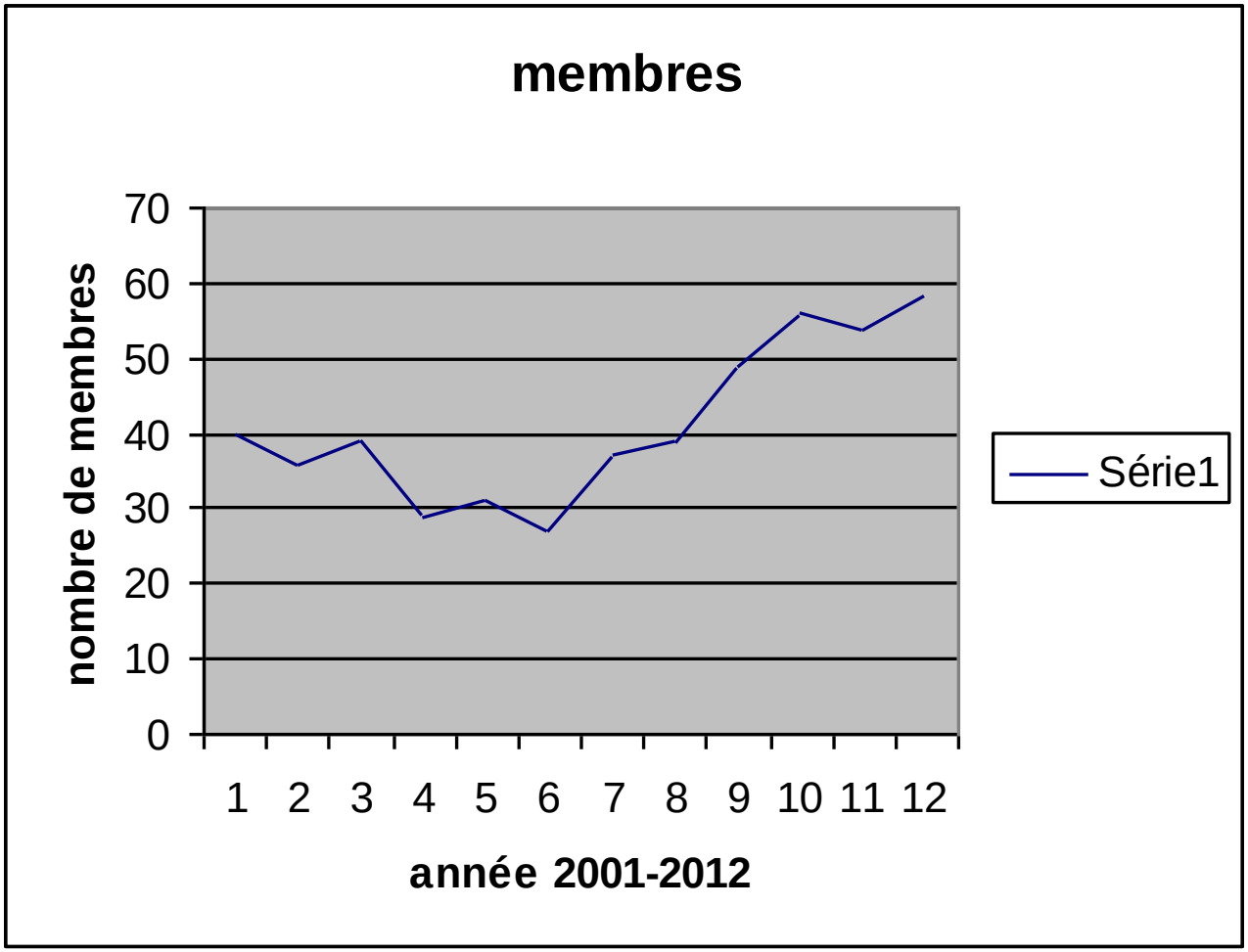
Entraide Santé 92

Assemblée générale 18 avril 2013

Rapport d'activité 2012

- Hôpital Ambroise Paré (APHP), Boulogne,
- Hôpital Raymond Poincaré (APHP), Garches
- Hôpital Louis Mourier (APHP), Colombes,
- Hôpital Max Fourestier, Nanterre,
- Centre Medico Chirurgical Foch, Suresnes,
- Hôpital Nord 92, Villeneuve La Garenne,
- Hôpital André Mignot, Le Chesnay,
- Hôpital François Quesnay, Mantes la jolie,
- Centre hospitalier Poissy- St Germain,
- Centre hospitalier Meulan Les Mureaux,
- Centre hospitalier Victor Dupuy, Argenteuil.
- IFSI de Levallois Perret

L’association



Réunions

- 5 Réunions février, avril, mai, septembre et novembre 15 à 25 membres.
  - CRH diffusés à tous les membres
- Echanges mails
- site : www.entraidesante92

Actions

- Togo
- Niger
- Tchad

Le Togo en 2012

Partenariat depuis 2009

Jan : C Dupont : comité de liaison

Mars : mission 3 pers/ appui labo

Sept : C Dupont ; Aes, hépatite B, trav du sexe

Mars : Colloque AES à Lomé

Echange régulier par mail : Mme Sawouli Bello, Labo

(partenariat maternités Louis Mourier et Atakpamé)

Divergence de perception d'Esther sur la place d'Entraide et inversement au Togo


C.H.R-AT
CENTRE HOSPITALIER REGIONAL DATAKPAME

Le Niger en 2012

Partenariat depuis 2005 + Gères depuis 2007)

Fev (3 j): E Rouveix + gérès

Juil : reprise de mission (DBS, PTME, ETP, résistance)

Mars : Colloque AES à Lomé

Recherche

- cohorte des couples femmes enceintes VIH/enfant suivis à la maternité GAZOBY
- Résistances sur DBS

Echanges par mails et réalisation d'un staff en ligne

Financement de l'inscription en DU d'un médecin nigérien

Poster : 605

Assessment of treatment efficacy with virological and pharmacological evaluations on capillary DBS in HIV+ patients enrolled in a West African Cohort

Mamane Daou [1,2], Minh Lê [3], Boubacar Madougou [1,2], Constance Delaugerre [4], Theodora Maillard [4], Gilles Peytavin [3], Eric Adehossi [1,2], Mamadou Saidou [5], Elisabeth Rouveix [2,6,7], Pierre de Truchis [2,6,7]*

1- Hopital National, Niamey, Niger; 2- GIP-ESTHER, Paris, France; 3- EA4409 Paris 7 University and Clinical Pharmacology Dpt, APHP-CHU X Bichat, Paris, France; 4- Laboratoire de Virologie-INSERM U941, Hôpital Saint Louis-APHP, Paris, France; 5- Laboratoire National de Virologie, Niamey, Niger; 6- Hôpitaux Universitaires Paris IDFOuest, APHP, France; 7- Entraide Sante 92, France

Dr Pierre de Truchis
p.de-truchis@rpc.aphp.fr

ABSTRACT

Objectives: To determine the rate of virological failure in HIV+ patients under 1st or 2nd line antiretroviral (ARV) according to WHO guidelines and to evaluate the feasibility and efficiency of DBS viral load (VL) and genotypic resistance assessment, coupled with DBS ARV concentration determination.

Methods: HIV+ patients treated for more than 1 year with 1st line ARV (2 NRTI + 1 NNRTI) or 2nd line ARV (ABC+ddI+LPV/r) were enrolled prospectively in an open cohort in Niamey, Niger. DBS capillary samples were done as 5 spots of 50µL. VL was performed using NASBA NucliSENS EasyQ® HIV-1 V2.0 (bioMérieux lower limit of quantification (LOQ)=800 c/ml). Resistance genotype was assessed on all detectable VL after RNA extraction using NucliSENS EasyMAG® and ANRS consensus methods. Blood ARV concentrations were determined using liquid chromatography coupled with tandem mass spectrometry. ARV blood concentrations determined 12h after the last drug intake (Cmin) were interpreted using usual plasma cut-offs after extrapolation of blood to plasma results according to gender, hematocrit and protein binding in African population. Median (IQR) results are presented.

Results: 245 patients were enrolled, 60% men, 41 (35-47) years old, 5 (3-7) years of HIV infection duration, 135 (60-247) CD4/µL at ARV initiation. After 4 (2-6) years of ARV treatment, CD4 gain was 188 (87-366)/µL and 83% of patients had VL≤800 c/ml corresponding to 87% and 86% of adequate ARV concentrations in 1st and 2nd lines, respectively. NVP and EFV Cmin were highly related with viral success in 1st line (p<0.001). RT mutations were identified in 1st line ARV failures, RT and Protease mutations in 2nd line ARV failures and 8 and 18 patients had HIV harboring etravirine and rilpivirine possible resistance mutations, respectively (according to the French ANRS algorithm 2012, v22).

Line	1st	2nd
Patients (n)	218	27
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
Genotypic amplification succeeded n (%)	[illegible]	[illegible]
NRTI Resistance n (%)	[illegible]	[illegible]
NNRTI Resistance n (%)	[illegible]	[illegible]
PI Resistance n (%)	[illegible]	[illegible]
Any Resistance n (%)	[illegible]	[illegible]
Plasma Cmin (ng/mL)		
NVP	[illegible]	
EFV	[illegible]	
LPV	[illegible]	[illegible]
All ARV merged < LOQ n (%)	[illegible]	[illegible]

Conclusion: This first cross-sectional analysis conducted in Niger shows a good immunovirological response based on DBS VL<800 c/ml after 4 years of 1st line ARV. Most of patients were adherent based on DBS ARV Cmin and the majority of failures were explained by DBS genotypic assessment. Using DBS may improve the early assessment of ARV failure in HIV-infected patients coming from low income countries.

BACKGROUND

- Niger is a sahelian country (West Africa, 16 Millions inhabitants) with an estimated HIV prevalence of 0.7-1.1%Niger is a sahelian country (West Africa, 16 Millions inhabitants) with an estimated HIV prevalence of 0.7-1.1%
- Antiretroviral (ARV) coverage is usually low over the country (20%), except in urban areas. In Niamey, ARV have been available since 2006. The recommended ARV (generic or brand) combinations are:
  - 1st line therapy: d4T+ 3TC+ NVP (Triomune®), ZDV+ 3TC+ EFV, TDF available for patients with HBV coinfection, PI/r (as in 2nd line therapy) for patients with HIV-2 coinfection
  - 2nd line therapy: ABC+ ddI+ LPV/r (Aluvia®)
- National guidelines recommend sampling for viral load (VL) determination at ARV initiation, after 6 and 12 months of treatment, and every 12 months thereafter
- VL samples are stored and analyzed in the Virology National Reference Laboratory in Niamey (results are often differed due to technical issues or reagents supply disruptions)
- Failure of ARV therapy is usually defined as clinical or immunological failure (WHO criteria)
- Genotypic testing and therapeutic drugs monitoring (TDM) are not available in Niger
- Dried Blood Spots (DBS) have been available in Niamey since 2011, for qualitative HIV DNA determination for newborns from HIV infected mothers

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OBJECTIVES

- To determine for the 1st time the rate of virological failure in HIV-infected patients under 1st and 2nd ARV line with DBS sampling
- To evaluate the feasibility and efficiency of DBS on:
  - VL
  - Drug-resistance
  - ARV concentration
- To analyze therapeutic failures

PATIENTS SELECTION

- Study: prospective and cross-sectional, in 2 clinical centers:
  - CTA Centre de Traitement Ambulatoire
  - Hôpital National de Niamey
- Patients: Inclusion criteria
  - Confirmed HIV-1 infection
  - Age > 18 years
  - Informed consent
- ARV Treatments:
  - 1st line for more than 1 year: 2 NRTI + 1 NNRTI or PI/r
  - 2nd line: ABC+ddI+LPV/r, enrolled in an open cohort in Niamey
- DBS collection and storage:
  - Capillary blood samples obtained by finger stick
  - 5 spots of 50 µL of whole blood per patient collected on Cards 3M®
  - Ambient air 4 hours drying
  - Storage in sealed bags with desiccant at 4° - 8° C

METHODS

Virological analysis

- Viral load (VL) was performed using NASBA NucliSENS EasyQ® HIV-1 V2.0 (kindly provided by BioMérieux Lyon, France)
  - Two spots were cut and eluted in NucliSENS Lysis Buffer 2 ml, and incubated on a roller mixer for 2 hours at room temperature. The total lysate volume of 2 mL was extracted using the NucliSENS EasyMAG® according to the manufacturer's instruction (BioMérieux)
  - Viral load quantification was performed with the NucliSENS EasyQ® HIV-1 V2.0 assay according to the manufacturer's instructions. The linear dynamic range of this assay ranges from 25 (1.4 log10) to 3,000,000 (6.4 log10) HIV1 RNA copies/ml when 1 ml of plasma is used. **The limit of quantification is 800 copies/ml when 2 spots of 50µl of whole blood are used**[1]. Qualitative Results were provided below 800 copies/ml with a limit of detection of 100 copies/ml (negative <100 copies/ml and positive between 100 and 800 copies/ml).
- Drug-Resistance genotype was assessed on all detectable VL above 100 copies/ml
  - The viral RNA extract with the NucliSENS EasyMAG® was used to be amplified with reverse transcriptase and protease primers and then sequenced according to the ANRS consensus methods (http://www.hivfrenchresistance.org/)
  - Alignement to the HXB2 HIV-1 reference strain and interpretation of mutations according to the French ANRS algorithm 2012, v22.

Pharmacological analysis

- Blood ARV concentrations were determined using liquid chromatography coupled with tandem mass spectrometry (Waters Acquity UPLC® and Acquity TQD®)[2]
- ARV blood concentrations determined 12h after the last drug intake (Cmin) were interpreted using usual plasma cut-offs after extrapolation of blood to plasma results according to gender, hematocrit and protein binding in African population
- Calculation of DBS plasma concentration[3] :

$$(DBS_{[analyte]}/[1\text{-Hematocrit}]) \times f_{bpp} = Plasma_{[analyte]}$$

  - $DBS_{[analyte]}$ = blood ARV concentration
  - Hematocrit = according to gender (41% for African women and 47% for men)
  - f_{bpp} = fraction of bound plasma protein (NVP 60%, EFV 100%, LPV 99% and RTV 99%)
- ARV plasma results are presented as median (IQR25%-75%)

Baseline characteristics: median (IQR25-75%)

	1rst Line	2nd Line
Patients, n	218	27
Female, n (%)	133 (61%)	13 (48%)
Age (years)	41 (34-46)	46 (39-55)
C CDC status, n (%)	87 (40%)	12 (44%)
HBV co-infection, n (%)	27 (12%)	3 (11%)
HIV infection duration (years)	4 (2-6)	7 (6-13)
CD4 nadir/mm³	138 (56-235)	87 (40-155)
ARV treatment, n (%)		
ZDV or d4T	183 (84%)	3 (11%)
3TC	197 (90%)	4 (15%)
TDF	26 (12%)	4 (15%)
ddI /ABC	0/3 (1%)	17 (63%)/16 (59%)
NVP	160 (73%)	1 (4%)
EFV	43 (20%)	1 (4%)
LPV/r	9 (4%)	21 (78%)

Immuno-virological outcome: median (IQR25-75%)

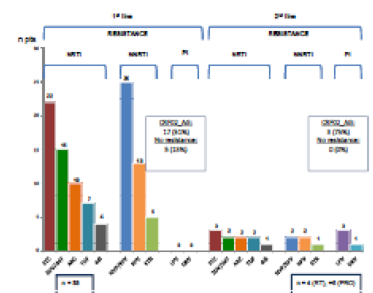
	1rst Line	2nd Line
Patients, n	218	27
Duration of ARV treatment (months)	43 (23-67)	44 (22-53)
Immunological response		
CD4 /mm³	393 (240-514)	367 (259-576)
CD4 gain /mm³	+197 (98-372)	+248 (60-362)
Virological efficacy*		
VL ≤ 800 copies/ml, n (%)	177 (81%)	23 (85%)
VL ≤ 100 copies/ml, n (%)	151 (69%)	20 (74%)
Virological failure		
VL > 800 copies/mL, n (%)	41 (19%)	4 (15%)
VL > 100 copies/mL, n (%)	67 (31%)	7 (26%)
VL at failure (copies/mL)	6,700 (1,900-45,000)	15,500 (3,425-72,750)

* Limits of Quantification (800 copies/mL) and Detection (100 copies/mL)

Drug-resistance at virological failure

		1rst Line	2nd Line
Patients, n		218	27
VL > 800 copies/mL, n (%)		**41 (19%)**	**4 (15%)**
amplification succeeded > 800 copies/mL, n (%)		29 (71%)	4 (100%)
VL > 100 copies/mL, n (%)		**67 (31%)**	**7 (26%)**
amplification succeeded > 100 copies/mL, n (%)		33 (50%)	5 (71%)
NRTI resistance n (%)		**24 (73%)**	**3 (75%)**
	ZDV/d4T	15	2
	3TC	22	3
	ddI/ABC/TDF	4/10/7	1/2/2
NNRTI resistance n (%)		**27 (82%)**	**2 (50%)**
	NVP/EFV	25	2
	RPV/ETR	13 / 5	2 / 1
PI resistance n (%)		**0 (0%)**	**3 (75%)**
	LPV/DRV	0	3 / 1
No resistance n (%)		**5 (15%)**	**0 (%)**
CRF02_AG n (%)		17 (51%)	3 (75%)

Drug-resistance at virological failure



Amplification succeeded at failure:
in 71% for VL > 800 copies/mL in 100% for VL > 800 copies/mL
in 50% for VL > 100 copies/mL in 71% for VL > 100 copies/mL

Pharmacological assessments: Cmin (ng/mL)

→ Adequate and effective plasma Cmin of LPV, EFV and NVP were found, with most of Cmin IQR25% > respective cut-off for NVP (3,000 ng/mL), EFV (1,000 ng/mL) and LPV (3,000 ng/mL) plasma Cmin
→ NVP and EFV Cmin were highly related with viral success in 1st line (p<0.001)
→ All ARV merged, only 4% of Cmin were < LOQ suggesting overall good treatment adherence

DISCUSSION

- When ARV scale up began in Africa a decade ago, there was concern that the lack of laboratory monitoring for patients receiving ARV drugs would be an obstacle to providing treatment
- In resource-limited settings, the diagnosis of therapeutic failure, based on clinical symptoms and CD4 evolution is usually differed, leading to accumulation of resistance mutations
- Our study conducted in Niamey (Niger) under practical field conditions, from capillary whole blood collection, without any special conditions for sample storage and international shipment, confirms the relevance of DBS for diagnosis and interpretation of :
  - High virological success rate under ARV therapy (>80%, cut-off = 800 copies/mL) in 245 patients followed during a median 44 months supported by a good treatment adherence
  - Virological failure assessed by Resistance and Therapeutic Drug Monitoring evaluations
- Using genotypic testing on DBS in 1st line therapy, virological failure was associated with Reverse Transcriptase resistance (to NRTI and NNRTI) in more than 80% of our patients
- Using TDM on DBS with corrected NVP and EFV Cmin, we demonstrated the PK-PD relationship with viral success in 1st line therapy (p<0.001)
- Some limitations of DBS evaluation might be underlined from our study:
  - The low sensitivity threshold of VL measurement, with a LOQ < 800 copies/mL for the diagnosis of virological failure, and uncertainty for VL between 100 and 800 copies/mL
  - The lack of sensitivity for genotypic testing of moderate virological failure, with low performance of amplification for VL < 800 copies/ml on DBS (amplification rate of 50%), regarding the low volume (50 µL versus 1 mL of plasma for classical resistance evaluation) and matrix effect
  - The high technical expertise requirement for ARV determination in DBS, needing complex extraction procedures and liquid chromatography coupled with mass spectrometry knowledge, difficult to realize in local laboratories
- This study was performed with a South/North collaboration, and allowed us to improve the therapeutic patient's monitoring in countries where local technical resources are insufficient, by overcoming the technical barriers encountered (lack of reactive for VL assessment, difficulties of plasma storage, cold chain interruption, need for genotypic resistance interpretation experience,…)

CONCLUSION

- This first cross-sectional analysis conducted in Niger shows a good immuno-virological response based on DBS VL < 800 copies/mL after 4 years of 1st line ARV (81% virological success)
- Most of patients were adherent to treatment based on DBS ARV pharmacological evaluation
- The majority of failures were explained by DBS resistance testing, with 85% of resistance to the current drug combination
- DBS is a useful tool improving the assessment of ARV failure in HIV-infected patients coming from resource-limited settings, and allows virological, genotypic, and pharmacological evaluations

References

1. Van Deursen P, Oosterlaken T, Andre P, Verhoeven A, Bertens L, et al. (2010) Measuring human immunodeficiency virus type 1 RNA loads in dried blood spot specimens using NucliSENS EasyQ HIV-1 v2.0. J Clin Virol 47: 120–125
2. Jung BH, et al. Simultaneous determination of 17 antiretroviral drugs in human plasma for quantitative analysis with liquid chromatography-tandem mass spectrometry. Biomed Chromatogr 2007; 21:1095-1104.
3. Kromdijk W, et al. Use of dried blood spots for the determination of plasma concentration of nevirapine and efavirenz. J Antimicrob Chemother 2012. 67(5):1211-16

Le Tchad en 2012

Partenariat depuis 2005 à Moundou + 2008 à Bebalem

Fév : radiologie(ESF)/charte soignant soigné

Juin : comité de liaison

Sept : accueil directeur de Moundou

Aide directe aux Malades (3 associations de PVVIH)

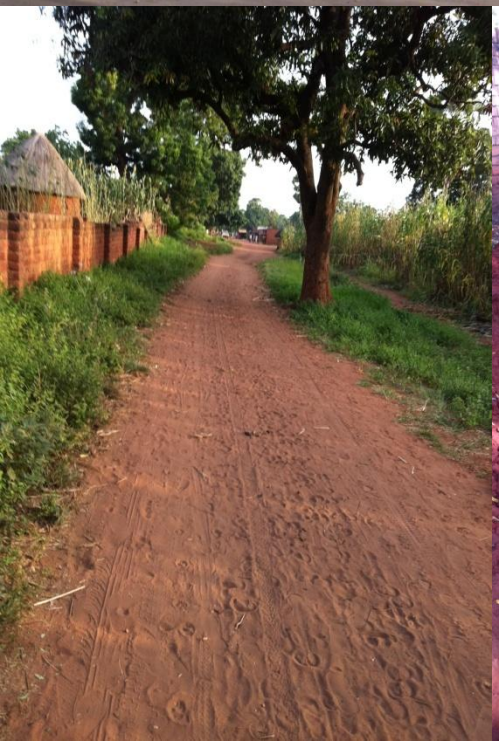
Infirmier soutenu pour 6 mois

Contact régulier mail (coordination, PNLT)

Projet Fondation de France accepté


HOPITAL DE JOUR


DEPARTEMENT
AEPVV
ASSOCIATION ESPOIR DES PERSONNES VIVANT AVEC LE VIH/SIDA BENOYE



Conventions en 2012

Conventions en cours en 2012

Niger

Convention avec le GIP Esther n°2010 01 55 signée le 8 aout 2010 prolongée jusqu'au 31 décembre 2012

Togo

Convention avec le GIP Esther n°2012 01 68 signée le 26 avril 2012 valable pendant 12 mois (avril 2013)

Tchad

Convention avec le Gip Esther n° 2012 0425 signée le 17 décembre 2012 valable jusqu'à 1er octobre 2013

Convention avec la Fondation de France du 28 novembre 2012 pour 2 ans (projet)

Recherche/présentations/publications

Communications orales et posters *2èmes journées scientifiques sur le VIH/SIDA au Togo*, Lomé, mars 2012

Orientations actuelles du dépistage et de la prévention de l'infection VIH C Dupont, .

Actualités sur la coinfection VIH tuberculose E. Rouveix.

6e Conférence Francophone VIH/SIDA - AFRAVIH 2012 Genève, mars 2012

Evaluation de matériels de sécurité pour prélèvement veineux sous vide (PV-SV) à l'Hôpital National de Niamey(NHH), Niger. G. Goutoundji I. Lolom, B. Madougou, C. Ciotti, S. Oumarou, H. Diaouga, C. Sadorge, E. Rouveix, E. Bouvet

6e Conférence Francophone VIH/SIDA - AFRAVIH 2012Genève, mars 2012

Quelle stratégie vaccinale peut-on proposer pour les professionnels de santé vis-à-vis de l'hépatite B dans des pays à forte prévalence : résultat d'une action menée à l'Hôpital National de Niamey (HNN) Niger.
W. Tosini, B. Madougou, I. Lolom, E. Adehossi, I. Kaza, R. Nabias, M. Saidou, E. Rouveix, E. Bouvet

Publications

Étude de la résistance de *Mycobacterium tuberculosis* chez les patients bacillifères au Tchad**.** Abdelhadi, J Ndokaïn, M. Moussa Ali, V. Friocourt, E. Mortier, B. Heym**.** Bulletin de la Société de pathologie exotique, 2012 ; 105(1) : 16-22

Is universal HBV vaccination of healthcare workers a relevant strategy in developing endemic countries? The case of a university hospital in Niger. Pellissier G, Yazdanpanah Y, Adehossi E, Tosini W, Madougou B, Ibrahima K, Lolom I, Legac S, Rouveix E, Champenois K, Rabaud C, Bouvet E. PLoS One. 2012;7(9)..

Approbation du rapport moral

Rapport financier
Entraide Santé 92
2012

Assemblée générale du 18 avril 2013

Rapport financier 2012

L'exercice a duré 12 mois, du 1er janvier au 31 décembre 2012

Les comptes ont été établis conformément aux règles et modalités d'établissement des comptes annuels des associations.

Compte de résultat **PRODUITS**

- Le total des produits imputés à l'année 2012 s'élève à 52 876,19 €uros (contre 72 803,53€ en 2011), dont :

➔ produits d'exploitation : 25 035,64Euros répartis de la façon suivante :

- *Subventions : 18 640,64 €uros*

  NIGER : 5714,10 €uros et *TOGO : 2041,46 €uros et 10 885,08 €uros*
- *Adhésions : 580,00 €uros*
- *Dons : 5815,00 €uros (adhérents)*

➔ produits financiers : 337,04€uros (intérêts des placements) ↓

➔ reprise des fonds dédiés 2012 : 27 503,51€

Compte de résultat **CHARGES**

- Le total des charges imputables à l'année 2012 s'élève à 51 605,85 €uros (contre 62606,69 € en 2011), réparties comme suit :

➔ charges d'exploitation : 37 513,90 €uros

➔ charges exceptionnelles : 4795,55 €uros (dons aux associations)

➔ engagements à réaliser (fonds dédiés) : 9296,40 €uros

➔ Compte-tenu des éléments ci-dessus, le résultat de l'exercice 2012 fait apparaître un excédent de 1270,34 Euros.

Quelques précisions

- **Utilisation des fonds propres de l'association :**

  Indemnités associations Bebalem : **2250,00**
  Indemnités Luc : 75,00
  Labo Biomérieux : 61,61
  Indemnités Luc : 150,00
  Labo Biorad pour labo Togo 106;50
  Labo Biorad pour labo Togo : 466,44
  DU épidémio H Moumouni : 186,00
  DU épidémio H Moumouni : 1500,00

on

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
GSK	3048.48					5000	1500				
Borhinger			1000		1000						
BMS	4573.47	4573.47	5000	5000							
Roche		5000									
Gilead	1000		400	450		2500	450				
Chiron	4573.47										
MSD	4573.47										
Abbott	4573.47		1000				4000	3000	3000		
Jansen cilag						1500				3000	

Récap Tchad

TABLEAU DES RESULTATS 2012

	DEPENSES	RECETTES	FDS DEDIES	TOTAL
TCHAD 2009 0308	13 827,78		13 827,78	-
NIGER 2010 0155	18 132,15	5 714,10	12 418,05	-
TOGO 2010 0299	3 299,14	2 041,46	1 257,68	-
TOGO 2012 0168	1 588,68	10 885,08	- 9 296,40	-
ASSO	5 461,70	6 732,04		1 270,34
	42 309,45	25 372,68	18 207,11	1 270,34

TCHAD 2007 0079

FONDS DEDIES AU 31/12/2012

	DEPENSES	RECETTES			
2006			-		
2007	17 363,98	44 362,57	*26 998,59*		
2007	2 052,99		*- 2 052,99*		
	19 416,97	44 362,57	*24 945,60*	FONDS DEDIES (missions 2008)	
2007	1 500,00			*Réaffectation dép 2007 GP/TCHAD*	
2008	44 039,19	29 575,05			
2008	2 763,75	33 308,16			
	67 719,91	107 245,78	*39 525,87*	FONDS DEDIES (missions 2009)	
2009	36 551,82	22 205,44			
diff RF et cpta	28,65				
	104 300,38	129 451,22	*25 150,84*	FONDS DEDIES (missions 2010)	
2010	2 120,46				
	106 420,84	129 451,22	***23 030,38***	FONDS DEDIES	23 030,38

TCHAD 2009 0308 81 113

	DEPENSES	RECETTES			
2010	41 857,71	52 692,52			
	41 857,71	52 692,52	*10 834,81*	FONDS DEDIES (missions 2011)	
2011	27 167,78	38 586,52			
	69 025,49	91 279,04	*22 253,55*	FONDS DEDIES (missions 2012)	
2012	13 139,42				
rec non reportée à reprendre en GP dép non effect	688,36				
	82 853,27	91 279,04	***8 425,77***	FONDS DEDIES (missions 2013)	8 425,77

Récap Togo + Niger

	82 853,27	91 279,04	8 425,77	FONDS DEDIES (missions 2013)	8 425,77

NIGER 2009 0089

	DEPENSES	RECETTES			
2009	10 721,74	13 462,51			
	10 721,74	13 462,51	*2 740,77*	FONDS DEDIES (missions 2010)	
2010	2 090,93				
	12 812,67	13 462,51	*649,84*		
Report FD		- 649,84		*report de ce reliquat (avenant 1 : 2011 0170)*	
	12 812,67	12 812,67	-		-

NIGER 2010 0155 + avenant 3 : 2012 0203

	DEPENSES	RECETTES			
2010	12 061,04	30 516,15			
	12 061,04	30 516,15	*18 455,11*	FONDS DEDIES	
2012	18 132,15	5 714,10			
Report FD		649,84			
	30 193,19	36 880,09	*6 686,90*	FONDS DEDIES (missions 2013)	6 686,90

TOGO 2009 0249 + avenant 2010 0058

	DEPENSES	RECETTES			
2009	5 746,96	9 107,40			
	5 746,96	9 107,40	*3 360,44*	FONDS DEDIES (missions 2010)	
2010	4 367,04	2 247,32			
	10 114,00	11 354,72	*1 240,72*	FONDS DEDIES	1 240,72

TOGO 2010 0299 + avenant n° 1 : 2011 0346

	DEPENSES	RECETTES			
2010	-	6 720,75			
	-	6 720,75	*6 720,75*	FONDS DEDIES (missions 2011)	
2011	5 431,82	-			
	5 431,82	6 720,75	*1 288,93*	FONDS DEDIES (missions 2012)	
2012	3 335,64	2 041,46			
dép non reportée à reprendre en GP	- 36,50				
	8 730,96	8 762,21	*31,25*		31,25

TOGO 2012 0168

	DEPENSES	RECETTES			
2012	1 588,68	10 885,08			
	1 588,68	10 885,08	*9 296,40*	FONDS DEDIES (missions 2013)	9 296,40

	48 711,42

Bilan 2011

Le total du bilan au 31 décembre 2012 est de 109 162,68 €uros.

L'actif est composé des :

- Placements (VMP) : 101 887,21€uros
- Disponibilités (banque) : 7 013,27€uros
- Charges constatées d'avance : 202,20 €uros
- Produits à recevoir : 60,00 €uros

Le passif se décompose ainsi :

- Réserves : 55951,92€uros (résultats antérieurs)
- Résultat de l'année : 1270,34€uros
- fonds dédiés : 48711,42€uros (engagements à réaliser sur 2013)
- Dettes fournisseurs et comptes rattachés : 2990 €uros

Fonds propres : 57 222,26 €

Quelques remarques

- Remercier: les comptables Niger et Togo
- Le plus simple : partir avec peu d'avance … le comptable rembourse toutes les factures justifiées.

Approbation du rapport financier

Renouvellement du conseil d'administration

Le Conseil d'Administration 2012 d'Entraide santé 92 est le suivant :

membres	Profession	Fin de mandat
Guilaine Barnaud	*Pharmacien biologiste*	*2014*
François Cordonnier	*Médecin*	*2014*
Caroline Dupont	*Médecin*	*2015*
Béatrice Collier	*Cadre infirmier*	*2015*
Elisabeth Rouveix	*Médecin*	*2014*
Frédéric Bidegain	*Médecin*	*2015*
Veronique Friocourt	*Technicienne laboratoire*	*2013*
Anne-Marie Simonpoli	*Médecin*	*2013*
Emmanuel Mortier	*Médecin*	*2013*
Sylvie Alglave	*Technicienne laboratoire*	*2015*
Céline Levacher	*Assistante sociale*	*2015*
Gérard Le Turnier	*Technicien de laboratoire*	*2013*
Ghislaine Padonou	*Cadre infirmier*	*2014*
Patricia Paillet	*Psychologue*	*2013*
Pierre de Truchis	*Médecin*	*2014*
Magalie Lio	*Infirmière*	*2014*
Louis Affo	*Médecin*	*2015*
Françoise Vernat	*Cadre administrative*	*2014*
Elsa Dos Santos	*Infirmière*	*2014*
Emmanuelle Capron	*Infirmière*	*2015*

5 places à pourvoir

Sortants :

- Veronique Friocourt
- Anne-Marie Simonpoli
- Emmanuel Mortier
- Gérard Le Turnier
- Patricia Paillet

Bureau sortant

- Président : Emmanuel Mortier
- Vice présidente : Gérard Le Turnier
- Vice présidente : Emmanuelle Capron
- Secrétaire : Béatrice Collier
- Secrétaire adjointe : Magalie Lio
- Trésorier : François Cordonnier
- Trésorier adjoint : Elisabeth Rouveix