total. With growing revenue from oil and gas exports, the Government must invest more in its ailing health system and specifically HIV/AIDS care and treatment.

Overseas Development Assistance (ODA) funding per capita in selected Asian countries



Source (Cambodia): Cambodia GFATM Round 6 AIDS proposal

On the other hand, overseas development aid (ODA) to Myanmar is the second lowest per capita worldwide, after India¹³. Compared to some of Myanmar's neighbouring countries it receives a tiny fraction of the ODA they do. Few of the big international donors, such as the Global Fund, World Bank, Asian Development Fund, and the President's Fund invest in the Government health system out of concern over the effective use of funds. Whatever their reasons, there is a massive under-investment in assistance in Myanmar and it is the general population who are suffering and will continue to suffer unless this changes.

Other international actors, including NGOs, who could fund HIV/AIDS treatment and care in Myanmar have been hesitant. This may be due to concerns that the substantial improvements in the Government health system necessary to facilitate an eventual hand-over of patients will not materialize. Alternatively, organizations

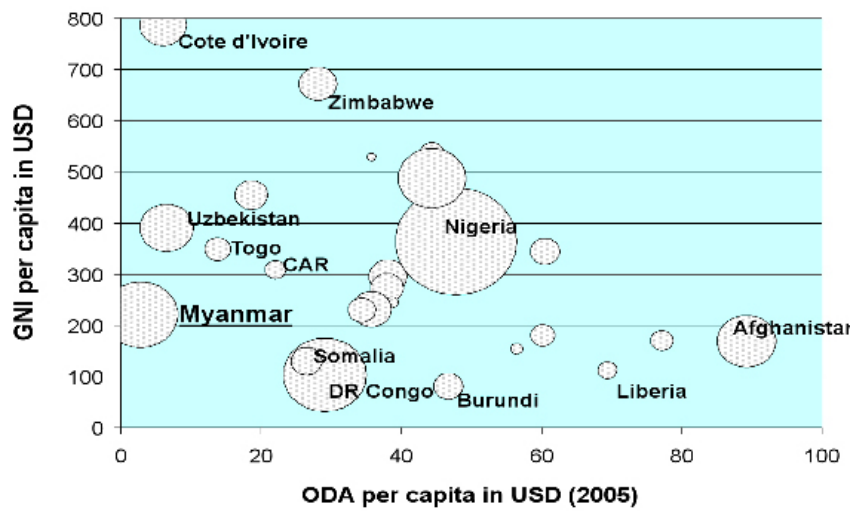
11 United Nations Development Program (UNDP) 2008.

12 Myanmar Department of Health website for 2007 expenditure on health per person per year of 849 Kyat (using 1 USD= 1200 Khat)

13 UNDP-comparing the bottom 50 countries in the Human Development Index

may be put off by the challenges posed by working in a country like Myanmar, including official constraints and difficult bureaucratic procedures. In some areas of the country, such as Kayah state, MSF has not been permitted to start AIDS treatment. These legitimate concerns however should not dissuade organizations from providing assistance where it is most needed. MSF has proven that providing independent and effective humanitarian assistance to people in Myanmar is possible and more to the point critical if unnecessary deaths are to be prevented.

Correlation of Gross National Product (GNI) and Overseas Development Assistance (ODA) per capita in relation to population size



Source: OECD Development Assistance Committee (DAC), data 2005. Myanmar is one of the lowest recipients of ODA and also has one of the lowest GNI per capita

MSF in Myanmar

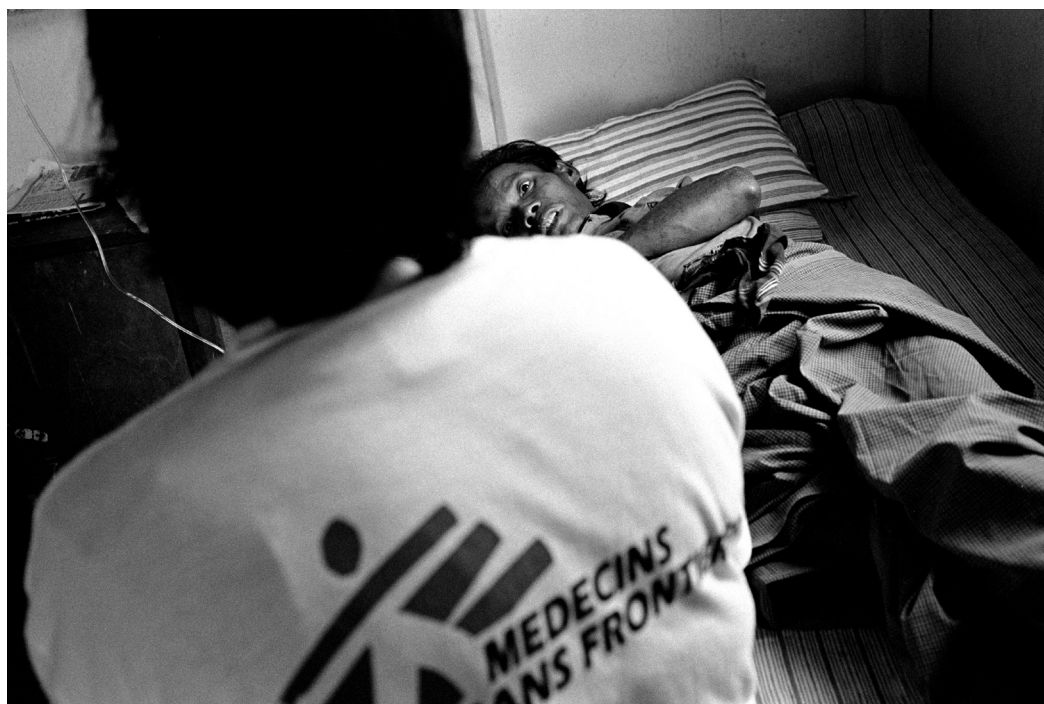
MSF has provided essential healthcare services in Myanmar since 1993 and began a programme to support people living with HIV/AIDS in 2003. Since then, MSF staff has assisted thousands of HIV patients, working from 23 clinics, in five states throughout the country. Services include counseling, testing, treatment of opportunistic infections, nutritional support, health education and most importantly antiretroviral treatment.

At the time of publishing this report, MSF provides ART to more than 11,000 patients. Patients are selected independently, purely on medical grounds and without political interference. Medicines are distributed directly to the patient. Monitoring of the program is done at the level of the beneficiary; an essential element of the program that helps to guarantee that the population benefits directly from MSF's services and that donor money is spent transparently.

***"It is not OK for us.
We cannot bear this burden.
Sometimes I wake up at
midnight and dream of my
patients. Women who come
in and are HIV positive – they
have three children at home
and the husband has passed
away and we cannot provide
any treatment for them".***

MSF National Staff Doctor, 2008

Having made an enormous effort to respond to the overwhelming need for ART treatment during the last five years, MSF can no longer take primary responsibility for ART scale-up in Myanmar. Pushed to its limit by the lack of treatment on offer by other care providers, MSF has recently been forced to make the painful decision to drastically reduce the number of new patients it can treat. With few options to refer new patients for treatment elsewhere, the situation is traumatic for both patients and staff.



Urgent and Rapid Scale-up of HIV/AIDS Treatment Essential

“All people must have a spirit of humanity in helping HIV patients regardless of nation, organization or government. We are all human beings so we must help each other”.
29 year old ART Patient, 2008

MSF calls for all sectors to urgently and rapidly scale-up lifesaving HIV/AIDS treatment in Myanmar, in the face of overwhelming needs. The public sector, through the Myanmar Department of Health (DoH), must take the lead and drive the scale-up of HIV/AIDS services, most importantly ART, with the support of international donors and organizations.

During the last two years, the DoH has treated patients with ART in 22 hospitals around the country, treating over 1,500¹⁴ people. This covers just a fraction of the needs, but is a good basis on which to develop services. DoH is the only actor with long-term potential to provide sustainable ART nationally. At present some of the DoH ART sites have a limit of just 20 patients. Such low numbers are not cost-effective and make the initial investment in set-up, training and ongoing drug supply hard to justify unless numbers are increased considerably. Once a site is established there need to be ambitious plans set to expand care and treatment. DoH has shown signs of wanting to develop its services in HIV/AIDS and must be supported to realize these ambitions. Geographical coverage also needs to be expanded, in areas such as Chin and Kayah states, which have no ART programmes at all. In Kayah State, some AIDS patients are attempting to access treatment in neighboring Thailand, which makes them vulnerable to the development of drug resistance, since having to cross the border frequently means that reliable adherence to the medication is difficult.

For those who are lucky enough to be able to afford ART on the private market, better advice and support needs to be available. Private practitioners are not always properly trained in prescribing medication for HIV/AIDS, which can cause serious problems for the patient. Therefore, proper training in HIV/AIDS care and treatment, supported by the provision of free-of-charge treatment, should be encouraged through the private sector.

To make scaling-up possible the Government of Myanmar desperately needs to invest more in its health infrastructure and specifically allocate funds to tackle the HIV/AIDS crisis. Likewise, the international community needs to provide increased support similar to that allocated to HIV/AIDS programmes in other developing countries and in line with the needs.

Alongside the Government of Myanmar’s need to redouble its efforts in scaling-up ART provision, it also needs to better facilitate the international community’s supporting role. Specifically, it should remove the constraints faced by NGOs which hampers

¹⁴ Government of Myanmar: more than 1500 patients were receiving ART by the end of 2007 and by the end of this year 1800 patients should receive the treatment.

them from implementing HIV/AIDS programs and ensure improvements in bureaucratic procedures such as the signing of agreements and import of goods.

In the year 2000, 189 member states of the United Nations, including Myanmar, committed to working towards achieving the Millennium Development Goals, including the aim to “Achieve universal access to treatment for HIV/AIDS for all those who need it, by 2010”. As it stands, this remains a far cry from becoming a reality in Myanmar. It is the responsibility of all actors, national and international to stand-by their commitment to HIV sufferers in Myanmar and urgently scale-up HIV/AIDS services – most importantly ART, to put an end to the needless suffering and waste of life.

“People affected by HIV/AIDS in Myanmar are desperate for more assistance. They want to live healthy and happy lives like any other. The ground-swell is there – HIV patient groups are forming around the country and our medical staff works tirelessly to assist patients. But it is just not enough, the problem is too big. Others must do more”.

MSF National Staff

