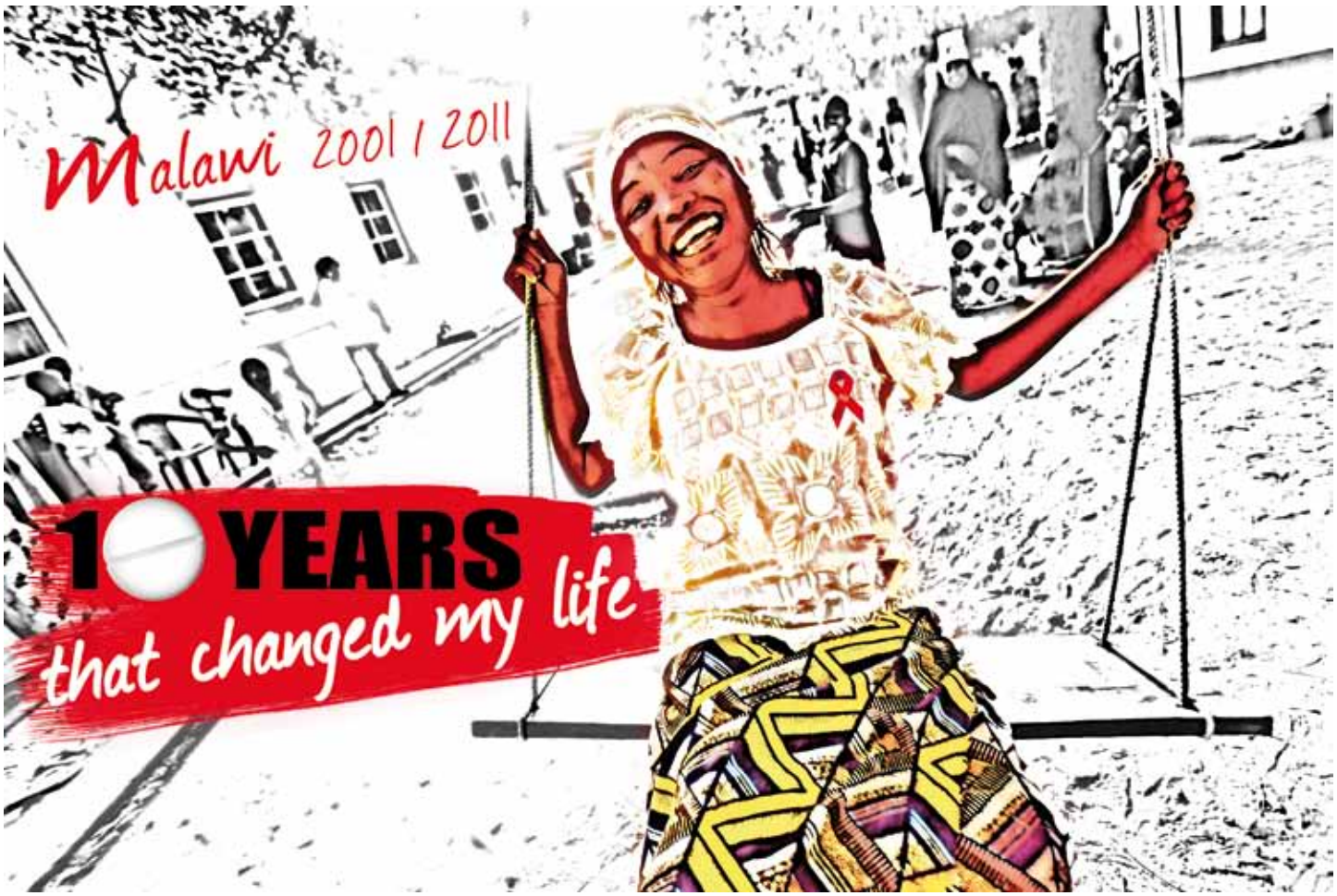
2001-2011

10 YEARS OF ANTIRETROVIRALS

TREATMENT IN MALAWI BY MSF



MEDECINS SANS FRONTIERES

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VOICES FROM THE FIELD

"When I found out my dead husband was HIV-positive, I cried. If my husband was HIV-positive, it meant that I was HIV-positive too. My children hadn't completed their schooling. The youngest was seven years old. How was I going to take care of them? I thought I would die very soon and I would have to leave my children. Even my own parents, my own relatives, started discriminating against me. People gave me different names. 'AK47'. Am I a gun? Why? 'Oh, she's a dead body. Like a poison'. It was a time I will never forget."

Esnart, MSF patient since 2001, now MSF information officer.

"Before 2001, we had no testing material and no ARV drugs. We could only treat opportunistic infections. We didn't have any alternative. Most of the patients were dying. Then MSF came. They introduced the ARV drugs. We started with a very small number of patients, then we scaled up. From then on, the death rate of HIV patients started to reduce."

Innocent Nuangulu, clinical officer for the Ministry of Health.

"In 2001, I heard that in Chiradzulu an organisation named MSF had come. I heard that MSF would give drugs to prolong my life. This encouraged me to go for an HIV test knowing that I'd get medical help from MSF if found HIV-positive."

Boniface, MSF patient since 2001.

"I am 53 years old. I was one of the first patients to be initiated in ARVs in August 2001. Since then, my health has improved greatly. In 2000, I couldn't go to work any more because I was sick. But since I started ARVs, the disease has retreated. I started working again. My life has gone back to normal."

Fred Minandi, MSF patient since 2001 and MSF peer counsellor.

In July 2002, Fred Minandi, one of MSF's first patients in Malawi to receive ARVs, spoke at the 14th international conference on HIV/AIDS, held in Barcelona. At that time, donors refused to fund HIV/AIDS programs as they did not believe that African patients would take ARVs on a daily basis.

Fred Minandi told the conference:

"I am lucky to be one of MSF's patients. I am one of the first ones to benefit from free treatment in Malawi and if I am here to talk to you about it today, that's because I am receiving treatment.

Some of you will say that Africans cannot take medicine properly because they don't know how to tell time. I don't have a watch, but I can tell you that since I began my triple therapy, I have never forgotten to take a single dose.

Today, my life depends completely on this medicine and I won't run the risk of forgetting to take it. My life is important - not just to me - but to my family, my friends and my whole country".

"The government of Malawi has been able to learn from the project we have here. Now there are ARV clinics nationwide, so this programme has helped a lot in terms of showing that it's possible and the steps one can take."

"MSF has been in Malawi for 10 years now, and you can see the big work MSF has done in treating our brothers and relatives in our district. Now we can see patients who have a good life. They're able to take care of their families, they're able to work again in their gardens. Now, even with HIV, life still goes on, and people can have normal life thanks to the treatment."

Fraser Chimbuzi, MSF counselling manager

MSF'S HIV AND ARVs HISTORY IN MALAWI

Malawi has one of the world's highest rates of HIV/AIDS, with 10.6 percent of people between 15 and 49 today affected by the virus[1]. HIV/AIDS is the main cause of death in what should be the country's most productive age group. The epidemic is the leading cause of death amongst adults, reducing life expectancy to just 43 years. The majority of HIV infection occurs amongst young people, and the rate of HIV prevalence is higher amongst women than men.

In 1997, MSF started its programme in the rural district of Chiradzulu, in the south of the country, which is home to more than 290,000 people (NSO, 2006), and where today 14.5 percent of the population between 15 and 49 is infected with the HIV virus (17.5 percent of women and 11 percent of men). At that time, as no ARV drugs were available in the country until 2001, MSF was focusing on the treatment of opportunistic illnesses and palliative care at the district hospital and on prevention of infections.

In 2001, MSF began providing antiretroviral (ARV) treatment and follow-up at the district hospital, giving priority to the sickest patients in danger to die. The first patients were placed on ARV drugs in August 2001.

The programme was designed to demonstrate that ARV drugs could be provided in low-resource rural contexts, where they would prolong life and allow people to regain their autonomy. The aim was also to show that those patients are able to follow a life long treatment. Although no one believed this could be achieved, MSF took up the challenge. Since MSF's ARV treatment programme began in 2001, more than 52,000 patients were followed by MSF teams. Today, more than 55% of the patients who started treatment in 2001 are still actively followed as well as alive and healthy

By September 2011, MSF is still following 30,000 HIV positive patients in the project. Not all patients are eligible for treatment, only those with a severe reduction of their immunity need to start treatment. Today 22000 patients are receiving ARV treatment in Chiradzulu, 12.5 percent of whom are children. Over the last three years, approximately 3,000 new patients were integrated in the project annually.

The Chiradzulu programme is one of MSF's largest HIV progammes, with an average of 175,000 medical visits and 50,000 counselling sessions held every year.

MSF was a pioneer in this field, and MSF's patient cohort is the most long-standing in the country. The project has already shown that when treatment is adapted to local conditions and supported by human and financial resources, rural health systems can effectively provide comprehensive HIV/AIDS care. The project has allowed many more people who were bedridden to get back on their feet and resume productive lives.

"MSF wanted to show that such a programme was possible in a poor, remote setting in Africa, to show that Africans too can take treatment correctly and also benefit from the treatment—so it really worked."

Fraser Chimbuzi, MSF counselling manager.

"Before ARVs, I was often sick and my CD4 count was low, but now I do not get sick often and my CD4 count has also increased. I'm able to manage my ARVs; I take them well and they are also efficient drugs. The major improvement is that I'm able to work, to cultivate my land. Currently, I'm able to cycle long distances without any problem. I have a lot of strength."

Augustin, MSF patient since 2001 and now MSF tracer.

"When MSF launched ARV programmes in Chiradzulu, things and people started to change. Those who had no hope could now have access to free ARV treatment, and we saw really sick people recovering, gaining strength, resuming their normal activities. It motivates other people to get tested, reckoning that even if you test positive you can lead a normal life."

Fraser Chimbuzi, MSF counselling manager.

"When I went to my second medical visit, I got on the scale, and it increased by 1kg. By that time, I could feel some power coming back to my body, little by little. Without MSF you would not even know me. I have managed to bring up all my children."

Esnart, MSF patient since 2001 and now MSF education officer.

"If there were no ARVs, I would have been dead by now. But because we now have ARVs, I'm thankful. And I know that if I continue taking them, I will have a good life until God decides to take my life."

Byson MAERE, MSF patient since 2001.

TEN YEARS OF MSF ACTIVITIES

Given the breadth of the health needs in Malawi, and given the country's shortage of health workers (there are just two doctors for the whole of Chiradzulu district), MSF has established new treatment approaches, in collaboration with the Ministry of Health.

1. Decentralisation : Bringing care closer to patients

In order to treat patients closer to their home, HIV treatment activities have been extended from the hospital to the10 health centres in Chiradzulu. Since December 2002, HIV clinics have been run at the health centres. This led to include a higher number of people living with HIV/aids in the MSF programme.

Beginning in early 2003, voluntary counselling and testing (VCT) was also introduced in health centres, allowing patients to begin ARV treatment without having to go to the hospital
In the hospital, which is now a referral center, MSF provides support to staff in the paediatric and TB units) to improve the quality of care there.

> *"Decentralisation had a big impact, because people all over the district could access the treatment quite easily."*
>
> **Fraser Chimbuzi, MSF counselling manager.**

2. Task shifting: more staff involved in care to treat more patients

Task shifting involves delegating certain medical responsibilities from clinical officers to nurses. In around 2004, MSF established training for nurses and medical assistants on patient management at health centres.

This increase in the number of new staff trained in HIV care has enabled more and more patients to access ARV treatment. Since 2009, nurses have been able to offer a full range of care, from screening, to initiation on treatment, to medical follow-up of patients receiving ARV drugs, in the district's 11 HIV clinics (10 in local health centres and one in the hospital).

> *"Since MSF started working here, I've seen a lot of changes. It used to be only MSF doctors who could manage HIV/AIDS patients; now national clinicians and nurses have the capacity to treat them too."*

Fraser Chimbuzi, MSF counselling manager.

> *"In order to address the increase in our patient cohort, we had to find additional medical staff. Nurses then began treating the less severe cases and initiated ARV treatment. This meant that, on a national scale, a large number of patients could be placed on ARVs."*

Jérôme Mouton, MSF head of mission.

3. Six Month Appointment programme: a simplified approach diminishing constraints for patients and staff

The Six Month Appointment (SMA) programme gives stable patients an interval of six months between appointments, thereby reducing clinic congestion and health workers becoming overloaded with consultations. SMA is a simplified approach which allows to diminish workload for clinical staff but also to diminish constraints for a patients following a life long treatment.

There are currently 3,500 patients in the SMA programme, which represents 7,000 fewer consultations per year out of a total of 175,000 consultations.

> *"SMA is a fantastic tool and a strategy that we would like to use to manage our cohort. Just as important, it is also a tool that empowers our HIV patients to be more self-managed. Currently in SMA we have 3,500 to 4,000 patients enrolled in the programme, but we would hope to see a definite increase in the coming months."*

Aisleen Glasby, MSF health centre nurse manager.

"We were dealing with patients, but now I can see we are dealing with clients. That is to say, the much more complicated cases have been stabilised."

Christopher Lington Blair, MSF clinician.

4. Counsellors: Helping patients to cope with their chronic disease

MSF counsellors work in all 10 health centres and at the hospital. They provide health education and adherence counselling, with a focus on HIV testing.

They provide to all HIV positive patients and their families information and education about their disease and their treatment and they support the patients to cope in their daily life with HIV. They explain how to take treatment correctly. They also support patients suffering from the stigma which still comes with HIV infection. The aim is to help the patient to live with HIV/aids and to encourage them to adhere to treatment as treatment interruptions are dangerous.

"I remember how the MSF counsellor would calm me down. The first day that I was counselled, I went home and thought, maybe I'll survive. The way he treated me brought me comfort. I could go on with positive living."

Esnart, MSF patient since 2001, now MSF education officer.

"In Chiradzulu, MSF is able to provide quality care for a huge cohort of patients; a cohort which is still growing every month. Thanks to decentralisation, we have been able to improve access to qualified care and medical technology. With simplified treatment and task shifting, we will deal with this increasing workload."

Fabrice Vast, MSF medical coordinator.

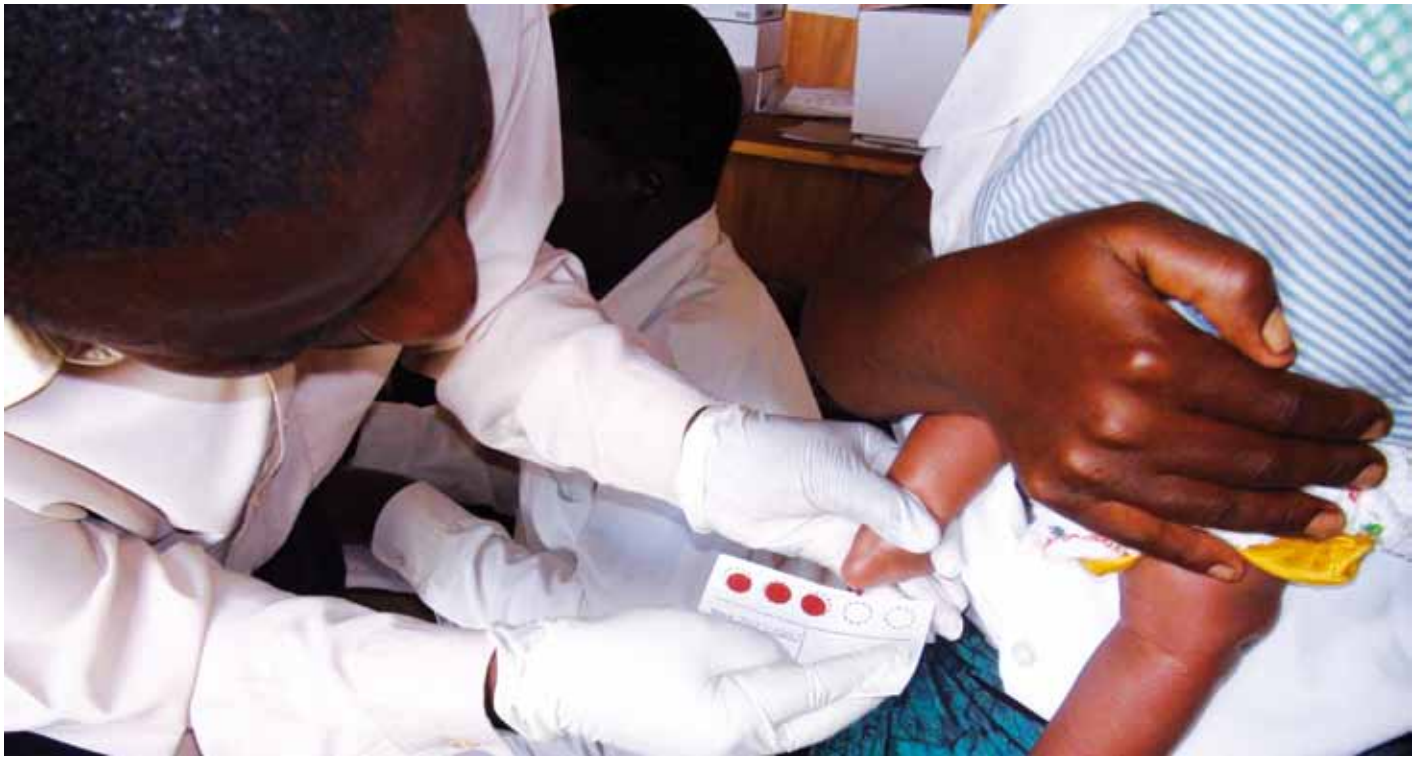
5. Tuberculosis: Focus on the most deadly disease

More than 80 percent of tuberculosis (TB) patients registered for treatment at the district hospital are HIV-positive As a result, one of our main objectives was to integrate TB activities into HIV care, creating a 'one-stop service' for patients.

MSF also pushed the national TB control programme to switch to the WHO-recommended treatment regime, which was later rolled out in all Malawi hospitals. In a high HIV burden context it is a medical priority to ensure timely and accurate TB diagnosis, especially for children and to ensure better management for people co-infected with HIV and TB.

> *"In the tuberculosis ward of the district hospital, more than 80 percent of the patients are co-infected with HIV-AIDS. The new WHO regimen will help; it will be more convenient for the management of TB patients. More patients will be enrolled. MSF has trained all practitioners. It is feasible."*
>
> **Dr Dominique N'guetta, MSF doctor.**

FOCUS ON THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION



A pregnant woman with HIV could transmit the virus of HIV / AIDS to her child in utero and during delivery. Yet it is possible to prevent this transmission so that the babies are born HIV negative. This is the objective of the PMTCT (preventing mother-to-child transmission) programme.

Before March 2008, the prevention of mother-to-child transmission (PMTCT) was implemented only at the hospital. In March 2008, however, MSF started to offer this programme within local health centres. There is now a 'one-stop service' for HIV and antenatal care, which are offered in one place by the same service provider throughout the woman's pregnancy.

Pregnant HIV-postive women and their babies benefit from treatment and specific ARV drugs, as well as from methods for preventing transmission, both in utero and during delivery. After delivery, the baby is followed at the HIV clinic from six weeks of age until his or her status is proven. If the status is negative, the baby is discharged from the programme at 24 months of age. Until this time, the baby receives prophylactic treatment.

The PMTCT programme offers tremendous hope for coming generations. While the rate of mother-to-child transmission approaches 40 percent without appropriate treatment, it falls to just 3 percent among those receiving treatment as part of a PMTCT programme.

As of late September 2011, 1,331 pregnant women were being followed in our PMTCT programme. Between January and September 2011, 745 deliveries occurred in connection with the programme, and 730 babies (representing 98 percent of those births) benefited from prophylactic ARV treatment.

In 2010, the WHO issued new recommendations for treating HIV/AIDS. They also addressed PMTCT programmes with the 'B+ option' : initiation of life-long ARV treatment for HIV-infected pregnant and

breastfeeding women with a new regimen, and treatment for infants of HIV-infected mothers up to the age of six weeks. MSF has implemented these changes in connection with its PMTCT activities.

"I think the new WHO regimen will help a lot of people. In the past we lost a lot of babies because mothers had to stop breastfeeding at six months and had nothing else to give to their child. Now, women will breastfeed their baby up till two years old. The issue of stigma will no longer be there because everyone will be breastfeeding. It's a real message of hope."

Demetria Mpando, PMTCT coordinator for the Ministry Of Health.

"With the new WHO protocols, the rate of transmission will decline further. The new generation could be saved!"

Christelle Scaparone, MSF nurse in charge of PMTCT activities.

"After my wife and I started taking ARVs, our first child died. We asked the MSF doctors about the PMTCT programme and my wife became pregnant. She gave birth to a baby boy. Today, he is alive. We were so happy that we went on to have another child, a baby girl. We have these two children, both HIV-negative. We are all healthy and happy."

Owen, MSF patient since 2011.

NEW CHALLENGES AHEAD

Today, international donors are withdrawing from HIV/AIDS activities. But Malawi is facing a specific issue: the Global Fund has not yet provided funds to the government. The country will only know in March 2012 if the next Round HIV/AIDS proposal will be accepted, and the funds given to the government.

At the same time, MSF has taken up a new challenge: to apply as much as possible the new WHO protocols, proposed in 2009, in Malawi's Chiradzulu district. The objective for MSF is to implement these recommendations for all concerned patients, in a context of donor crisis and limited visibility for the future.

The 2009 WHO protocols involves 3 main changes that MSF is planning to put in place at a large scale at district level to support the Ministry of Health:

Changing the first-line treatment to Tenofovir
This ARV drug has far fewer side effects than previous ARV drugs, and thus promotes better treatment adherence among patients.
Since October2010, MSF has implemented parts of the new guidelines, according to Malawi national policy: Tenofovir is now prescribed for certain groups of patients such as pregnant women, co-infected patients with HIV/ and Tuberculosis and patients suffering for severe side effects to the former regimen.
However, in a long-term perspective, MSF is very much supportive to introduce the Tenofovir based ARV therapy to all patients.

“Tenofovir is less toxic and causes far fewer side effects. Also, this drug requires only a single daily dose. This has tremendous advantages for the patient. We can imagine that adherence will significantly improve and that the patient will need fewer consultations, less hospitalisation and fewer additional tests. This is a significant relief for a public health programme of this magnitude.”

Fabrice Vast, MSF medical coordinator

The ’B+ option’ for pregnant women living with HIV/AIDS and new born

The ‘B+ option’ involves universal initiation of life-long ARV treatment for HIV-infected pregnant and breastfeeding women with the new regimen FDC TDF/3TC/EFV, and Nevirapine prophylaxis for infants of HIV-infected mothers up to the age of six weeks.

MSF will monitor the introduction of this ‘B+ option’, as no one has experienced it yet.

Initiating HIV/AIDS patients earlier

The new recommendations are to treat patients with ARV at an earlier stage of the disease, meaning with a CD4 rate of 350 rather than 250 CD4, with an immune system less degraded. Patients will receive treatment in a less advanced stage of the disease, will have less medical complications, and therefore early mortality will be reduced. This will also increase the number of patients in the project (nearly +20% of patients). The challenge for MSF will be to simplify further models of follow up and care in order to provide quality care to this growing cohort of patients.

MSF has also decided to develop a programme to circumcise adult men. According to recent studies, this can reduce the risk of HIV/AIDS infection for men by approximately 60 percent.

“The main problem is funding. Malawi has chosen to put in place some of the new WHO protocols. These partial recommendations should be implemented till the end of 2012. Malawi has found funding for this within the budget limits that existed already. Everything will depend on the current negotiations with the Global Fund. If this one refuses the funding, it will be a big problem for HIV patients in Malawi. MSF, for its part, is committed to ensuring continuity of treatment for its Chiradzulu patients, but it could be a huge financial cost for us.

MSF has a buffer stock of essential drugs, which allows us to avoid treatment failures. A patient who stops taking his or her ARVs is at risk of opportunistic infections, but also of developing drug-resistance, which would require a second-line treatment, heavier, more expensive and with more side effects.”

Fabrice Vast, MSF medical coordinator.

"We're at a very interesting time in the project at the moment. We're celebrating ten years of dispensing ARVs in Malawi. And we're also in the middle of phasing in the first phase of the new WHO guidelines. This is a very interesting time: for Malawi, for the management of HIV in the country, and for Africa. With the implementation of the new WHO guidelines, we are going to see a tremendous increase in patients. A lot more people will be eligible for ARVs, which is a wonderful thing. Hopefully in ten to 15 or 20 years time we will see a decrease in the prevalence of HIV in Malawi."

Aisleen Glasby, MSF health centre nurse manager.

"In 2012, Malawi will have to submit a new funding request to the Global Fund. Even if, overall, international funders are pulling back, implementing new treatment protocols requires financial resources. The fate of all Malawi patients depends on it"

Jérôme Mouton, MSF head of mission.

"Chiradzulu was the first district to benefit from the ARVs, but now we see patients coming forward from other districts to access the care. That is a big success!"

Fraser Chimbuzi, MSF counselling manager

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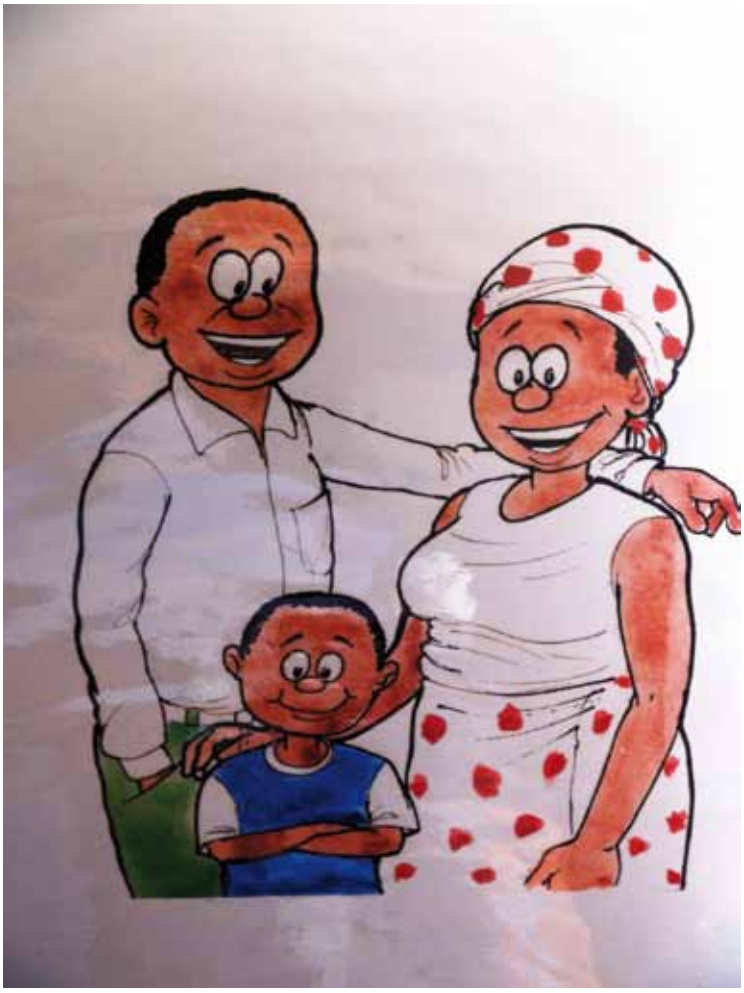

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