

HATIP

HIV & AIDS Treatment in Practice

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Amsterdam workshop on scaling up treatment (meeting report)

Summary

Meeting report by Julian Meldrum

A meeting on scaling up ARV treatment was held in Amsterdam earlier this month, just before the Paris meeting which is covered in the aidsmap news reports linked above. Keynote presentations on behalf of WHO, the International AIDS Society and the Global Fund to fight AIDS, TB and Malaria spelled out their respective roles and agendas. These were followed by a number of case studies from particular countries where some treatment is being provided and thematic working groups, as described in a previous issue of HATIP.

Issues raised repeatedly, to be followed up in future issues of HATIP, include:

- The need for simpler and better treatment regimens. Ideally, one tablet, once daily, with minimal side effects that do not require hospital treatment or expensive lab tests. At present, most providers use what treatment they can get hold of, rather than what might be most suitable. As soon as there is a real commitment to providing large scale treatment, then there is an opportunity to change this.
- The need to make best use of human resources, maximising the involvement of nurses, counsellors, healthcare assistants and community organisations so as to make best use of the few well-trained physicians who are available.
- The need for simpler and cheaper diagnosis and monitoring

Who, When and Where?

An International Workshop on Strategies for Scaling-Up HIV/AIDS Treatment in Resource-Poor Settings was organised by the US-based AIDS Healthcare Foundation in Amsterdam the week before the IAS meeting in Paris. 120 participants included a number with direct experience of providing services, particularly with small treatment programmes run between NGOs and governments. However, it was not a representative group and some areas of expertise were presented better than others.

This report summarises presentations, rather than the workshop recommendations, which are available from the AIDS Healthcare Foundation as a rapid report including suggestions for areas that might benefit from further research.

The report is in English, 6 pages, 120 Kbytes as an Adobe Acrobat file available [here](#).

A translation into Russian, and many related information resources are also available, [here](#).

Why treat? - WHO's new agenda

Dr Joep Lange, President of the International AIDS Society and co-chair of the forthcoming 2004 Bangkok International Conference on AIDS, gave the principal keynote address to the workshop. There had been real progress since 1996 towards widespread access to antiretrovirals which, he claimed, were the only cost effective treatment for HIV and AIDS.

Dr Lange felt, after reviewing the alternatives, that it was one of the most positive things that could be done to address the problem of HIV and AIDS in Africa and other countries, including India.

Education alone did not work: in Botswana, the epidemic had grown to be massive despite enormous efforts to raise awareness. There is still widespread reluctance to use (male) condoms, which were still not as available as they need to be, and female condoms are not really an attractive alternative. Use of ARVs to prevent sexual transmission might be more likely to work than microbicides, and could incidentally be more woman controlled, but still need to be proven effective and safe for widespread use. Vaccines are still "10 years" away, after many years for which this had been promised, without guarantees they would work. As for preventing mother-to-child transmission without treatment for the parents he had to ask, is it worth it?

Political commitment remains a major challenge and he quoted a saying, Of all the ills that kill the poor, none is as lethal as bad government. Sometimes the public health care sector was incompetent, corrupt, or simply not extensive. On the cost of care, he acknowledged that the problem can seem overwhelming and asked how Europe or North America would cope with 20% of the adult population HIV positive. He acknowledged that HIV is just one of many problems faced by societies and governments.

Immediately, he proposed a model based on accredited treatment centres that could be used to establish expertise, sustained by contracts with companies, NGOs, embassies, and others, bringing private sector know-how to bear in turn on meeting the needs of public sector services. This is one of the goals of PharmAccess International, an organisation he founded and works for.

On the risks of the drugs, he said, it is better to let two out of a hundred people die of HAART-toxicity, because of minimal monitoring, than a hundred out of a hundred die of HIV because HAART is not available.

To move from treating thousands to treating millions, it would be necessary to tackle a series of interrelated needs, all at the same time. These included:

- Robust drugs [he was concerned that nevirapine (NVP) and lamivudine (3TC) are each vulnerable to single mutations, making regimens like NVP/3TC/d4T (Triomune) less than ideal as a treatment regimen]
- Drug distribution
- Cheap and simple monitoring
- Expertise and manpower
- A simple regimen [favouring fixed dose combinations where possible]
- Financing health care
- Prevention of HIV transmission
- Operational research [on how to implement care, treatment and prevention]

This he saw as needing a concerted global effort, based on a broad coalition of participants, including public and private sector members, with clear divisions of responsibility and accountability for action.

The International HIV Treatment Access Coalition, formed in December 2002 with WHO providing the secretariat, is intended as a global focus for such efforts, and further information is available from its website at: <http://www.itacoalition.org/>

Dr Jos Perriens, of WHO, traced the emergence of WHO's present commitment to expanding access to ARV treatment. UNAIDS had rightly highlighted the need for a multisectoral response to HIV and AIDS; WHO's proper role was to mobilise the health sector. While the possibility of ARV treatment had begun to be discussed from 1995, WHO had not really kept up with the need for a health sector response to support treatment. This was now transformed, with a strong commitment to the UN General Assembly's target of putting 3 million people on treatment by the end of 2005.

Dr Perriens estimated that 5 to 6 million people in developing countries now urgently need ARV treatment, 4 million of them in Africa, but only 300,000 have access now, of whom 50,000 are in Africa. The target figure of 3 million was based on an assessment of what might be delivered, based on what is being done in other health fields, such as childhood immunisations, TB treatment, and so on.

Reasons to focus on ARV treatment included:

- It greatly improves quality of life and life expectancy, decreases absenteeism, hospital admissions, cost of OI treatments
- It preserves human capital for development with an impact on education, the transmission of life skills, prevention of orphanhood
- It strengthens prevention through increased uptake of VCT, PMTCT, and behaviour change. He claimed that in Khayelitsha, near Cape Town, the rate of condom use is now the highest in South Africa, following an increase in take-up of VCT which may have been twelve-fold or more.

Without it, he foresaw that in three generations, southern Africa could be reduced to the present state of central Africa, in social and economic development terms.

It was important to set goals high enough to be worth achieving: set them too low, and you'll never get there.

There were five components, as he saw it, to what was needed.

- Simplified decision making with standardised protocols and simplified monitoring. WHO supports this approach.
- Optimised use of human resources, delegating from physicians to nurses and other health cadres. If there are no complications, the doctor doesn't need to see them.
- Involving people with HIV and community members in delivering treatment.
- Cost minimisation strategies to deal with the costs of drugs and monitoring, including support for alternative monitoring technologies and simpler clinical monitoring.
- Integrating ARVs in existing structures with other interventions including HIV testing, PMTCT, OI management and TB treatment.

In practical terms, countries needed to produce national treatment guidelines, decide on a delivery model that can be scaled up and is appropriate to existing systems level of development, develop a short and medium term implementation plan, ensure best use of public and private health service infrastructure and human resources.

This is not complicated if one builds on one's strengths rather than focuses on one's weaknesses.

WHO itself would:

- Advocate for action on treatment access
- Propose norms, standards, materials for action, making full use of materials developed by other agencies where possible
- Support individual countries in their planning

- Support a culture of collaborative action that involves all major stakeholders in the health sector [with ITAC as the basis for this]
- Develop a global procurement plan for ARVs, together with UNICEF and the International Dispensary Association IDA [a non-profit agency based in the Netherlands, which supports governments, NGOs and faith-based services in procuring essential drugs and medical supplies]
- Identify, document and publicise best practice.

What happens in individual countries?

Dr Arletty Pinel of the Global Fund to fight AIDS, Malaria and TB [responsible for Latin America and Europe], stressed that the Global Fund was set up as a funding mechanism, not to provide technical support which needed to come from other agencies. She discussed different approaches taken in a number of countries.

CHILE had worked with a very small team (of 8 people) running its Country Coordinating Mechanism, which meant they were able to meet every week and take decisions fast. Their goal was to provide ARVs to all who met clinical criteria, by the end of this year.

HONDURAS had a major problem with capacity, through lack of trained physicians. This would be dealt with by seconding 12 experienced Cuban physicians, each of whom would work with a team of two Honduran doctors for one year, to treble the number of people with HIV on treatment from 500 to 1500, which could be expected to go on rising to more than 4,000 people relatively soon.

UKRAINE currently has just 50 people on treatment, but has set a target of 4,000 on treatment by the end of December. Political commitment has been a challenge, especially since the epidemic is associated with injecting drug use raising some of the same issues that occur in Latin America and the Caribbean where men who have sex with men are heavily affected by HIV.

She saw the main challenges as being:

- Making the most of the opportunity to connect treatment with prevention and other aspects of the response to HIV and AIDS
- Political will to increase coverage
- Partnership coordination in increasingly complex programmes
- Supporting adherence to treatment at a community level (to secure public health benefits from treatment).

Learning from experiences

During the course of the workshop, a range of different programmes were presented, including:

BOTSWANA: a visit to the ARV access programme for the UN Millennium Project HIV/AIDS Task Force commented on what happened where clinicians gave priority treatment to people who were most ill. The doctors then found that in managing the more complex and difficult cases, they didn't have time to see other patients and put them on treatment too. Nonetheless, an accelerating number of people are now going onto ARVs and there are differing reports about the waiting list to start treatment. The need to transfer some routine medical care from doctors to nurses, and to transfer adherence support and counselling from nurses to non-medically-trained lay counsellors, pharmacy technicians and other assistants, has been clearly identified. By the end of April 2003, 6,000 patients had been enrolled of whom 4,700 were actually on treatment, in the first four treatment centres (two referral hospitals and two district hospitals). Another 9 major treatment centres are lined up for the next phase of expansion.

[Botswana's experience was presented in Paris by Dr Ernest Darkoh, with a transcript available - though not easily read - [here](#).]

BRAZIL: the development of the Brazilian national AIDS programme was reviewed by Dr Ricardo Marins. This has been presented before, at international conferences including in Barcelona. Dr Paolo Teixeira, who has headed the programme, is now a principal adviser to WHO's Director General on expanding access to treatment on a global scale. The most recent developments include the establishment of a national network of laboratories to monitor and test for HIV drug resistance mutations and the recent extension of the list of available ARVs to include tenofovir.

MALAWI: Medecins Sans Frontieres programme in the Chiradzulu District, one of the smallest in the country, is currently among the largest ARV treatment programmes that MSF is supporting. MSF began work with the two hospitals in the District and is now decentralising ARV care to 10 community health centres. Initially, these were served by mobile medical teams but responsibility is being transferred to the nurses in charge locally (who will continue to receive support from the mobile teams). While the programme began using AZT (zidovudine), 3TC and nevirapine, it has shifted to using generic d4T, 3TC, nevirapine (Triomune, as a fixed dose combination) as its first-line combination. This was mainly because of the rate of anaemia they were seeing with AZT. Of course, now they are seeing peripheral neuropathy due to d4T, but that has not been so difficult to manage.

MOZAMBIQUE: plans to implement large scale ARV access have been developed with help from the Clinton Foundation. The Irish and Canadian governments are backing what could soon be one of the largest programmes of its kind, one of the largest initiatives the Ministry of Health has ever undertaken, and with a five year budget of US \$330 million. (As with other large funding initiatives, this has inevitably raised some questions about diversion from other programmes as distinct from 'new money'.) The goal is to have 34,000 people on ARV treatment in 18 months, rising to 132,000 by 2007, which is more than the far wealthier South African health care system has so far been committed to. This treatment would be provided through a network of services including 19 day hospitals, plus home care services and local health centres. Directly observed therapy would be given for 30 days in a clinic, followed up in the community. Only Mozambicans would be delivering HIV treatment, but some 100 additional staff would be recruited from overseas to provide other services currently being provided by the very small number of Mozambican doctors currently working in the country (450, half of whom live in the capital, Maputo, in a country of 18.5 million people). The health ministry currently employs some 16,000 staff in total, which should rise by 1250, excluding VCT counsellors. All health staff would shortly be receiving a 30% pay increase to raise morale and increase the chances of retaining staff.

SOUTHERN AFRICA: the Secure the Future programme sponsored by the multinational pharmaceutical company Bristol Myers Squibb is now in its fourth year. Among many other projects, this has sponsored ARV treatment for several hundred children and is now setting up some additional 3-year pilot treatment projects in public sector healthcare sites across 4 countries. 1,200 people at each site will be provided with ARVs. These projects would be focussed on supporting the role of community organisations, looking at the use of ARVs in regional and district hospitals (though two sites would in fact be national referral hospitals), assessing the operation of WHO's guidelines for access to treatment in limited-resource settings, and also introducing pan-leucogating technology (developed in South Africa) for access to low-cost CD4 counting.

UGANDA: while ARVs are available to several thousand people who can afford to pay for the drugs from their own resources, there

are only three relatively limited services which currently provide them free of charge to adult patients. The AIDS Healthcare Foundations own programme is one of these. Uganda Cares works in cooperation with the Uganda Ministry of Health to support the provision of free ARVs at one hospital in Masaka District, to patients supported by the community organisations TASO and Kitovu Mobile. At present, this treats some 100 patients, but during the workshop it was announced that this would be expanded to 1,000 patients with support from the US pharmaceutical company Gilead including provision of their two ARVs, tenofovir (TDF) and emtricitabine (FTC). MSF France is providing free ARVs in Arua, in the north of Uganda, and there is a further project providing treatment to 40 parents run by GTZ in Fort Portal.

In conclusion

Issues that emerged in strong focus during the meeting included:

The need for nurse- and hospital-officer-led treatment services

to address the very limited number of doctors available in many countries. Working to establish and maintain a pattern of services, where some people are routinely seen by nurses and referred to doctors only when strictly necessary, is a significant challenge. Some would seriously doubt whether current ARV treatments are sufficiently well-understood to be provided by such services, yet what alternative is there? Legal obstacles for example, laws preventing prescriptions of certain drugs by nurses may need to be reviewed.

The need for simpler treatment regimens

. A regimen delivered as one tablet or capsule, once a day, is close but not yet achieved. There is no ideal regimen available, though efavirenz or nevirapine with d4T/3TC may currently come closest (difficulties in managing anaemia make AZT problematic as a basis for large scale first line treatment). Achieving WHO's goal of putting 3 million people on ARVs by 2005 is likely to depend in large part on the use of d4T/3TC/NVP whether as Triomune, GPOvir or in another formulation. There is still no answer from WHO as to where this combination is in their pre-qualification process, and it remains absent from their model Essential Drugs List.

Whatever regimens are chosen, large-scale procurement of supplies is likely to require significant investment in manufacturing plant, which will depend on guarantees of future purchases. Yet, given the limitations of these regimens, a strategy to replace them when more suitable drugs become available is also needed. Perhaps today's first choice can become tomorrow's alternative to be kept in reserve, but is that enough of a guarantee to get production lines moving?

Monitoring requirements may need to be reviewed. Access to VCT including a confirmed HIV antibody test is essential, but how necessary are other baseline tests? Anaemia monitoring may only be needed with AZT-based treatment, and low-technology (visual) approaches to checking it may become available. However, the training implications of such methods may be challenging. It is suggested that if NVP liver damage is severe, this is likely to be due to an immune reaction rather than a more traditional form of hepatotoxicity. If so, then clinical vigilance may be as useful as liver enzyme tests. But how many people who are taken off NVP due to raised liver enzymes would have lost their life if the drug had not been stopped? How can we find out?

If a clinician is very experienced, it may be that ARV toxicity problems can be clinically diagnosed, from the treatment history

and careful examination. However, if treatment and care is being

expanded very fast, most clinical staff will not be so experienced and there may still be a great need for laboratory tests and other support.

about HATIP

A regular electronic newsletter for health care workers and community-based organisations on HIV treatment in resource-limited settings.

The newsletter is edited by Theo Smart (Cape Town) and Keith Alcorn, NAM's Senior Editor (London).

For further information please visit the HATIP section of aidsmap.com