Revised 10.09.03

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A Médecins Sans Frontières (MSF) background paper
for the the 2nd IAS Conference on Pathogenesis and Treatment, Paris, July 13-16, 2003

The challenge of scaling up

Today in developing countries more than six million people urgently need antiretroviral treatment (ART). At the XIVth Conference on HIV/AIDS in Barcelona last year, the World Health Organization (WHO) committed itself to ensuring that 3 million people would be treated by 2005. A third of the time has already elapsed, but there is no evidence to show that we are on track to make this goal. In December 2002, a mere 300,000 people living with HIV/AIDS in the developing world were receiving ART[1]. Half of these live in Brazil, the only country that has so far implemented universal access to ARVs.

There are many real and perceived barriers to expanding treatment to large numbers of people in the developing world. Among those most often referred to are lack of political will, the high price of ARVs; the lack of trained staff and other elements of healthcare infrastructure; the complexity of treatment protocols and laboratory monitoring.

Médecins Sans Frontières (MSF) believes these should not be viewed as reasons to accept the status quo. Despite facing many of these problems in its HIV/AIDS treatment projects around the developing world, MSF is showing that these barriers are not insurmountable. In July 2002, MSF was treating 2,300 patients in ten countries. At the Barcelona conference, MSF set itself the goal of doubling the number of patients it treated by the end of 2003. Now MSF has 23 projects in 14 countries with 4,472 patients (310 of these are children) receiving ART.

MSF's most frequently used first-line regimen is stavudine, lamivudine and nevirapine and fixed dose versions of these combinations are being used in a majority of projects. In MSF projects the price of first-line therapies ranges from US$277 (Cameroon) to US$593 (Ukraine) per patient per year.

MSF ART projects are on a relatively small scale and cannot possibly reach the multitude of people in need across the developing world. Nonetheless, lessons can be learned from these experiences. This document presents basic facts and figures about MSF ART projects, and highlights some lessons MSF has learned in three of its projects: centralised procurement in Cameroon, decentralisation of care in Malawi, and community involvement in South Africa.

Médecins Sans Frontières (MSF) antiretroviral treatment projects worldwide

Médecins Sans Frontières has been caring for people living with HIV/AIDS in developing countries since the early 1990s, and the first ARV treatment projects began in 2000. As of June 2003 more than 5,000 people have received ARVs in MSF projects. Eighty eight percent of these are still on treatment.

Although the places and contexts are very different for each of these treatment projects, a certain number of common denominators exist: MSF focuses on offering care to the poorest and most destitute people; and to ensure that a maximum number of people can be treated and that programmes are sustainable, efforts are made to identify the least expensive sources of medicines. In many cases, this means using generic versions of ARVs.

[1] UNAIDS 2002

Revised 10.09.03

MSF does not offer ART 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 (PMTCT)), voluntary counselling and testing (VCT), treatment of opportunistic infections, ART and nutritional and psychosocial support.

MSF treats people with antiretroviral drugs in its projects in the following countries (June 2003 figures):

Country	Place	Number of patients total	Children
Cambodia	Phnom Penh, Siem Reap, Sotnikum	736	28
Cameroon	Yaoundé, Douala	281	7
Guatemala	2 projects in Guatemala City; Costepeque	421	0
Honduras	Tela	118	17
Kenya	Homa Bay, Mathare, Nairobi	461	29
Malawi	Chiradzulu, Thiolo	673	59
Mozambique	2 projects in Maputo; Tete; Angonia	130	3
South Africa	Khayelitsha	480	60
Thailand	Bangkok, Surin	717	86
Uganda	Arua	305	1
Ukraine	Odessa, Mykolayiav, Crimea	20	20
New country projects			
Burkina Faso	Ouagadougou	20	0
Burma	Kachin state, Rangoon, Shan state, Rakhine state	25	0
Indonesia	Merauke	2	0
Total number of patients		4,472	310

Scaling up challenges - procurement issues in Cameroon

Cameroon – vital statistics
In Cameroon, an estimated 920,000 people or 11.8% of the adult population have HIV/AIDS[1]. Currently, about 7,000 patients receive antiretroviral treatment.

One of the main barriers to access in developing countries is the high cost of antiretroviral treatment. But Cameroon has shown clear political will to bring down the prices of ARVs. A centralised public procurement system, CENAME, uses competitive tenders and quality assessments of generic and originator producers to ensure that it buys quality antiretroviral drugs at the lowest prices. Prices paid by CENAME are among the lowest available internationally.

The government also took necessary measures to overcome patent barriers, thereby implementing the Doha Declaration, which stresses that the TRIPS Agreement "can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all".

MSF has projects in Yaoundé and Douala in Cameroon and offers ART to almost 300 patients. MSF buys its antiretroviral drugs through CENAME, and pays US$ 277 per patient per year for a first line triple therapy (fixed dose d4T+3TC + nevirapine). Prices have come down 300% in the last two years.

Centralised procurement systems offer institutions buying ARVs the ability to purchase the drugs in one place rather than entering into time-consuming negotiations with different ARV producers. Centralised drug procurement is also a useful mechanism to ensure that drug prices are the lowest possible, thus allowing the largest number of patients to be treated. It also helps avoid supply gaps and disturbances that can lead to treatment interruption at patient level.

Scaling up challenges - decentralisation in Malawi

MSF follows 2,500 patients, 655 of whom are on ARVs in the Chiradzulu district in the south of the country, where an estimated 25,000 people are living with the disease. 5,000 are estimated to need treatment now. There is just one 100-bed public hospital to serve the whole district, and its four clinical officers deal with 200 consultations per day. But many more patients never make it to the hospital.

Malawi –vital statistics

In Malawi, an estimated 800,000 people or 15% of the adult population has HIV/AIDS[1].

As a proactive strategy to reach a maximum number of people, including those who cannot get themselves to the district hospital, MSF set up mobile treatment clinics at each of the 10 health centres in the district. The mobile team is made up of two clinicians, one nurse and one counsellor. It makes a rounds of all the health centres, offering on-site HIV rapid tests, management of opportunistic infections and antiretroviral treatment, including adherence counselling. CD4 tests are processed at the district hospital..

In order to decentralise care and hand over part of the treatment to existing community-based centres, it is critical to simplify and standardise ARV treatment. MSF uses a fixed dose combination (d4T + 3TC + nevirapine) which is easier to administer. The combination is purchased at US$288 from a generic provider (intense competition from multiple generic companies has, in most cases, reduced prices to the lowest levels available internationally). MSF follows uniform guidelines for treatment, and minimises use of laboratory tests, relying instead on clinical monitoring of patients by trained staff. In Chiradzulu, basic patient care and follow up is delegated to nurses/healthworkers (for medical monitoring) and community counsellors (for education, supporting adherence to treatment and general treatment literacy).

Scaling up challenges - community involvement in South Africa

The South African government has doggedly refused to put in place a national treatment programme, but in Khayelitsha, where an estimated 50,000 people are living with HIV/AIDS, antiretroviral treatment has been available for the last two years. MSF set up an HIV/AIDS programme in Khayelitsha township in 2000, and started offering ART in May 2001.

South Africa – vital statistics

With 5 million of its citizens living with HIV/AIDS (or 20.1% of the adult population)[1], South Africa has the heaviest HIV/AIDS burden.

Every day, almost 600 people die of AIDS in South Africa.

At the same time, grassroots treatment advocacy organisations such as the Treatment Action Campaign (TAC) developed community-based education programmes and drummed up strong civil society pressure on the government. Health education and "treatment literacy" programmes have led to an increase in understanding of the disease which are helping break the taboo surrounding HIV/AIDS in the community. They also facilitate follow-up of patients and adherence to treatment and contribute to prevention efforts.

With knowledge comes responsibility – the community understands the medical facts of the disease and the benefits of ARV, but is also strongly aware of HIV/AIDS as a political issue. The Khayelitsha township and other communities around South Africa have mounted a vast lobby campaign to convince the government to scale up treatment at national level and develop a comprehensive response to the HIV/AIDS epidemic.

Revised 10.09.03

Although in April 2002 the government announced that it would soon be detailing a national treatment plan, to date no one is getting ARVs in the public sector and more than 600 people die every day.

Moving forward

MSF expects to be treating at least 10,000 people by the end of 2003. This year and next, MSF will open new projects in Angola, Benin, Burundi, Cambodia, Chad, China, DRC, Ethiopia, Guatemala, Guinea Conakry, Honduras, Kenya, Laos, Nigeria, Rwanda, Peru, Zambia and Zimbabwe.

MSF is also stimulating the debate on treatment simplification to move toward a once-a-day treatment regimen with minimal lab monitoring for high prevalence countries.

Regarding drug prices, today MSF's lowest first-line drug price per patient per year is US$277. Offers are already coming in at US$209 (from Aurobindo) and US$201 (from Hetero), suggesting that lower prices are well within reach. MSF is advocating for a price of US$70, which experts say will be possible with large volume purchases.

Many countries are beginning treatment programmes and scaling up existing efforts, but they will need more international resources and technical support. Some funds are starting to arrive on the ground from institutions such as the Global Fund, the World Bank and the Clinton Foundation, but an enormous funding gap remains. For instance, Global Fund pledges so far are a small fraction of the US$ 8-10 billion estimated annual need.

For further info

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- Drug patents under the spotlight, MSF, May 2003

Revised 10.09.03