

World AIDS Day 2003:

Médecins Sans Frontières Campaign for Access to Essential Medicines

November 20th 2003

In the developing world today, 40 million people are HIV positive. More than six million people are in urgent need of antiretroviral (ARV) treatment, 4.1 million of whom live in sub-Saharan Africa. An estimated 6500 people die of AIDS each day in this region. It is estimated that a mere 400,000 people living with HIV/AIDS in the developing world are receiving antiretroviral treatment. One third of these live in Brazil, the only developing country that has so far implemented universal access to ARVs.¹

MSF is in the process of adapting its approach to AIDS treatment to better fit the real-life conditions faced in developing countries. Our projects are using treatments with fewer pills, relying less on sophisticated laboratory tests, taking better advantage of the skills and resources of existing health care professionals such as clinical officers and nurses, and decentralising the point of care to district hospitals and health posts.

MSF believes its experiences can offer some valuable lessons to countries' efforts to scale-up treatment. MSF also believes the primary responsibility for scale-up needs to lie with national governments.

Latest Global Developments

During the past year, there have been several positive developments both at the national and international level:

- The launch of the World Health Organization (WHO) 3x5 initiative (three million people on AIDS treatment by 2005) to mobilise international efforts to expand the number of HIV+ people on treatment;
- The decision by the government of South Africa to establish a national treatment program;
- The prices of ARVs have continued to fall: for example, the Clinton Foundation has negotiated a price reduction for some developing countries which nearly halves the lowest price to date to \$132 per patient per year;
- Money from the Global Fund to Fight AIDS, Tuberculosis and Malaria is beginning to reach endemic countries; and
- Developing countries are beginning to put into practice the WTO "Doha Declaration" by actively stimulating competition between drug producers.

¹ Sources: UNAIDS and WHO, unpublished statistics, November 2003

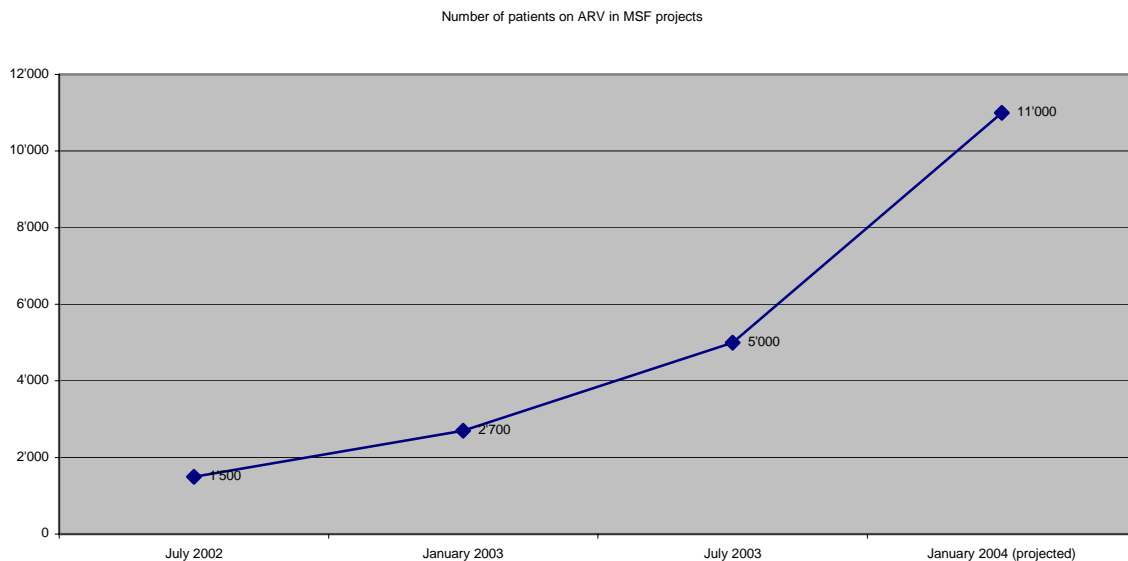
MSF's AIDS treatment experience

MSF has been caring for people living with HIV/AIDS in developing countries since the early 1990s, and the first MSF ARV treatment projects began in 2001. Approximately 9000 patients, including about 500 children, are currently on ARVs in 42 MSF projects in 19 countries worldwide.

The countries where MSF is treating patients with ARVs are: Burkina Faso, Burundi, Cambodia, Cameroon, China, DR Congo, Guatemala, Honduras, Indonesia, Kenya, Laos, Malawi, Mozambique, Myanmar, Rwanda, South Africa, Thailand, Uganda, and Ukraine.

These figures have increased rapidly over the past year - in July 2002, MSF was treating 1,500 patients in 10 countries. We expect the total number of patients treated to reach 25,000 in 25 countries by the end of 2004.

MSF does not offer ARV treatment in a vacuum, but instead aims to integrate treatment into a continuum of care: projects include prevention efforts (health education, prevention of mother-to-child transmission of HIV), voluntary counselling and testing, treatment and prevention of opportunistic infections, ARV treatment and nutritional and psychosocial support.



Clinical observations

MSF looked at clinical data for 10 of its larger projects which began during the period 2001-2003² and found that 87.6% of a total of 6,134 patients who initiated treatment were still on ARVs, while 9.9% died and 2.0% were lost to follow up or stopped treatment. In these 10 projects, MSF has observed that 70% of patients began treatment with an advanced HIV status (WHO stage 3 or 4).

² The projects observed were Chiradzulu and Thyolo in Malawi, Uganda, Kenya, South Africa, two projects in Maputo in Mozambique, Cameroon, Cambodia and Thailand.

Concerning the efficacy of first-line treatment, in eight of the 10 projects where data are available, first-line treatment failed in an average 0.7% of cases. In the seven countries where these data are available, patients showed an average CD4 cell gain of 145 after 12 months. In countries where viral load is available, such as South Africa, MSF observed that 87.7% of 146 patients studied presented with an undetectable viral load after six months.

These figures show good results. In nine out of the ten projects examined, a simplified first-line regimen - one pill twice a day - is used.

Some lessons from MSF's ARV experience

We have learned some clear lessons from treating patients in diverse settings in developing countries and believe these observations could be useful for governments' efforts to scale-up:

"One pill twice a day": adhering to treatment must be made as easy as possible. For this reason, we are working to have 80% of our patients on triple fixed-dose combinations (FDCs) by January 2004. Nine out of the 10 largest MSF projects are using triple FDCs as their first-line treatment. That is, patients will be taking the three different antiretroviral drugs they need in one pill, twice a day. Taking a smaller number of pills per day facilitates compliance and therefore can encourage better clinical results, and also brings less risk of drug resistance (as it is impossible to take partial doses).

"Decentralise and adapt": treatment protocols must be designed to be implemented in places where there are few hospitals, few doctors and even fewer laboratories. In Chiradzulu, Malawi, MSF has set up mobile treatment clinics at each of the 10 local health centres, making treatment more accessible to communities. Basic patient care and follow up is delegated to nurses and health workers (for medical monitoring) and community counsellors (for education, adherence support and treatment literacy). MSF follows uniform guidelines for treatment minimising use of laboratory tests - in many cases, treatment begins after a positive HIV test and clinical assessment by trained staff. More difficult cases are referred to the district hospital. This has allowed the number of patients under treatment in the district to rise quickly, to a rate of 250 new patients in October 2003 alone.

"Available to even the poorest": the cost of treatment for the patient should never be a barrier. Scaling up the numbers of people on treatment in the poorest countries means that treatment will have to be free for the majority of patients. This is necessary not only for humanitarian reasons but also for medical ones, so that all those who begin treatment can remain on it.

"Price matters": the lower the price of medicines, the more patients can be treated and the more sustainable treatment is in the long term. In MSF projects, the price of first-line treatment ranges from US\$270 to US\$593 per patient per year. In MSF's experience, crucial factors in bringing about lower prices for ARVs include

government commitment (to overcome patent barriers when necessary) and the availability of generic medicines to foster competition.

“Involve the community”: the knowledge and participation of patients themselves is key to the success of treatment. At its HIV clinic in Khayelitsha, South Africa, MSF and grassroots treatment advocates have fostered community-based education programmes. With community involvement adherence to treatment and prevention efforts are boosted, the taboo surrounding HIV starts to be broken, and a strong civil society pressure is built for an appropriately urgent response to the pandemic.

MSF and the new WHO AIDS treatment initiative

MSF welcomes WHO's willingness to provide global leadership in tackling AIDS. Its goal of getting three million people on treatment by the end of 2005 is highly ambitious. If the plan is properly funded and implemented, it will be a significant boost to countries' efforts to scale-up treatment.

Invited by WHO to put forward its experiences, MSF has shared the lessons it has learnt from its own treatment experiences and has urged WHO to facilitate the adaptation of treatment protocols to real-life conditions in high-prevalence countries.

There are two further issues which MSF believes need to be addressed by WHO:

Urgent need for research and development of new tools: It will not be possible to solely base scaling-up efforts on existing tools. New tools will have to be developed to respond to specific needs in high-prevalence countries. For example, at present, ARVs aren't well-suited for use by children, so for instance fixed-dose liquid formulations for infants and low-dosage or breakable fixed-dose combination tablets for children are needed.

The pharmaceutical industry is not going to spontaneously fill existing and future gaps such as easy-to-use first-line treatment for children, simplified second-line treatments and simplified diagnostic tools. The public sector, including WHO, should seek to define and lead the work on this research agenda.

Need to ensure that international HIV initiatives are politically and financially supported: Financing is still a problem. Since its inception in January 2002 the Global Fund to Fight AIDS, Tuberculosis and Malaria has received only US\$4.7 billion in contributions from donor governments (for all three diseases), far less than the US\$7-10 billion annually the United Nations has estimated is needed to fight AIDS.