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A Prescription for Injustice: Part 2

On the Frontlines of the Epidemic: Interview with Father Gérard Tonque Lagleder

by Kate Baggott



There is no cure for AIDS. Antiretroviaral (ARV) treatment, though, can prolong lives in the hopes that people with AIDS will survive until a cure is found, or failing that, at least until their children grow up. This survival that is the result of ongoing treatment is being realized in North America and Western Europe. In SubSahran Africa, however, ARV treatment has been out of reach of most people with AIDS.

Five years ago, the situation was becoming desperate. In a 2001 editorial, *America* magazine said, "the five major international pharmaceutical companies offered to sell the triple-combination therapies to governments in developing nations at reduced prices. Negotiations with individual governments, however, have been slow and the results disappointing. In Senegal, for instance, the yearly per-patient cost for the medications is $1,000, still far too high for most Senegalese."

Public pressure on the drug companies to find ARVs for Africa increased and included intervention by the Vatican *(to be covered in part 4 "Who's Helping")*. In April of 2001 a coalition of 39 pharmaceutical companies dropped its opposition to generic versions of their drugs for sub Saharan Africa. The move cleared the way for the 3 by 5 Campaign.

3 by 5

The campaign was determined to provide generic versions of ARV to 3 million people by 2005. Even without patent concerns, the cost the undertaking was estimated at $3.8 billion by the World Health Organization.

Success was not assured when the pharmaceutical industry reversed its stance. While work continues to distribute ARV therapy though out Africa, the campaign failed to meet its ambitious target by the end of 2005.

The following interview, conducted by email, highlights the difficulties of getting treatment to patients in the middle of the AIDS pandemic. The issues are far more complicated than ensuring AIDS patients have access to ARV therapy. Father Gérard Tonque Lagleder O.S.B., 51, is the founder and director of Blessed Gérard's Hospice and Care Center in the province of KwaZulu-Natal, South Africa.

South Africa has one of the highest rates of HIV in the world and within the country, most new cases are found in KwaZulu-Natal. In this Zulu Kingdom, better known for its many tourist attractions, more than 1 in 4 residents is HIV positive.

Father Gérard, originally from Germany, has worked in Africa for almost 20 years and with AIDS patients for 14. In his view, from the frontlines of the epidemic, drug companies don't register as part of the problem.

BustedHalo: In the developed world, people who are HIV+ live with that diagnosis for an average of 15 years before they develop AIDS. How long do you believe your patients have between an HIV diagnosis and the development of AIDS?

Father Gérard Tonque Lagleder: I think that the main problem is denial. Even if patients start thinking that there is something major wrong with them, they avoid going for an HIV test, because a possible positive result is seen as a death sentence, and it is better—they think—not to know and pretend everything is fine. In other words: Most of the HIV patients come to us, when they are already in full blown AIDS, when they can hardly walk any more and suffer from a long litany of opportunistic diseases. We rarely see an HIV patient before the AIDS phase.

BH: What proportion of your patients, if any, would you estimate have received antiretroviral treatment?

FGTL: We are providing antiretroviral treatment ourselves. One of the conditions for our Highly Active Anti Retroviral Treatment (HAART) Program is that the patients be ARV naïve. When patients from other ARV programs come to us for palliative care they are mostly patients with treatment failure. In almost every case this is because of adherence failure *(where patients fail to follow the prescription protocol precisely—ED)*. As our own antiretroviral roll-out started before the government roll-out there were no patients on antiretroviral treatment before.

BH: South Africa is often said to have the best AIDS treatment strategy in Africa. What does this mean to you in the day-to-day operations of the hospice?

"It is very easy to sit in an American or European office and design a blueprint for service delivery in Africa, but it is extremely difficult to put it into action."

FGTL: There is a BIG difference between strategies and the status quo of the actual care delivery. We have voluminous documents with wonderful declarations of intent, plans of action and monitoring and evaluation procedures, but South Africa is faced with enormous problems to put them all into action. There is a critical shortage of doctors and nurses in our country. Many join what we call the "brain drain" and leave the country for greener pastures overseas. The remaining health professionals are absolutely overwhelmed with work, earn considerably less than their colleagues overseas, and many become de-motivated. Some of them acquire a negative, uncaring attitude. There have been numerous media reports about the deplorable state of affairs in the public health sector, but it is not good enough just to criticize. We must become part of the solution.

BH: The World Health Organization failed to meet targets of the 3 by 5 Campaign. In your opinion, why did the campaign fail?

FGTL: It is very easy to sit in an American or European office and design a blueprint for service delivery in Africa, but it is extremely difficult to put it into action. When we were first asked to get involved in the antiretroviral treatment in September 2003 we were totally unaware of the absolutely enormous commitment such a program would require.

The first question we were asked was, how many we could possibly put onto treatment in year one, two and three. My guess was very inadequate at this time. The success of antiretroviral treatment does not just depend on the supply of the drugs, but it starts with a proper and ongoing specialist training of the medical professionals involved, a good and thorough drug readiness and adherence training for the patient and his or her treatment supporter (a "treatment buddy" whose role is to constantly remind the patient not to forget to take his/her medication), which is really not easy in cases when you try to teach illiterate people, for example, about adverse drug reactions of non-nucleoside reverse transcriptase inhibitors.

The success of the treatment further depends on a thorough adherence monitoring after treatment has commenced. The buddies are often not reliable. So you need a proper system of therapeutic counselors who make frequent home visits. Setting up such a system is very involved and quite a mission. It has to be constantly monitored and evaluated and all that cannot be implemented just by prescribing unrealistic targets to Africa.

BH: What actions do you think those of us in the developed world should take to bring the political will and focus back to the AIDS epidemic?

FGTL: When Tsunami struck the world in 2004 the Secretary General of the United Nations had to appeal that governments would not just redirect monies, which had been earmarked for other relief operations—like the AIDS pandemic in Sub-Saharan Africa - for Tsunami relief, as good and necessary as it was to help there too.

Nevertheless it happened and Africa became a Tsunami victim too. Lots of international aid was redirected and left Africa with dwindling financial support, but flooded by the AIDS wave.

Pages: 1 2