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HIV/AIDS: Behandlung und Pflege

Feasibility, models of care, challenges

The process of accessing ARV treatment

Von Alexandra Calmy

Despite some differences in models used, there are a number of common grounds within MSF antiretroviral (ARV) treatment projects which can be summarised as follows: multiple entry points of care, HIV/AIDS care given through HIV clinics, free care, no direct observed therapy though prior attendance is a criteria before starting ARV treatment, and use of fixed-dose combinations (FDCs) as first-line treatment.

Today, six million of people living with HIV/AIDS are in urgent need of antiretroviral treatment in the developing world, 4.1 million of which live in sub-Saharan Africa. An estimated 6 000 people die of AIDS each day in this region. Currently, fewer than 5% of those who require ARVs can access them. Only about 400 000 persons are being treated, and over one-third of these in Brazil.

Médecins sans Frontières (MSF) has been caring for people living with HIV/AIDS in developing countries since the early 1990s, and the first ARV treatment projects began in October 2000. At the end of November 2003, 7 848 patients were on antiretrovirals in 42 MSF projects in 19 countries world-wide. Since then, this number has increased to about 11 000 patients on ARVs in 43 MSF projects in 20 countries (February 2004). The number of patients is expected to reach 25 000 at the end of 2004. This huge increase in two years was achieved by tripling the number of projects and dramatically increasing the number of patients put on ARVs in some projects.

Different models of care have been used to prove the feasibility of ARV use in resource-poor settings and biological efficacy in African settings, mainly through the establishment of 'pilot projects'. These projects have progressively broadened: some have adapted an integrated approach offering a wider range of care at district level by adapting monitoring and evaluation, aiming at proving feasibility of antiretroviral treatment at district level. To do so, the following points have been considered: simplification of protocols, inclusion rate analysis, uptake of TB/HIV patients, and optimal use of human resources.

Many are the lessons learnt. After six months follow up, outcomes in November 2003 are favourable in a highly immuno-depressed population of patients: 12.6% between deaths and patients lost to follow-up after more than 60 days, continuous increase of CD4. Results are comparable to results seen in developed countries in terms of survival and clinical outcomes. Moreover, as of November 2003, 51% of the total number of patients were on 3TC/D4T/NVP – more than 72% of new patients started on fixed-dose combinations in the past six months.

By turning around the corner of lessons learned, MSF is inevitably confronted with new challenges, in terms of simplification, adapting treatment protocols to a different population, increasing community involvement, pushing for international involvement in terms of funding and generally by looking forward. Accessibility to second-line treatment – which costs 10 to 20 times more than first-line treatment, adapting fixed-dose combinations to children's needs and adjusting diagnostic tools to the specific needs of difficult contexts are fundamental issues that must be confronted through research and development in the shortest of delays.

The process of accessing ARV treatment is ongoing, however it needs everybody's support. Switzerland has an important role to play and therefore must rise to the challenge. More can be done both by the Swiss government and scientific community, in terms of funding, open support to the WTO Doha Declaration and through assistance to ARV programs in developing countries.

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Some MSF key documents on HIV/AIDS treatment

From Durban to Barcelona: Overcoming the Treatment Deficit

This advocacy and information document, published by MSF in the framework of the "Access for essential medicines" campaign, outlines recommendations to increase access to treatment for people with HIV/AIDS. While NGOs can help show that AIDS treatment can and must be implemented in resource-poor settings, it is seen as the task of governments and the international Community to tackle the pandemic on a global level. (16 pages, 2002)
www.doctorswithoutborders.org/publications/reports/2002/fdtb_07-2002.pdf

2 pills a day saving lives: fixed-dose combinations (FDCs) of antiretroviral drugs

Fixed-dose combinations (FDCs) of ARVs - that is, pills containing two or three AIDS drugs in one tablet - are widely recognized as being a key element in efforts to scale up AIDS treatment in developing countries. FDCs are recommended in the World Health Organization (WHO) treatment guidelines and several generic FDCs have been pre-qualified by WHO. Based on its own experience delivering ARV treatment in resource-poor settings, Médecins Sans Frontières (MSF) has become a strong advocate of triple FDCs.
www.accessmed-msf.org/documents/factsheetfdc.pdf

Surmounting Challenges: Procurement of Antiretroviral Medicines in Low- and Middle-Income Countries. The Experience of MSF

As the price of antiretrovirals (ARVs) in low and middle-income countries has fallen in recent years, governments, international agencies and non-governmental organizations (NGOs) have been able to start developing treatment programmes for people living with HIV/AIDS (PLWHA). Procurement strategies are a key element in this global scaling-up process.
www.accessmed-msf.org/documents/procurementreport.pdf

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