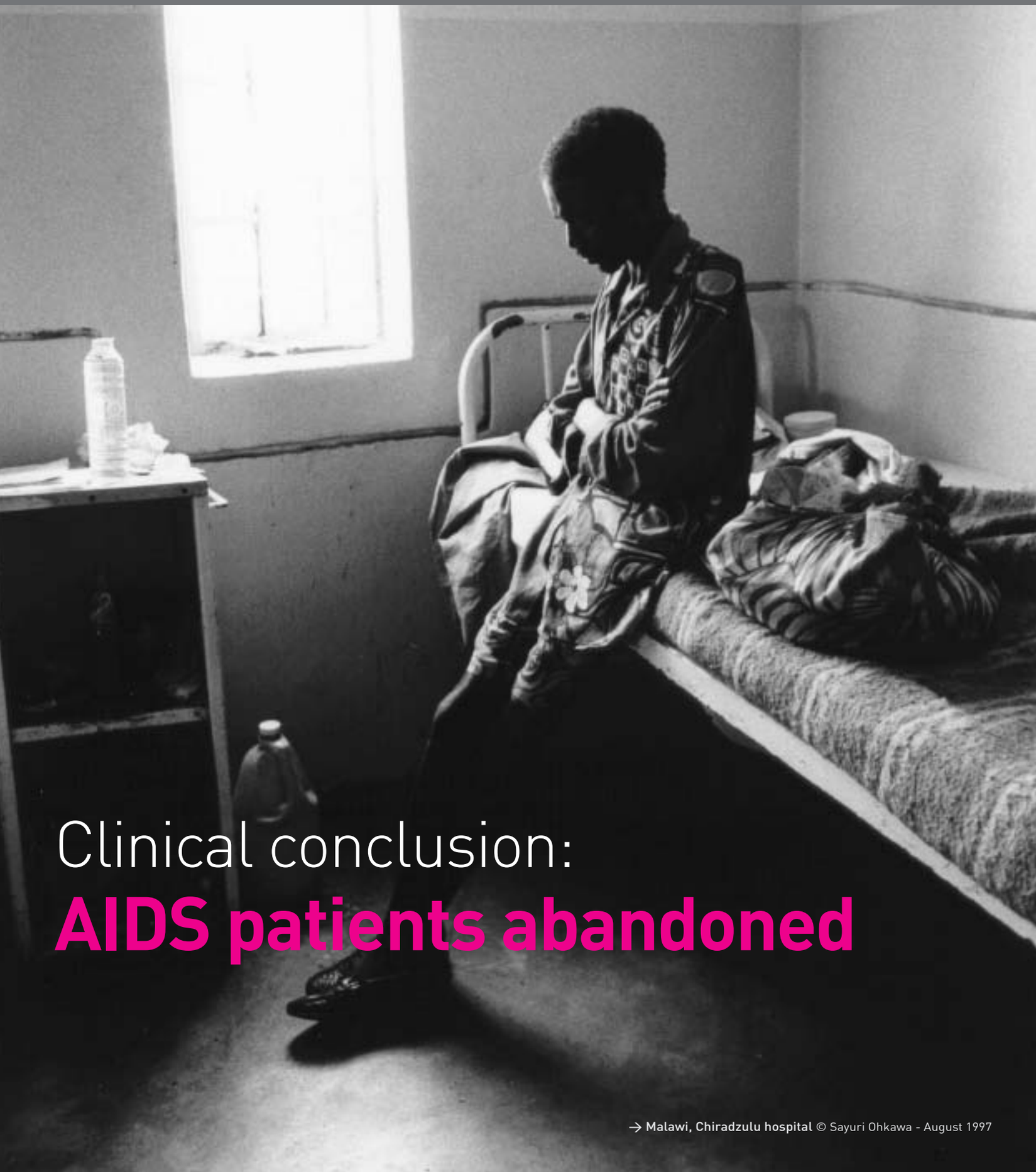
messages

→ **N° 133** / **December 2004** / Médecins Sans Frontières' newsletter



Clinical conclusion:
AIDS patients abandoned

→ **Malawi, Chiradzulu hospital** © Sayuri Ohkawa - August 1997

Number 133

Over the last few years, repeated statements seem to indicate that there is finally the political will and that victory over AIDS is imminent. However the facts speak for themselves: over the last three years, the number of patients under treatment has barely increased and 5 million new people were infected with HIV in 2003. In other words, practically none of the total number of patients are under treatment. As for research, despite epidemiological evidence, it is focusing its efforts on the Northern hemisphere only, whereas the immense majority of patients live in the southern hemisphere.
This failure is compounded by a sense of horror. Although the western world vies for statements of good intentions, the fact is it has nevertheless decided to sacrifice dozens of millions of people.

SUMMARY

CLINICAL CONCLUSION: AIDS PATIENTS ABANDONED

AIDS, 20 MILLION DEATHS LATER

Political failure and medical imp

MSF / November 2004 / Dr. Jean-Hervé Bradol, President of Médecins Sans Frontières

More than 20 years after the AIDS pandemic broke out – and 20 million deaths later – fewer than 5% of AIDS victims are being treated and no preventive vaccine is in sight. The disease is spreading steadily: in 2003, more than 5 million people were infected. More than in 2002, fewer than in 2004.

In the 49 countries that have been hardest hit in which the World Health Organization intends to focus its efforts, nearly 4.5 million patients require urgent treatment to avoid dying in the very short term. Out of this figure, only 187,000 patients (4%) are being treated.

While the disease is spreading exponentially, the same is not true of the number of patients receiving treatment: at the end of 2002, they numbered just over 300,000 worldwide...and only 440,000 in July 2004! It is worth pointing out that more than 100,000 of those treated live in Brazil, an industrialised southern country that has been a forerunner in this area (thanks to long battles against international trade laws and an ambitious health policy). Worldwide, the ratio between newly-infected patients and those given care is still grossly lopsided.

Yet the chorus of politicians, drug manufacturers, international organisations, and research institutes has been spreading good news. An effective treatment, tri-therapies, was discovered in 1995, and an international trade agreement was signed in 2003[1] to make it accessible to all patients. The facts clearly belie such an optimistic account of the actual international response to the AIDS pandemic.

In the early 2000s, however, a major event took place. Hundreds of thousands of patients who could otherwise not afford it were given treatment. The key factor of this watershed event was unimaginable several years earlier: generic forms of drugs, which were produced in India (still not subject to WTO rules), were sold at 30 times below previous prices. For 300 dollars - instead of 10,000 - patients could be kept alive. This was revolution! This forced States (and their health ministries) and the WHO to drop the economic pretence masking their lack of political will. They finally expressed their support for treating patients in the hardest-hit countries, i.e. countries with limited material and human resources.

Since then, the Cancun summit, the Bush plan's 15 billion dollars, the WHO's "3 by 5" initiative (3 million patients treated by the end of 2005),

(...) the Cancun summit, the Bush plan's 15 billion dollars, the WHO's "3 by 5" initiative (...) and additional price cuts announced by major laboratories have had a much smaller effect on patient survival.

and additional price cuts announced by major laboratories have had a much smaller effect on patient survival. A close examination reveals these efforts to be largely red herrings. Their purpose is not to respond to the concrete situation, i.e. the limited access of patients to treatment and the failure to develop a vaccine able to stop the spread of the pandemic. It is rather to protect, through public relations, the credibility and institutional interests of

→ **Malawi, Chiradzulu hospital** © Didier Lefèvre/editing - November 2002

asse

those that bear responsibility for the dramatic dearth of medical research and political will.

On MSF's missions, we have seized on the opportunity presented by the 2001 price cut with particular enthusiasm following our campaign in favour of this measure. Today, we monitor 23,000 patients under antiretrovirals (ARV) in 27 countries. Our medical records show that, contrary to a popular misconception, these patients comply with their treatment regimen just as well as patients in so-called developed countries. The results are good, as treatment has allowed a large number of them to survive. The factors underpinning this success are obvious given the precarious situation surrounding the effort: free treatment, prescribed mainly on the basis of clinical exams in order to do as few laboratory tests as possible, fixed-dose generic combinations (which reduce the number of pills to be taken every day), major commitment to informing patients of the rules to respect in following the treatment, having treatments monitored by nurses owing to the scarcity of doctors, etc.

Still, this relative success remains extremely fragile. First, the total number of patients treated shows that the medical institutions that prescribe ARVs are very isolated, particularly in Africa. Although simplified, the treatment is complex and expensive (around $1,000 per patient per year in MSF's projects, including drugs). We also know, through experience in the United States and Europe, that resistance to these drugs will inevitably develop. The reprieve won by the patients whom we treat will last only a few years. They are being kept alive through stopgap measures.

We are already beginning to lose ground. Beginning in 2005, the WTO will make it impossible for new molecules created in response to the development of drug resistance to be produced in low-cost generic form. In addition, the constant introduction of new drugs with increasingly complex conditions of use is appropriate for Europe, not for poor countries. As a result, there is an urgent need to devise strategies, diagnostic tools, and treatments appropriate for precarious situations in which resources and doctors are in short order. They need to be devised and made available to the practitioners, doctors and nurses who need them most. For this, we must move mountains. We must overcome the obstacles posed by national health policies, international trade rules, and the need for international financing for these measures. Research is not everything, but it is the starting point.

The reprieve won by the patients whom we treat will last only a few years. They are being kept alive through stopgap measures. We are already beginning to lose ground.

Unfortunately, few concrete signs show that medical research is headed in this direction. Despite the epidemiological evidence, its main purpose is to partially satisfy the needs of a minority of patients living in rich countries. If it continues in this direction, our patients will not survive for more than a few years.

Steps have been taken in recent years, but the progress is limited. We have won a reprieve for

→ **Zambia** © Pep Bonet - April 2003

hundreds of thousands of people who would otherwise be dead because they could not afford drugs sold at criminal prices. But millions of others are still waiting for tri-therapies in order to survive. We must not conclude that the obstacle is purely financial. A radical reversal of perspective is needed industry-wide to ensure that this wait is not in vain (research, national and international medical policies, trade rules, conditions governing marketing and distribution, health-care systems). The goal must be to treat the majority of patients, who live in poor countries. The effort must not be limited to the minority of patients who live in the rich countries where international decisions are taken - decisions that sometimes portray the death of millions of people left untreated as a question of fate. ■

1- In Cancun (Mexico), during a summit of the World Trade Organization (WTO)

> *"On track to a modest initiative, governments must now firmly express their intent, just as institutional donors must now finally put their grand statements into concrete effect."*
>
> **Dr Guillermo Bertolletti**
> **Operations Director**

→ Malawi, Chiradzulu hospital © Didier Lefèvre - November 2001

MSF PROGRAMMES

The Future of Our Projects

MSF / November 2004 / Interview by Olivier Falhun, translated by Leah Brumer

With patient treatment begun three years ago, how far have our programmes evolved today? What have we learned from our mistakes? What limits have we come up against? What are the next steps in our fight against AIDS? Dr. Guillermo Bertolletti, Operations Director, offers some answers.

"As a medical NGO, we felt we had to propose something besides preventative tools and methods in countries where importing and registering medications was already an obstacle and where even available medications cost $10,000/year per patient. That was around four years ago.

In the beginning, faced with internal and external criticism and reservations [see box], but also fearful of making mistakes, we decided to set up tight controls. At first, we included only around 20 patients each month. They received the same monitoring and treatment as provided in the North. In the objectives drawn up when our programs opened, we even specified set programme durations of five-years. In our hearts we knew full well that, financing aside, we could not possibly abandon our patients without the assurance that they would continue to receive treatment. We thus created extremely rigorous and complex projects, both in terms of monitoring and inclusion criteria. Three and one-half years later, what have we proved?

→ THREE YEARS LATER

Certain controls have been lifted. We quickly realized that the need for treatment and its effect on patients outweighed the need prevention. In spite of everything, patients have begun to stand up to stigmatization, particularly in Africa. Patients who recover their health, return to work and become active member of the community again are the best publicity we can hope for.

But if we were to be provocative, with three years' perspective, the only thing we have proven is that it is possible to distribute pills in Africa. I think it is still too risky to gloat or make predictions about the future and beyond our programs. Although we have more than 9,400 patients on ARVs today, our AIDS experience remains limited. We are a long way from being able to draw lessons. Our experience allows us only to show the way and serve as an example, based on these several thousand patients whom we have kept alive.

These results were made possible thanks to lobbying campaigns (which brought down the price of first-line antiretrovirals from $10,000 to under $300/year per patient) and were

obtained only by drastically simplifying our projects and our approach to the disease and patient monitoring. We moved from extremely restrictive inclusion criteria to placing patients under antiretroviral treatment on the basis of clinical criteria, achieving new monthly inclusions of 200-300 patients in certain programs.

There are still unanswered questions on political intentions. The fact is government declarations and institutional donors' grand statements have not produced any effects in the places where we work. In Malawi and Cambodia, 90 percent of patients under treatment are being treated by MSF. In Kenya, we will soon have 4,000 patients receiving triple therapy through our Homa Bay project , while the Kenyan government, with help from the Global Fund, has earmarked only 60 treatments to this hospital-and the patients have to pay for their treatment. Where are the staff qualified to treat patients? Where are the billions the donors promised? How much is really available for patients? Many questions remain unanswered.

if we were to be provocative, with three years' perspective, the only thing we have proven is that it is possible to distribute pills in Africa. I think it is still too risky to gloat or make predictions about the future and beyond our programs.

There is also the issue of the immense difficulty we have in obtaining the institutional financing required for our AIDS programs. While these projects today represent 10-12% of our operational budget, institutional support remains virtually non-existent. This is additional proof of the gaping divide between statements of intent to combat the pandemic and reality, but also, perhaps, the first challenge we must address.

→ THE CHALLENGES

We are still far from having learned, tried and done everything for patients in reprieve. Operational and medical challenges are mounting. In seeking to place more eligible patients on ARV treatment, our decision to simplify patient monitoring means that there will be more difficulties and delays in detecting resistance. We must anticipate this and think about ways to monitor or detect resistance.

However, these detection methods will not compensate for the increasing ineffectiveness of available medications. This could well become more pronounced over the next two years, requiring us to respond both with better-adapted first-line treatments and with effective second-line treatments for an entire cohort. Will we be able to prescribe them? Based on what criteria? At what price will we be able to obtain them? The problem of resistance takes us back four years to the struggle for appropriate medications, available at a cost below the current $3,000, and to the start of a new struggle for access to therapies that the North guards jealously [see page 13] - in short, back to where we started!

We are still at that same starting place when it comes to children. This is a weak point and research has not yet been successful in this area. There are no simple paediatric formulations or diagnostic tools for children under 18 months. The result is that it is very difficult to provide proper treatment to the 584 children in our programs. Similarly, we are faced daily with the difficulty of monitoring and treating pregnant women and, more generally, the problem of tools to improve patient monitoring.

We will also have to make major improvements in treating our tuberculosis patients in our specific programs. The tuberculosis co-infection challenge is significant.

→ THE LIMITATIONS

While our treatment capacities are limited, for obvious reasons of resources but also of quality and commitment to our patients, they are a constant point of friction between our own internal planning, our patients' countdown and political priorities.
While legitimate, our early precautions have turned out to be a setback: only 10-15% of our patients benefit from more than six months' monitoring. This lack of perspective prevents us from drawing reliable lessons about our patients' future or that of our programs.

For lack of expansion possibilities, several programs have already reached maximum capacity, raising the issue of determining when and how to decide whether to halt new patient inclusions. Empirically speaking, we could say that that question has been answered: we have already reached and exceeded our limits in some of our AIDS project. Wanting to promise too much, we have ended up making some eligible patients give up hope or even losing them.
The issue of halting inclusions comes up once our legitimacy - different according to its scientific, political or medical nature - can be based on a "critical mass" of patients, whose diversity is matched only by the many patients from seeking access to treatment (see page 17) and even the tendency to hold foreigners responsible for the illness.

With governments tending toward denial and refusing to see reality, they responded to our fears with overcautiousness, fearful of confronting a fait accompli and then having to assume responsibility - at a prohibitive cost -- for patients whose treatment MSF had initiated. But there were other obstacles, too, like the statements and strident cries of certain institutional donors. Some considered Africans incapable of taking medications at specified hours. Others called us criminals, arguing that we were going to flood Africa with resistant strains. There was a long list of people voicing their doubts...

11,400

The MSF France section has placed 11,400 patients on ARV treatment since the programs began. Of the 2,000 who died, 50% did so during the first three months after being placed on treatment (data updated in late September 2004)

→ Guatemala,
© Juan Carlos Tomasi - March 2002

A DIFFICULT AND CRITICIZED DECISION

When we began providing ARVS treatment four years ago, AIDS patients occupied up to 70% of our hospital beds. The willingness of staff in the field coincided with the election of new Board members, creating the conditions for overcoming the first major obstacle: our own failure to act. Our inertia can be explained, in part, by the prospect of taking a leap into the unknown, with all the accompanying and legitimate concerns, in the face of an incurable disease. At the time, one of our major fears was the prospect that hundreds of thousands of people would flood our programs. If that had been the case, some thought we could invite the BBC or CNN to see the crowd at our doors. But we dramatically underestimated the extent to which AIDS stigmatized people, as well as the social constraints that prevented

→ **Zambia** © Pep Bonet - April 2003

584

There are 584 children under 13 among the 9,400 patients currently alive and on ARVs.

(MSF France programs - data updated late September 2004)

→ South Africa
© Tom Stoddart/IPG - 2002

diversity of our projects. For example, 1,000 patients in Malawi is not the same as 1,000 patients in China. A given mortality percentage does not mean the same thing in a hospital context as it does in an outpatient setting. Do we have to hold to an arbitrary limit that we cannot exceed? Must we limit the number of patients based on quality indicators? Once the idea of treating the largest number of patients, regardless of cost, has been put aside, this question arises with respect to every project.

(...) we have already reached and exceeded our limits in some of our AIDS project. Wanting to promise too much, we have ended up making some eligible patients give up hope or even losing them.

Authorities' appeals can be heard in these inclusion limitations, as they take hold of the AIDS problem with greater or lesser delay, energy, will, pressure and support. In large part, our operational future is based on that criterion and extends beyond it.

→ THE OPERATIONAL FUTURE

Today, MSF's French section is leading eight specific programs that currently put all eligible patients rapidly on treatment. While we continue to include patients and place them on antiretrovirals, we will only do so once our commitment is assured, without however committing ourselves to opening new programs.

The proactive attitude of countries like Thailand or Indonesia means we can plan the progressive withdrawal - partial and total, respectively - from these two countries, with the assurance that the authorities will take responsibility for treating our patients (with first-line medications).

Following our field observations, we should also get to work on defining a treatment protocol for AIDS patients outside specific projects, despite the "ethical" problems posed by how long we will remain present in the field. Choosing countries that now show a proactive attitude could limit the dilemmas that inevitably arise when facing the possibility of leaving. In that case, one ethical problem replaces another: before there was the issue of patients whom we treated for TB and died of AIDS, next there will be the patients we'll also treat for AIDS, but whom we will no longer treat tomorrow. If there is no one to take over, we will at least have to ensure that a year of treatment is available before we leave.

(...) before there was the issue of patients whom we treated for TB and died of AIDS, next there will be the patients we'll also treat for AIDS, but whom we will no longer treat tomorrow.

As for government appeals, we need to respond as realistically as possible, supporting the ministries of health that are trying to obtain treatments from institutional donors, without however substituting for the public health politicians. That is not our role.

Since we became involved in AIDS projects over three years ago, we have initiated, secured and improved access to treatment for more than 10,000 patients. On track to a modest initiative, governments must now firmly express their intent, just as institutional donors must now finally put their grand statements into concrete effect." ■

THE EXAMPLE OF MALAWI

ARV's in Malawi... what is the next step?

MSF / October 2004 / Isabelle Ferry, translated by Steven Durose

For the last three years, Médecins Sans Frontières has been treating AIDS patients in the Chiradzulu region of Malawi with antiretroviral drugs. By simplifying admission criteria and patient treatment procedures, and decentralizing follow-up care to local health centres, MSF has been able to put 2500 new patients on triple therapy in one year.

→ **Malawi** © Sayuni Ohkawa - 1997

A recent virological study showed the efficacy of triple therapy in Malawi, where extremely encouraging results are comparable to those obtained in European countries. But unless new treatments are made available in the future, concerns remain about how long patients will continue to enjoy this new lease of life.

Patient numbers were initially limited by a quota and extremely strict admission criteria. "It was clear," says the programme's manager, Chris Brasher, "that the technological 'case by case' treatment of patients, based on the Western model, could not work in the context of a soaring epidemic in which increasingly large numbers of patients required treatment."

→ TOWARDS SIMPLIFICATION

New procedures were adopted in 2003 when the admission criteria were radically modified: quotas were abandoned, laboratory follow-up tests were reduced or eliminated, and clinical follow-up was simplified. All eligible HIV positive patients, who are WHO stage 3 or stage 4, now start treatment after a simple clinical examination, without laboratory testing. For patients at stage 2 and stage 1, laboratory test are carried out to ascertain their CD4 count. If the count is lower than 200, the patient is put on treatment. However, in order to limit the risk of failure and the development of drug resistance, an emphasis is placed on patient awareness and access to information before the HIV test and during the initial treatment stages. "Treatment education, which is much better than in France, is fundamental if we want people to appreciate all aspects of the treatment and to ensure strict compliance," explains Michel Rosenheim, a doctor and member of the MSF AIDS Committee.

Simplifying ARV treatment using a generic "3-in-1" drug allows medical staff and nurses with antiretroviral training to monitor patients twice monthly and dispense treatment to clinically "stable" patients. There are currently only 3 doctors for 2500 patients under ARV treatment. "In the future, we would like these nurses to manage the patient inclusion process," explains Chris Brasher. "Tasks normally performed by doctors, who are in short supply in Malawi, as in the rest of sub-Saharan Africa, must be delegated to nurses and health workers."

We are certain that these treatments will not be effective in the long-term because the virus is in perpetual mutation. Patients will develop resistance to the drugs, requiring the discovery of new combinations

In addition to the simplification of treatment procedures, a decentralized activity has been set up in ten community health centres offering services similar to those of the hospital in Chiradzulu: testing, education, dispensing ARV drugs and follow-up. CD4 samples are taken on-site before being sent to the hospital. The MSF team and doctor currently visit each centre twice monthly. The long-term aim is for nurses who have completed a training course to run the health centre autonomously.

→ ENCOURAGING RESULTS

The aim of the strategy is to provide treatment for an average 200 new patients every month. Over the last four years, 3800 patients have received treatment; 2800 are still alive. Fifty percent receive follow-up in local health centres. "Until now, there has been no virological study to show the efficacy of the treatments used in our African programmes," says Chris Brasher. "Certain indirect indicators, such as body weight, showed that patients were in reasonably good shape. However, we wanted scientific proof that the treatment was effective and that our patients were not falling ill one or two years down the line. We carried out a virological study of 458 sample patients who had been receiving treatment for at least six months. Eighty-five percent of people tested presented a viral load (an indicator that the virus is in the blood) that was undetectable, i.e. below 400 copies (fragments of the virus) per ml, a level comparable to European results."

→ EXTENDING LIFE

Although these positive results prove that it is possible to treat HIV infection in Malawi, the challenge of drug resistance has yet to be met. "We now know treatment is still effective after six months, or a year, but what happens after five years? We are certain that these treatments will not be effective in the long-term because the virus is in perpetual mutation. Patients will develop resistance to the drugs, requiring the discovery of new combinations", adds Brasher. These risks are currently minimized in Malawi by the use of single-tablet triple therapy and the provision of treatment education. If patients develop resistance to the first-line treatment - which is already the case for some patients - they can still benefit from second-line treatment. But it is impossible to monitor the progress of individual patients, as is the case in France. "We risk seeing some of our patients die before they can even benefit from a second treatment. And we currently have nothing to offer patients who develop resistance to all the treatments. We are in a position to extend patients' lives," says Brasher, "but for how long?" ■

THE EXAMPLE OF MALAWI

Malawi compared to France*

MSF / October 2004 / IF, translated by Steven Durose

Is it necessary to transfer the treatment model used in industrialized countries – with its sophisticated biological follow-up – or should treatment be adapted to local conditions?

Michel Rosenheim, a doctor and member of the MSF AIDS Committee is now convinced that simplifying the medical follow-up is a suitable epidemiological response to the AIDS pandemic in Africa. He applied the AIDS data from Malawi to France to show how a rich country with a similarly high rate of infection would be unable to sustain its HIV treatment programme in its current form.

→ MALAWI DATA APPLIED TO FRANCE

If 50 percent of the French population were aged between 15 and 64 - as in Malawi - 30 million French people would fall into this category. Assuming that the AIDS virus was as common among this population as it is in Malawi (between 15 and 20 percent), 5.25 million people in France would be infected (compared with the actual figure of 120,000).

The follow-up procedure currently used in France would bring the total cost of patient treatment to 2.5 billion euros (16 percent of the health insurance deficit), exclusive of the cost of drugs! This level of expenditure would be a difficult to sustain, even in a rich country like France. ■

*** See also page 12**

> *"Epidemiology is more important than economic development in defining the type of treatment adopted by a country."*
>
> **Dr. Michel Rosenheim, Member of the MSF AIDS Committee**

→ **Malawi** © Tom Stoddart/IPG - 2001

THE EXAMPLE OF MALAWI

What are MSF's options in Malawi?

MSF / November 2004 / Arnaud Jeannin, medical coordinator / translated by Janet Wells

Now it has been shown that it is possible to put patients on antiretroviral drugs in a country with limited resources, what are the courses of action available to MSF? Here is what Arnaud Jeannin (medical coordinator in Blantyre) thinks.

In 2001, MSF made the operational decision to treat AIDS patients with antiretroviral drugs. The stated aim was to demonstrate the feasibility of the treatment in a country such as Malawi. This objective has been achieved: the Malawi government, having waited for Global Fund aid for 2 years, is launching a treatment programme for over 40,000 patients between now and the end of 2005. Given this situation, what are MSF's options for the future?

→ LEAVE SATISFIED

We can slowly withdraw. After all, MSF's presence in Malawi is justified by the absence of support from the national system. Once political will exists, what relevance do our actions have?

→ HELP SET UP GOVERNMENT PROGRAMMES?

We have acquired a certain expertise over the last three years. Two recent epidemiological studies showed that the effectiveness of the treatment in our programmes was, for the time being, comparable to that observed in wealthy countries.
We could therefore reply favourably to the government's call, asking us to participate in its war effort. Although the dollars are there, they are lacking in human resources, training and supervisory skills. Why not be pragmatic and offer to employ, supervise and manage part of the system?
If the funds exist to buy ARVs, which account for 80 to 90% of costs in our projects, they certainly have enough for recruitment and training. Malawi should receive nearly $400 million over the next 5 years. If all patients are treated, the cost of ARVs for that period will be $230 million. This leaves enough to recruit field and management personnel. But the Ministry of Health is not authorised by its backers to increase its fixed expenditure (salaries, building, etc.).
Giving in to the pressure of government cooperation demands would be giving in to pressures that we can barely handle: structural adjustment plans, debt problems. It could well mean facilitating the shedding of responsibility of governments to put more on private organisations.

We have only diagnosed a fraction of the people living with HIV where we work. When we start ARV treatment, not all the patients survive. We use simple treatments which will soon be outdated.

→ STAY AND PROVIDE BETTER TREATMENT?

Although we have every reason to feel happy with current results, we would be very strange doctors indeed if we felt entirely satisfied. We have only diagnosed a fraction of the people living with HIV where we work. When we start ARV treatment, not all the patients survive. We use simple treatments which will soon be outdated. Children are treated with tablets for adults (as for most of our treatments in the field).

→ WE CAN DO BETTER THEN

To succeed, we need new epidemiological facts and new diagnostic and therapeutic tools. So far, we have based our actions on knowledge acquired in developed countries. But this knowledge is not totally relevant or necessarily valuable in the contexts in which work. Existing protocols use a lot of laboratory tests that are unavailable here. Our patients are suffering from different diseases which manifest themselves and are treated differently.
At the moment there are only a few people we can count on to respond to the issues we are raising. Research that is adapted to field problems does not go down well with institutional donors.
The irrelevance of subjects currently being researched to the problems we have in the field is a disgrace. We will have to, at the same time as denouncing it, throw ourselves into more advanced research activities than in the past if we want to maintain legitimacy in treating AIDS patients and remain independent. Because our patients cannot wait. ■

→ **Malawi** © Didier Lefèvre - November 2001

MSF and the treatment of AIDS patients

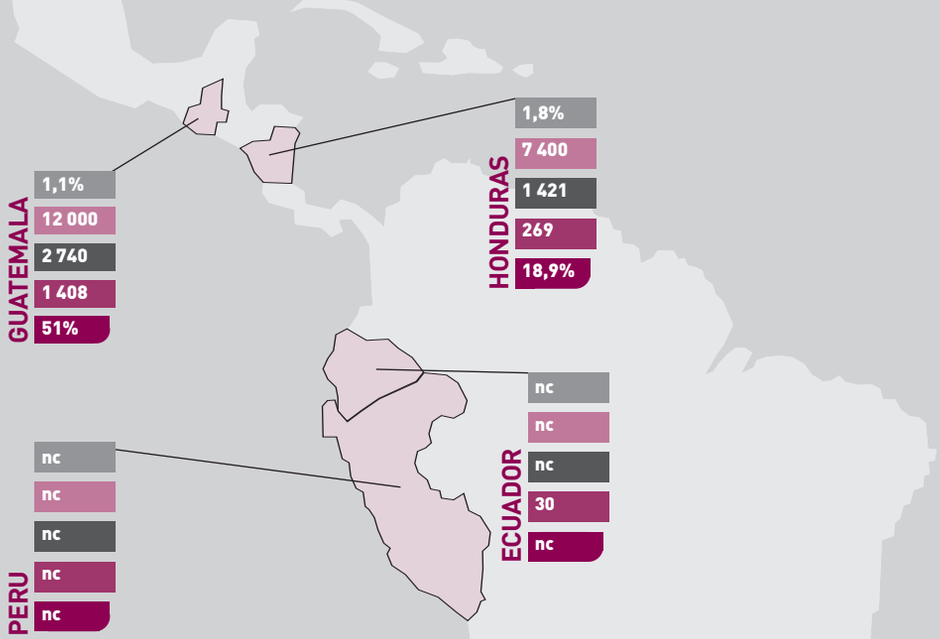
Prevalence (WHO estimate at the end of 2003, amongst the adult population)

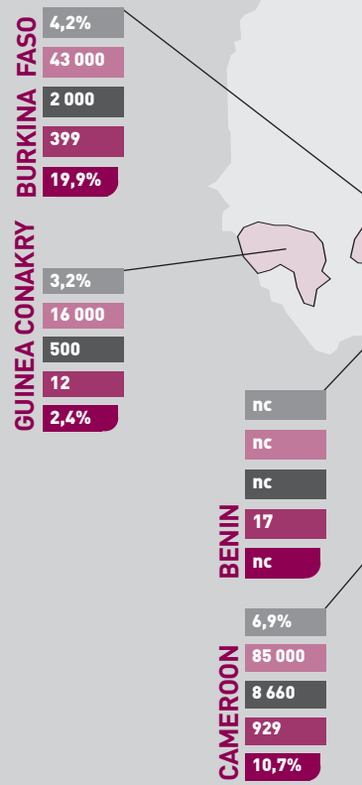
Number of patients that need treatment
(WHO estimate for 2005)

Number of patients that receive treatment

Number of patients under treatment with MSF
(first figures available June 2004, latest figures available August 2004)

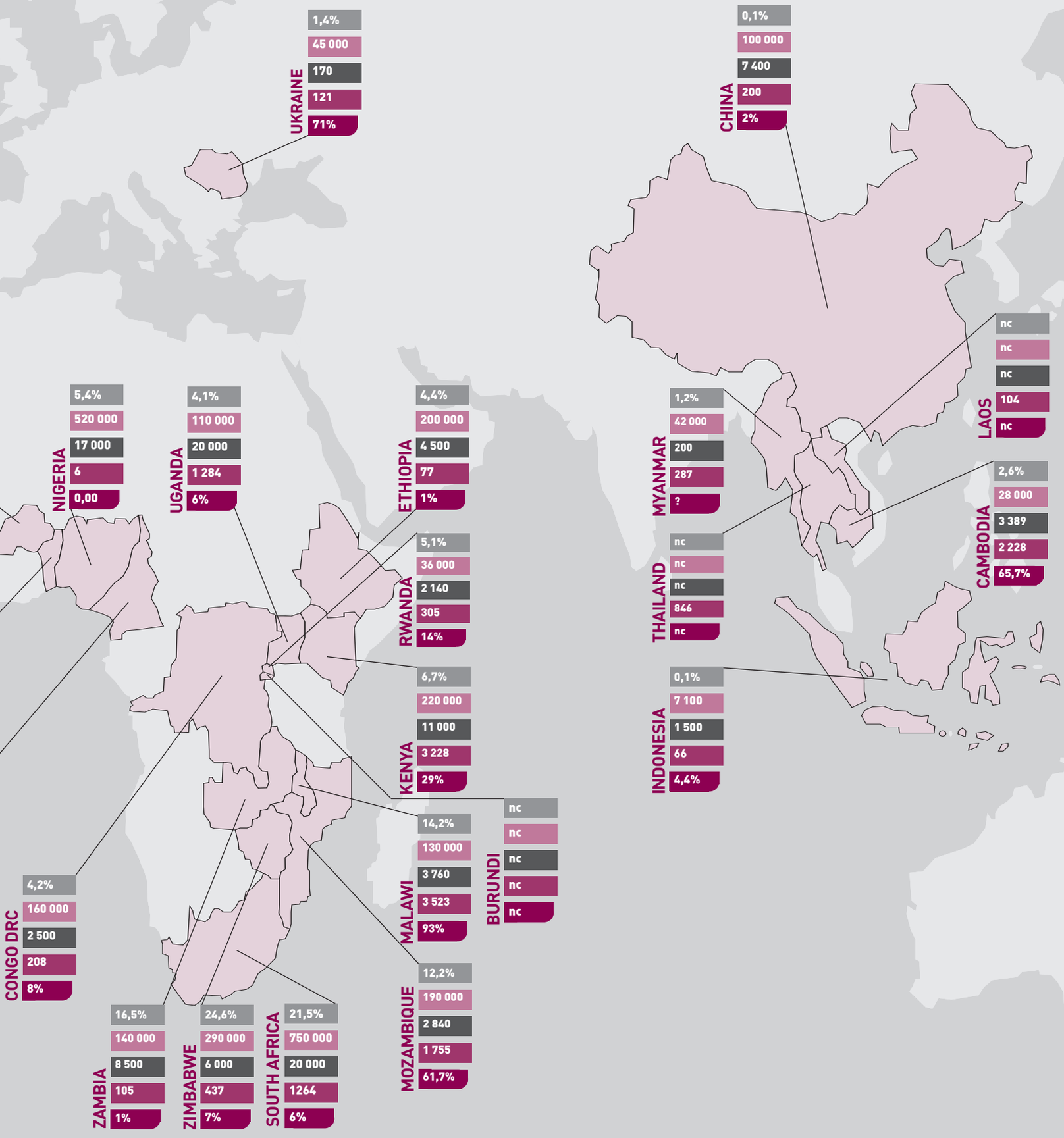
Percentage of patients under treatment with MSF compared to the total number of patients under treatment





MSF has over 23000 patients on HAART (including 1340 children under 13 years old) - latest figures September 30, 2004.

For further country by country information on AIDS and Médecins Sans Frontières' activities: www.msf.fr/sida.
For the latest update on the Campaign for Access to Essential Medicines see: www.accessmed-msf.org.


UKRAINE
1,4%
45 000
170
121
71%
CHINA
0,1%
100 000
7 400
200
2%
LAOS
nc
nc
nc
104
nc
CAMBODIA
2,6%
28 000
3 389
2 228
65,7%
MYANMAR
1,2%
42 000
200
287
?
THAILAND
nc
nc
nc
846
nc
INDONESIA
0,1%
7 100
1 500
66
4,4%
NIGERIA
5,4%
520 000
17 000
6
0,00
UGANDA
4,1%
110 000
20 000
1 284
6%
ETHIOPIA
4,4%
200 000
4 500
77
1%
RWANDA
5,1%
36 000
2 140
305
14%
KENYA
6,7%
220 000
11 000
3 228
29%
BURUNDI
nc
nc
nc
nc
nc
MALAWI
14,2%
130 000
3 760
3 523
93%
MOZAMBIQUE
12,2%
190 000
2 840
1 755
61,7%
CONGO DRC
4,2%
160 000
2 500
208
8%
ZAMBIA
16,5%
140 000
8 500
105
1%
ZIMBABWE
24,6%
290 000
6 000
437
7%
SOUTH AFRICA
21,5%
750 000
20 000
1264
6%

ADAPTED CASE MANAGEMENT

AIDS - a different approach in developing countries?

MSF / October 2004 / Caroline Livio, translated by Melanie Stallard

> *Sub-Saharan Africa has just over 10% of the world's population, but is home to close to two-thirds of all people living with HIV. In 2003 alone, an estimated 3 million people in the region became newly infected, while 2.2 million died of AIDS (i.e. 75% of deaths due to AIDS in the world in 2003).*
>
> **Excerpt from UNAIDS 2004 Report on the global AIDS epidemic**

Though different initiatives appear to be developing in favour of the most deprived patients, they have not led to a noticeable rise in the number of patients taking antiretrovirals «in the field ». Annick Hamel, Head of the Campaign for Access to Essential Medicines, describes how the current case management of patients is unsuitable and calls for a new approach for patients in countries with poor health systems.

«A number of treatment initiatives have been developed over the last few years », notes Annick Hamel, Head of the Campaign for Access to Essential Medicines in the French section of MSF. The most recent initiative, which has certainly received the most media coverage, is the one that the World Health Organization (WHO) launched in December 2003. The goal of the «3 by 5» programme is to get three million people living with HIV/AIDS under treatment by the end of 2005. Dealing with the treatment of patients, implementing large scale initiatives - even if their pertinence and feasibility still remain to be proven - is a mini revolution in the field of AIDS in poor countries. Above all, this initiative shows that the treatment issue is on the agenda at last, after so many years when action for AIDS patients in developing countries was limited to preventing the disease.

→ THE PROOF OF POLITICAL WILL?

The Clinton initiative is another major advance. In October 2003, the former American president, via his Foundation, announced an agreement with four producers of generic medicines: three Indian laboratories, Cipla, Ranbaxy and Matrix, and Aspen, a South African laboratory. The agreement, that concerns different countries in the Caribbean and Africa, considerably reduced the cost of triple therapies, from an average $300 to $140 per patient per year. After the major decrease in the cost of triple therapies thanks to the arrival on the market of the first generic medicines, in particular those from India, this new initiative shows that when there

→ South Africa © Francesco Zizola / Magnum Photos - November 2003

is a political will to make progress, it is now possible to produce triple therapies at a reasonable cost. As for the Bush administration, it announced at the beginning of 2003 that it would spend 15 billion dollars over five years on combating AIDS. But only 10% of that sum will be allocated to the Global Fund to fight AIDS, tuberculosis and malaria. The rest will be used to implement bilateral agreements between the United States and the beneficiary countries and not necessarily for issuing generic medicines (see page 14). On the other hand, since its creation in 2002, the Global Fund has been putting a little more emphasis on treatment and is now declaring for example that 1.6 million people will be able to benefit from ARV treatment over the next five years thanks to money from the Fund.

→ A BITTER REALITY

« In other words, » added Annick Hamel, «we now feel that there is a political will to treat AIDS patients, and that money is available, even if we could wish for more money. Treatment is available at a fairly reasonable cost. But in concrete terms, in the field, very little has changed.» Out of six million AIDS patients awaiting triple therapy, which is the only means of saving their lives, only 440,000 people were receiving treatment in July 2004. Over 100,000 of these patients are in Brazil, one of the few countries to have implemented a national policy for treating AIDS. How should we interpret this significant lack of results? "Perhaps existing patient case management is not suited to AIDS patients in developing countries," explains Annick Hamel. "Not suitable because of the size of the epidemic in the most affected countries, and also because the means available for diagnosing the disease and treating AIDS victims were designed to fight a moderate epidemic in the North". Thus, for example, after several years of treatment with first line medicines, AIDS patients will inevitably develop resistance to these medicines, and it is therefore essential to start second line treatment, which is more complicated, gives rise to more side-effects, and is also more expensive. Furthermore, even by simplifying the treatment and monitoring of patients as much as possible, it is nonetheless necessary to train staff, and to spend time with AIDS patients to improve adherence.

→ TAKING DIFFERENT ACTION

« All the tools available were designed to monitor patients individually, as happens in the North, and not to provide large-scale treatment to deal with the massive needs of poor countries. Suitable tools are lacking, even if we have tried to simplify the treatment and monitoring of patients in our programmes as much as possible." And research and development in the field of AIDS is not focused on the needs of poor countries. We are lacking diagnostic and monitoring tools that are easy to use, treatments that do not require pills to be taken every day, and also a first line treatment with a longer life that could be used for ten years or so without generating resistance for example. Some researchers are working on new ideas, such as research into virucide products that could kill the virus after unprotected intercourse. But none of the research carried out so far enables us to envisage a solution in the short term that would make it easy to diagnose the disease or treat patients in poor countries. «We can dream for example of a therapeutic vaccination with a monthly injection," concluded Annick Hamel «or a diagnostic device in the form of a simple strip making it possible to ascertain the viral load or the CD4 count in a few seconds". ■

THREE MAJOR ISSUES

Intellectual Property

MSF / November 2004 / CL, translated by Angela Dickson

On 1st January 2005, production of new generic anti-retroviral medications will become impossible.

In 1994, the member countries of the World Trade Organisation (WTO) signed an agreement to harmonise rules on management of intellectual property: the famous TRIPS agreement (Trade-related aspects of Intellectual Property Rights). For medications, this agreement grants exclusive commercial rights to the patent-holding laboratory for a minimum of 20 years. This agreement was applied in 1995 by industrialised countries, and should be applied from 1st January 2005 by developing countries (in 2016 in the least advanced countries). This delay has permitted some developing countries with successful pharmaceutical industries (India, Brazil, Thailand) to commence the production of generic medicines in the meantime. Thus, from 1st January 2005, these same countries must bring their legislation into line with the WTO agreement, if they have not already done so. In reality, this means that they will no longer be able to produce generic versions of new medications. So, when new drugs come onto the market, they will be protected for a minimum period of 20 years, and the manufacturer will fix a price and sell them at that price. Moreover, it is known that manufacturers of brand name medicines have been obliged to reduce the prices of their medicines because of the competition generated by the arrival on the market of generic medicines. This competition will no longer be possible from January 2005, and we can only fear that the price of new drugs against AIDS will once again be unaffordable for patients in poor countries. ■

THREE MAJOR ISSUES

AIDS money

MSF / November 2004 / Kevin P.Q. Phelan

What questions do the implementation of the Global Fund[1] and the Bush plan raise in the fight against AIDS in developing countries? Interview with Rachel Cohen, US Director for MSF's Campaign for Access to Essential Medicines.

> *Lacking the possibility to benefit from these drugs [anti-retrovirals], the poor are proposed information, prevention and abstinence.*
>
> **Annick Hamel, *In the shadows of just wars*, edited by Fabrice Weissman Hurst & Company, 2004**

→ What financial resources are needed to confront the HIV/AIDS global pandemic?

Everybody has a different assessment of what the actual number is, but it's certainly far more than what is being committed today. The latest projection from UNAIDS is that $12 billion is needed by 2005, and less than half this amount is being spent. There have been important developments over the last couple of years, particularly with a rhetorical shift when President Bush agreed to commit 15 billion dollars over five years through PEPFAR (President Emergency Plan for Aids Relief). But the US money comes with a lot of strings attached and no other government has come even near that.

Kofi Annan call to action in 2001 - he said we need a "war chest" of ten billion dollars per year to fight AIDS - led to the creation of the Global Fund. It was supposed to be a multi-lateral response to the AIDS pandemic that would make an efficient use of global resources to reach larger numbers of people more quickly. It sought to avoid the proliferation of donor initiatives with different requirements and parallel structures. The US government, though, made a very deliberate choice in 2003 with the President's Emergency Plan for Aids Relief (PEPFAR.) Instead of putting a huge amount of money into the Global Fund and really making it a viable, reliable funding mechanism, the US government took this unilateral approach, and created what I think we now clearly see is something of a monster.

I am not saying the Global Fund is the best mechanism for funding ARV treatment, but it is clear that it is not today what it could have been had the US and other donors decided to support a truly international funding mechanism.

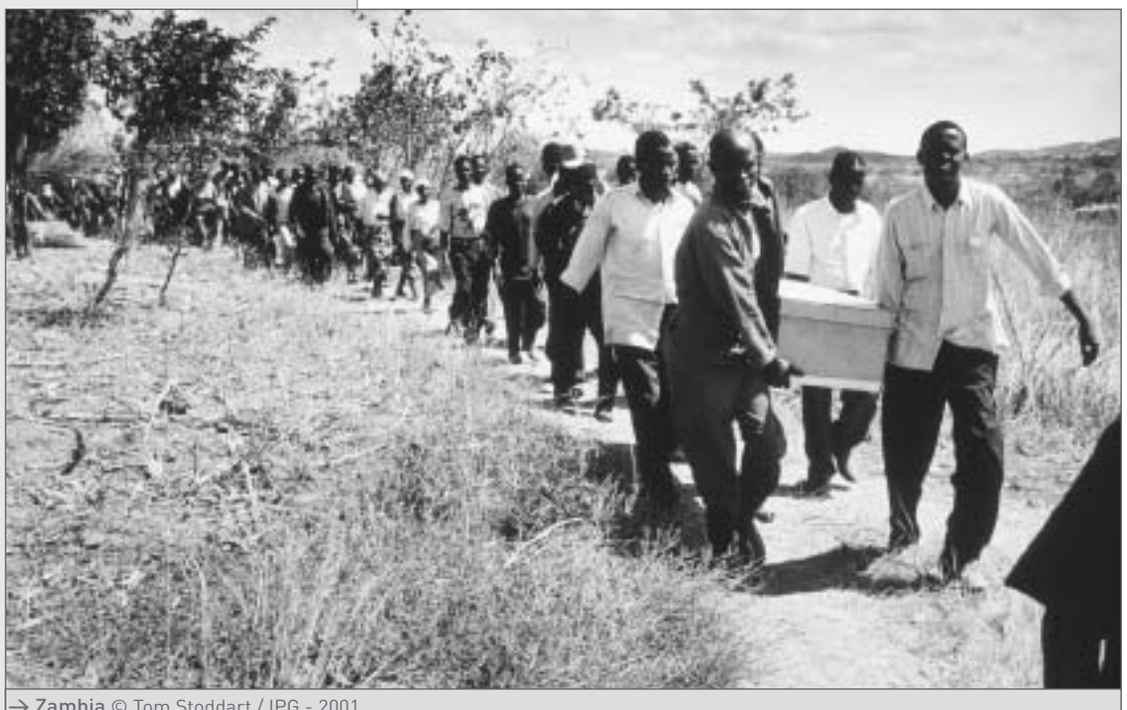
Over the long term, there are huge questions about the sustainability of funding. PEPFAR has a mandate to operate until 2008. The Global Fund has a shortfall of more than $2 billion. There's not enough money for 2005 renewals let alone additional rounds. If this is the case now, how will these programs continue after these first few years when the world's attention is no longer focused on AIDS treatment. What is going to happen with all of these programs without long-term, predictable funding? What will happen to people with HIV/AIDS whose lives depend on this funding?

→ Has the recent infusion of funds led to a huge increase in the number of people receiving treatment?

We are still in a situation today, as we were three years ago, where an overwhelming majority, over ninety percent of the people with HIV who need anti-retroviral therapy still don't have access to it, and that is just a fact. The Global Fund estimates that existing programs will provide ARV treatment for 1.6 million people over five years. PEPFAR says they will be responsible for providing treatment for 2 million people by 2008. The reality is that no one knows how many people are on treatment as a direct result of these initiatives. It is certainly on a more positive trajectory, but the increase in resources is not suddenly leading to hundreds of thousands of people on treatment.

→ What are some of the difficulties encountered with the Global Fund and PEPFAR?

Looking in the countries where we are providing AIDS treatment there are all kinds of problems with the Global Fund: problems with disbursement, problems with the country coordinating mechanisms, and problems related to the lack of input from affected communities or the exclusion of certain marginalized groups.



→ **Zambia** © Tom Stoddart / IPG - 2001

→ **Cambodia** © Didier Lefèvre / editing - November 2002

But PEPFAR gives more cause for concern. Programs will be locked into buying brand name drugs, spending at a minimum about six hundred dollars per person per year instead of about two hundred dollars per person per year with generic medicines. This means they are going to be treating far fewer people with every given dollar that they spend. The parallel procurement mechanisms and supply chain management system they are setting up may completely bypass or undermine local procurement strategies and force other donors to go through those mechanisms.

Fundamentally PEPFAR could be about a lot of money going to US-based organizations and companies. Rather than having a huge infusion of cash at the ground level to make a real difference at the national level through the public health system. I worry that most of the money will end up staying in the US or at least in the pockets of people from the US. Essentially these are all huge contracts, multi-million - in some cases billion - dollar contracts for what are known here "the Beltway bandits" - those people who never actually leave Washington DC or who subcontract from the US and descend in droves upon Nairobi, Johannesburg and other capital cities. Certainly the biggest chunk of that money will go to the pharmaceutical industry.

Instead of putting a huge amount of money into the Global Fund and really making it a viable, reliable funding mechanism, the US government took this unilateral approach, and created what I think we now clearly see is something of a monster.

→ How will MSF operate in an environment where PEPFAR is the dominant force?

It will be hard in places overwhelmed by initiatives that have very different objectives than we do. The obvious example is in Zimbabwe. While Zimbabwe is not a PEPFAR focus country, all US programs are affected by PEPFAR policies. Not only does MSF work in the same hospital as the US Centers for Disease Control, we share a pharmacy with the program. MSF is already treating several hundred patients and our side of the pharmacy shelves are filled. On the US government side, the CDC side, shelves are empty because they haven't been able to get a clear signal about what medicines they are allowed to procure.

By that I don't only mean whether they can procure brand name drugs or generic medicines, but even just what the procurement system is. We have the same protocol - the Zimbabwe national protocol. In the end, the CDC will not be procuring generics, and, again, spending three times more on brand name drugs.

At a programmatic level it means that they are treating one person when they could be treating three. For patients, this means taking six pills a day instead of two. At the most basic level, you could have people who are not only in the same community, but literally in the same household who have different regimens and who have no idea why they are taking different medicines. I think it can completely confuse our efforts.

Another thing I have been concerned about for some time is the confusion about why a couple of generic drugs have been removed from the WHO qualification list. With different quote-unquote "standards" being applied in different programs operating in the same environment, there could be a perception that some programs are accepting lower standards, specifically with regard to drug quality. The misinformation about the quality of generic medicines coming from the US government could undermine confidence in the MSF program. We don't have evidence of that yet, but I think it's a real concern. If you are getting told by the big bully in the room, "Take these brand name drugs because they are better, and we are not going to compromise on quality for Africans just because these drugs may be a little bit more expensive," that sends a very strong, inaccurate, and dangerous message which we have been fighting against for so many years. ■

1- Global Fund to fight AIDS, tuberculosis and Malaria.

THREE MAJOR ISSUES

The current state of research

MSF / November 2004 / Aurélie Grémaud, translated by Mary Davis

Current treatment strategies, and associated areas of research, do not take into account countries with limited health systems. However, some areas of research, such as those concerning therapeutic vaccines and, in the field of prevention, those concerning microbicides, are providing some hope. Doctors Suna Balkan, Myrto Schaeffer and Elizabeth Szumilin discuss these different fields of research.

MICROBICIDES

→ Applied on vaginal mucous, microbicides, in the form of a gel, cream, suppository or other, would reduce the risks of HIV transmission. It would do so either by destroying or immobilizing the HIV, by boosting the vagina's natural defenses against HIV, or by preventing the proliferation of the virus once it has penetrated the cells.

Source IPM http://www.ipm-microbicides.org/index.html

Given the scope of the pandemic and the number of patients in developing countries that require treatment, the strategy of individualized treatment that exists in rich countries is impossible to implement as it requires health infrastructures that are beyond the reach of the poorest (and most affected) countries.

→ RESEARCH INTO TREATMENTS

HIV research is largely geared towards the discovery of new molecules. By doing so, it is addressing a major issue in rich countries: that of patients whose treatment has failed after second, third or nth line treatment.

"In France, we have the technical means and a range of anti-retroviral drugs that allow us to provide very personalized therapy for patients. This luxury does not exist in developing countries. We are thus we are unable to provide the same treatment as in the northern hemisphere, which is based essentially on progressively stepping up therapy as resistance appears. In these countries, we need an immediate and tougher therapeutic combination whose efficacy remains steady with time," explains Dr. Balkan.

→ FIGHTING DECREASING IMMUNITY

For the millions of patients who will need antiretrovirals in the fairly near future, the different areas of immunology research are vital: this could lead to simpler case management strategies that are more adapted to the contexts in which we work. Research is currently being carried out to find ways to boost patients' immune systems so they can maintain an adequate level of CD4, with the hope of postponing or even avoiding the use of anti-retroviral drugs.

Unfortunately, the funds allocated for this research are extremely insufficient compared with those used by private laboratories in the search of new anti-retroviral drugs.

→ **Indonesia** © Tse Tse Wah / MSF - February 2004

PAEDIATRIC ANTI-RETROVIRALS: UNSUITABLE MEDICATIONS

Children living with AIDS today cannot be properly treated due to a lack of suitable medication. For adult patients there are triple therapies that are relatively simple to use (drug combinations at a fixed dose which means patients only have to take one tablet twice a day, and available at an affordable price), but these combinations do not exist in paediatric doses. And, even when there exists a paediatric formulation for anti-retrovirals, the cost is six times higher than for adults. Thus, a course of treatment for a child (weighing 14kg) taking three different liquid mixtures, containing three different drugs, costs $1300 per year, compared to $200 for the same combination for adults.

There is a more restricted choice of medications for children. Doctors are often obliged to use adult tablets, and to crush them so that children can swallow them, or to cut the tablets (which are not designed for this) in order to give the correct dose. As a result of this, treatment is even more difficult.

Children suffer from the pharmaceutical industry's lack of interest in paediatric ARVs. In rich countries, very few children are born infected with HIV, thanks to the successful prevention of transmission of the virus from mother to child. Paediatric formulations, particularly liquid mixtures, have therefore been developed for these children at a price that is unaffordable for developing countries, and they may even be unavailable in these countries if laboratories do not take the trouble to register them. Again, this is not a profitable market for the big laboratories.

Nevertheless, it is estimated that 2.5 million children in the world* are living with HIV/AIDS. Due to a lack of appropriate medicines, nearly 50% of children born HIV positive die before the age of two. While 6% of people infected worldwide are children, they represent 17% of deaths.

***Source Unaids - 2003 figures**

As for a preventative vaccine, we still have a long way to go, because of a lack of funds and technical difficulties.

→ WHILE WAITING FOR A VACCINE

Although there is still a long way to go before a preventative vaccine is available, research on microbicides (see margin) offers interesting perspectives. But this research is not advancing quickly enough: Zeda Rosenberg, Director of the International Partnership for Microbicides, says that microbicides will not be available before 2007. Nonetheless, this does provide reason for hope, even if the cost issue remains to be examined.

"It is inconceivable that this kind of product would not be distributed freely or at a very low price. A medication that would prevent contamination! AIDS is considered to be such a significant threat that it was a subject of discussion for the Security Counsel of the United Nations! How could we justify not making sure that a product that works is financially accessible to everybody?" says Elisabeth Szumilin.

→ PEDIATRICS AND MOTHER-CHILD TRANSMISSION

A simple observation explains why research is not centered on the pediatric aspects of HIV-AIDS: in the United States, 500 children are contaminated per year; around the world, 1,800 children are infected daily. Pharmaceutical companies, who focus mainly on the profits they can generate in rich countries, do not see any interest in developing pediatric forms of treatment.
"In rich countries, we are willing to pay a lot for the health of our children, but since AIDS doesn't currently affect them much, the result is that there are few specialists around the world," explains Dr. Myrto Schaeffer, who works particularly on HIV treatment for children.

The issue of prevention is also important. It is currently possible to greatly reduce the transmission of the AIDS virus from a mother to her child through the use of antiretrovirals during pregnancy, through a caesarian section, and through artificial nursing.

However stopping breast-feeding, for example, is often impossible in the countries where we work. There is currently little or no research being done on ways to prevent transmission despite breast-feeding. "In fact, we know almost nothing about this. Other than stopping breast-feeding and using industrial milk, there is currently no solution," Myrto explains. Yet, the risk of HIV transmission during the nursing period is at least 30%. Once again, in the presence of such an emergency, research is still inadequately financed.

"Some papers have been written on this subject. But we don't have enough data to make recommendations," concludes Balkan. ■

MATERNITY AND AIDS

→ On the African continent, over 5 million women of child-bearing age are infected with the AIDS virus. In antenatal clinics in the main urban areas, one pregnant woman in three is HIV positive.

Source Unaids

AIDS AND WOMEN

AIDS in women - the role of men

MSF / November 2004 / Olivier Falhun, translated by Angela Dickson

Worldwide figures show there are more men with AIDS than women (52% compared to 48%[1]), however these figures mask the particular vulnerability of women. The number of HIV positive women is currently increasing, particularly in the 15-24 age group, in which 60% of people infected are women. Speaking from their experience of MSF programmes in Africa, Drs Suna Balkan and Elisabeth Szumilin, of the medical department, discuss these figures alongside the division of roles in African society and the issue of male domination: the other vector of AIDS.

Elisabeth: The risk of contracting the disease is greater for women than it is for men. There are biological factors that partly explain this: the risk of transmission is higher in 'receptive' vaginal intercourse than in 'insertive' vaginal intercourse, and the fragility of the mucus membranes makes women more vulnerable than men. However, this does not explain the proportions seen in certain age groups and on certain continents: in Africa, in the 15-24 age group, women are three times more at risk than their male counterparts!

Suna: This figure is connected to the socio-cultural environment, particularly in sub-saharan Africa, where 77% of HIV positive women live. It all starts with access to education: in many countries, if you have the choice, the priority is to send the boy to school. And if someone is ill at home, it's primarily the woman who looks after them, it's the girl who will have to leave school to take care of a relative... It's not surprising, then, that awareness is spreading more slowly among women, when everything is done to distance them from all possibility of emancipation, all access to awareness.

Elisabeth: It's true that awareness of the risk of AIDS is spread by access to education, and in particular sex education. This is where real prevention work can begin, and unfortunately this is inaccessible to many young girls. Other reasons for their being exposed and infected earlier than men of the same age, particularly between 15 and 24 years old, include

AIDS

CLINICAL CONCLUSION: AIDS PATIENTS ABANDONED

> *"At one moment, he had cardiac problems, that was on Thursday. He died on the Saturday, that was Saturday 1st December, world AIDS day. I was there. The situation is very bad for AIDS widows, the family takes everything away from you after his death. I had lots of possessions, they took everything."*

A woman with AIDS, Mathare (Kenya) 2002

the fact that they are dependent on and at the mercy of older people, and that they must submit themselves to 'rites' handed down by their elders.

Suna: In some areas, in order to obtain a 'cure' or a 'purification', older men (who in some cases know they are infected) will go and obtain the favours of a young girl!

Elisabeth: And vice versa! If one argument doesn't work, the opposite does: in some cultures, there is a specific status, that of 'cleanser'. In some regions of Malawi, for example, an adolescent girl who has just had her first period must be 'cleansed'. She goes to the elder of the village, the 'cleanser', who is endowed with the power of 'purification' which is dispensed through sexual relations... There are also 'sugar daddies', men who financially support young girls in exchange for sexual relations, or other forms of sexual violence...

(...) in all our programmes in Africa, the majority of patients are women, with an average age of 34, often widowed or abandoned because of their HIV positive status.

Suna: The 'servitude' that is promoted by economic and social beliefs and situations - take prostitution, for example - does not further the cause of African women, and it greatly increases the risk of infection. Not to mention marital practices like polygamy, which greatly increase the risk of transmission of the virus.

Elisabeth: Or levirate marriage, a custom which sometimes has hidden motives: initially set up for social reasons (to ensure that the widow is not on her own), this practice, which requires that the widow marries the younger brother of the deceased, has been diverted from its initial objective: families now rapidly invoke it only to conserve the husband's inheritance. Whatever the reason, the risks are multiplied.

Suna: This is perhaps an explanation for the fact that in all our programmes in Africa, the majority of patients are women, with an average age of 34, often widowed or abandoned because of their HIV positive status. Do they realise the seriousness of the illness following the death of their husbands? Is their sense of self-sacrifice so great that they wait for their husbands' death before coming to see us? It is clearly not in their interests to tell their husbands about their HIV positive status, as they risk being repudiated and rejected by the community. At the start of our PMTCT[2] programme at Arua in Uganda, among the young pregnant women being diagnosed at the maternity unit, there were many who we lost to view when they learned of their HIV positive status...

Elisabeth: Another example is Mathare in Kenya, this shanty town in Nairobi where many widows live after having been left to themselves on the death of their husbands, and who have lost everything. [see margin]. Out of the total number of patients seen in the MSF centre at Mathare, 78% are women!

However, we could add that in the case of Malawi, for example, women come forward for screening more often than men. Perhaps this is connected to their role at home, particularly with regard to their children. Their responsibilities may lead them to overcome certain obstacles, with the aim of assuring the protection and future of their family. They also have to overcome the weight of social pressure! The

→ **Mozambique** © Martin Beaulieu - January 2004

figures concerning access to treatment are therefore biased at MSF, as we basically treat women who have already succeeded in reaching us! We also sometimes treat men (in Malawi, for example) who arrive - when they do arrive - in an appalling state of health, often worse than the women. They too are perhaps caught in society's trap, where they feel obliged to provide for the family's needs and therefore to work until they drop, and their health takes a secondary role... In this respect, as long as the existing social order is not questioned, access to treatment will remain difficult, for men and women.

Suna: The issue of access to treatment is not limited to Africa. In Asia, the proportion of women infected is apparently smaller than the proportion of men, the figures for attendance on our programmes are noticeably different: while in Africa 70% of our patients are women, this figure is just 40% in Cambodia and 30% in China (where the project has just started)!

Elisabeth: Women have very little power to negotiate for safe sex. The policy of AIDS prevention by condom use has reached its limits... and the female condom is both too expensive and not sufficiently widely available! We know that there is a project to study microbicides, which would allow women to protect themselves from the virus while 'keeping control', independently of men. As for when this will be available...

Women have very little power to negotiate for safe sex. The policy of AIDS prevention by condom use has reached its limits...

Suna: Despite all this, one still has the impression that in Africa, women are taking much more action than men. They have organised themselves, and set up networks of mutual support, such as Nacowla (National Community of Women Living with AIDS) in Uganda. This is an association of women living with the disease, who help one another and who fight for their rights, for prevention and for access to treatment. This is perhaps the only positive thing in this situation: we see that paradoxically, thanks to AIDS, women are asserting themselves within African society. ■

1- Source : Unaids - 2004
2- Preventing mother to child transmission

BIOLOGICALLY MORE VULNERABLE

During heterosexual intercourse, women are more vulnerable to AIDS than men. The concentration of the virus in sperm is nearly ten times that in vaginal secretions. The risks of transmission are therefore greater in (receptive) women, especially as sperm can stay in contact with the vaginal membrane for several hours and even days, while the man is only exposed to the virus during intercourse itself.
The surface area of mucus membranes exposed to the virus is much greater in women (cervical and vaginal membranes) than in men (balano-preputial membrane).
Moreover, the fragility of the vaginal mucus membrane (particularly during menstruation, but also in forced sexual relations) means it is particularly vulnerable to lesions and risk of infection.
The presence of STIs facilitates the transmission of the virus (the presence of genital herpes type II is considered one of the strongest co-factors in the transmission of HIV during heterosexual intercourse - source: Université Pierre et Marie Curie, www.upmc.fr).

MSF STAFF AND AIDS

It needs to be said...

MSF / October 2004 / OF, translated by Jane Wells

The AIDS pandemic is also threatening the health of Médecins Sans Frontières members. Our activities – and not only our specific programmes – mean that the 6,500 people working in the field for the French section are exposed to the virus. The risks are very real, as incidents of accidental exposure to blood show. Here is what Arnaud Laurent from the human resources department has to say about the context of our work, prevention and the treatment proposed by MSF.

→ In preparing for this interview, you stressed the importance of risk awareness. Can you explain why?
A.L. : Before tackling the issue of awareness, people must accept the reality that risks exist. However, there are still certain people - expatriates or members of national personnel - who consider themselves to be immortal heroes saying they've seen worse, or for cultural or political reasons continue to deny the existence of the disease. That said, the issue of awareness is raised simply because we are confronted with a high prevalence in most of the countries we work in, and in carrying out our actions in general. Thus AIDS concerns are present in other actions, such as operations or vaccination campaigns, which require increased vigilance. Of course health per-sonnel are at risk, but logistics staff are also particularly exposed: destruction of waste and handling of used syringes are part of their job. Finally, we can't talk about AIDS at MSF without mentioning risky sexual practices and methods of protection. Things that go without saying perhaps need to be said.

→ What prevention tools and methods do you have?
A.L. : From raising awareness to prophylaxis, there is quite a wide range of methods available: the distribution of condoms before each departure, but also their availability in each MSF house or office in the field, is both a preventative and symbolic measure. In another vein, briefings and internal communication tools are a regular reminder of certain rules, for example the roadmap distributed to "First missions" or the "Santé en mission" guide available in all

THE PEP* KIT

Comprising a folder explaining steps to take according to the degree of exposure, and prophylaxis medicines, the "PEP kit" is available on all missions and for all personnel: from day staff to national and international personnel and staff paid in "incentives". The kit tries to cover all eventualities in the event of accident, and contains preventive treatment (bi-therapy and soon tri-therapy) to be taken within 72 hours of high-risk exposure. The prophylaxis significantly reduces the risk of infection.

*Post exposure prophylaxis

AIDS

CLINICAL CONCLUSION: AIDS PATIENTS ABANDONED

Each month at MSF, more than one accidental blood exposure is reported to headquarters in Paris. It can be assumed that there are cases that are not reported.

→ **Cambodia** © Espen Rasmussen - February 2004

field libraries. But we especially need to prevent the risk inherent in our activities. Accident prevention measures have been set up, such as sharps containers that avoid direct contact with used needles. In the event of exposure, there is the "PEP kit": a kind of first-aid kit that is regularly updated by the medical department and available on all missions [see box page 19]. Finally, the responsibility of the medical coordinator should be emphasised here. He/she ensures that rules are observed and precautions are taken in every health facility, and must be informed of any accidental exposure.

→ In addition to this preventative aspect, what is the treatment policy in the event of contamination, and what are the limits?

A.L. : In the case of expatriates, and in addition to social security coverage, MSF takes out insurance for "professional risks". It is not obligatory to have this insurance to go on mission with MSF, but to subscribe to it volunteers must be tested for HIV and HVC (hepatitis C)[1]. But things are more complicated when it comes to national personnel. If medical expenses are only partially or not covered at all by social security, MSF will try to compensate by taking out private insurance. Sometimes MSF finds itself in the position of employer-insurer which is far from ideal. This has led us to stipulate the various coverage provided by MSF in a reference document[2]. As for personnel on "incentives"[3], who are employed by the local health service and work with MSF, this "co-responsibility" is a grey area. In terms of prevention, heads of mission must provide information and provide everyone with the same tools. However, the issue still remains of shared responsibility and treatment expenses, which has many unanswered questions. Are ARV drugs available in the country? Does the ministry of health provide them? Is there a social security system and what does it cover? It is only once questions of this type have been answered that we will be able to refine the scope of our cover.

Finally, mission closures also constitute a limit, although we do not leave without giving the personnel concerned the equivalent of one year's treatment if their expenses are not covered by the authorities. A limit... and perhaps also a reprieve, which reminds us of our responsibilities since we began to treat AIDS patients. ■

1- This must be carried out 15 days before departure, then within 3 months of return (six months in the case of hepatitis C), in compliance with procedures and confidentiality. MSF is not informed of the result.

2- See "Health and social security cover for national personnel" document, available in all coordination teams.

3- The number of people paid in the form of "incentives" (bonuses paid by MSF) varies between 500 and 1000.

SPECIAL AIDS

Press Contact:

caroline.livio@msf.org
laurence.hughes@msf.org

For further information:

- on the activities of the French section of MSF: www.msf.fr
- on the activities of the other MSF sections: www.msf.org

messages

Médecins Sans Frontières - 8, rue Saint Sabin - 75544 Paris Cedex 11 - Tél: +33 (0) 1 40 21 29 29 - Fax : +33 (0) 1 48 06 68 68 - www.msf.fr Editor in chief: Bénédicte Jeannerod - Editing: Olivier Falhun - Photo librarian: Christine Dufour - Translation : Caroline Serraf/TSF - Layout: Sébastien Chappoton / TC Graphite - Design: Exces communication - Print: Artecom.