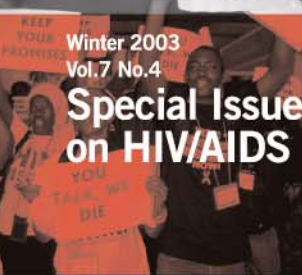


GENERIC DRUGS NOW!

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SAVE OUR FUTURE!

Winter 2003  
Vol.7 No.4  
Special Issue  
on HIV/AIDS

# ALERT



MEDICINS SANS FRONTIERES  
DOCTORS WITHOUT BORDERS



# VOICE FROM THE FIELD BRINGING ANTIRETRO- VIRAL THERAPY TO SOUTH AFRICA

Nowhere has the impact of HIV/AIDS been more visible than in South Africa. Today, more than 4.5 million of its inhabitants are HIV positive—the largest number of people living with HIV/AIDS in any one country. In Khayelitsha township, a poor area near Cape Town, Eric Goemaere, MD, head of MSF in South Africa, works with colleagues and local AIDS advocacy groups to bring antiretroviral (ARV) treatment to those who need it and to push the country's government to do much more.

In May of this year, 200 patients attended the second anniversary celebration of the introduction of ARV treatment in our clinics. As the patients and their doctors and nurses know, without treatment they probably would not have survived this long. They also know that the situation in Khayelitsha is unique. In South Africa, HIV is widespread, but access to life-extending treatment is rare.

Each day, an estimated 600 people die of AIDS and 1,700 are infected with HIV in South Africa. The South African government has consistently refused to provide life-prolonging ARVs, despite the overwhelming success of this treatment in other countries. Recent government statements have demonstrated a sudden willingness to integrate treatment into the national AIDS protocol. Currently, each province is preparing a treatment plan. There is talk of providing treatment for half a million people by 2008. This would make South Africa's ARV treatment program the largest in the world.

Doctors Without Borders/Médecins Sans Frontières (MSF) has been working in Khayelitsha township since 1999. Here, most families live in corrugated iron shacks without running water or electricity. Unemployment is high, crime is rampant, and HIV prevalence is 25.5 percent in prenatal clinics.

Initially, we assisted with what was then the country's only government-supported project to prevent mother-to-child transmission of HIV. Now we provide care and treatment for HIV-positive clients in three HIV/AIDS clinics in Khayelitsha. Our doctors, nurses, and counselors see more than 1,800 clients a month, including more than 600 who receive ARVs. Of the latter, 72 are children. We have recently begun to provide care and treatment in the rural Eastern Cape province too, with the support of the Nelson Mandela Foundation. Our project was initiated to show that the use of ARVs in a primary health care setting, in a resource-poor African environment, is feasible and affordable. After more than two years of ARV treatment, this assumption has been indisputably demonstrated. Now, the number of patients on treatment must increase and the successes must be replicated in other communities and in larger numbers.

Three years ago, people chose to remain silent about HIV out of fear of the consequences of disclosing their status in an atmosphere where stigma and discrimination

Above: Eric Goemaere, MD, head of MSF in South Africa

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#### Cover:

MSF medical teams treat people living with HIV/AIDS in projects around the world.

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are widespread. We have seen firsthand how the link between the disease and imminent death can frighten people into silence. When we first arrived in Khayelitsha, everyone told us that our clinics would be empty. But the clinics have been flooded with patients almost from the day they opened. And, with treatment available and outspoken treatment activists educating the community, the stigma surrounding HIV has decreased significantly. In the last two years, we have seen ARV therapy both destroy the perception that HIV is fatal and break the silence.

The statistics speak for themselves, and the clients at the clinic can speak of the effect that their treatment has had on their CD4 counts and viral loads. They have seen the effects of the disease and witnessed their rapid clinical deterioration alongside a plummeting immune response. But now the patients are gaining weight and returning to normal activities. For the overwhelming majority, after only three months of treatment, the virus cannot be detected in their blood.

While the medical impact of the treatment has been dramatic, the social effects have been comparably impressive. People have embraced old strategies to challenge a new enemy. Here, the fight for treatment is the new "struggle." When people living with HIV found out there was a medicine that could save their lives and the lives of their families and friends, they demanded access to it. They proudly wore t-shirts emblazoned with the words "HIV POSITIVE," encouraging others to speak out.

The challenge now is to scale up treatment: treat thousands rather than hundreds, but maintain excellent outcomes.

In South Africa, there is some evidence that the government position on treatment is shifting from one of intransigence to one of collaboration and action. In August, the cabinet announced that the government must produce a treatment plan. But a treatment plan is only a start. Without ongoing political pressure from people living with AIDS, access to treatment will never be a reality for the poor. In the meantime, we will continue to support our South African colleagues as they demand to be treated with dignity, and with urgency.

*Eric Goemaere, MD*

Above left: Former South African President Nelson Mandela talks with Zackie Achmat, (second from left) of the Treatment Action Campaign, and others living with HIV/AIDS while visiting the Khayelitsha project. © Eric Miller 2002

Above right: A woman receives her ARV medication at the MSF clinic. In sub-Saharan Africa, women and girls make up the majority of those living with HIV/AIDS. © Sebastian Charles 2002

# SCALING UP TREATMENT THE KEY TO COMBATING HIV/AIDS

*“We no longer have to stand empty-handed watching our patients die needlessly. We are providing ARVs that are transforming people’s lives.”*

—Didakus Odhiambo, head of mission for MSF’s HIV/AIDS project in Chiradzulu, Malawi

AIDS is a medical, social, economic, and political crisis. Today more than 42 million people are living with the disease—95 percent of them in developing countries—and each day more than 8,000 men, women, and children die from it. Although effective treatments exist, a mere four percent of the six million people who are in urgent clinical need of antiretroviral (ARV) therapy have access to it.

The notion that AIDS treatment in developing countries is impractical or even infeasible has been disproved in the past few years, and the potential for extending life and transforming the face of AIDS by using ARVs in developing countries has been clearly demonstrated. In Brazil, for example, the national AIDS program, which guarantees universal access to ARVs, reports that between 1996 and 2002, treatment of people with HIV/AIDS averted 90,000 AIDS deaths, prevented 60,000 AIDS cases, and avoided 358,000 AIDS-related hospitalizations.

Yet many governments, UN agencies, and others have been slow to adopt measures, or have failed to deliver on promises, to increase access to treatment. The dramatic deficit in AIDS funding has led to debates about how to allocate scarce resources, and, for example, some have argued that prevention is more cost-effective than treatment.

*“As a medical doctor, an MSF member, and as a citizen of Ukraine, I can confirm that until treatment is provided for all people living with HIV/AIDS in Ukraine, until the term ‘death sentence’ is no longer associated with HIV infection, all the huge efforts of the main international organizations focusing on prevention will not be effective.”*

—Konstantin Lezhentsev, MD, Kiev, Ukraine

Doctors Without Borders/Médecins Sans Frontières (MSF) believes that it is medically unethical to deny people living with HIV/AIDS access to life-extending treatment. Our experience in the field shows that the availability of treatment creates conditions that improve the effectiveness of prevention efforts. MSF teams working in Malawi, South Africa, and Kenya, for example, report that treatment has helped to break patterns

of denial and stigma surrounding HIV/AIDS. People are openly disclosing their HIV status for the first time, which is leading directly to increased voluntary counseling and testing.

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## WHY ARE ARVs CRUCIAL?

More than 20 years after the first AIDS-related death was reported, there is still no cure for this disease. However, with the advent of triple-combination ARV therapy in the mid-1990s, AIDS was transformed from a death sentence to a chronic, manageable disease for most people in wealthy countries. In places like the United States, ARV treatment has dramatically extended and improved the lives of people living with HIV/AIDS, reducing AIDS-related deaths by more than 70 percent. Without access to ARVs, people living with HIV/AIDS will eventually experience the deterioration of their immune systems, becoming susceptible to a variety of opportunistic infections such as tuberculosis, pneumonia, and meningitis, and will ultimately die. While other medicines merely treat the infections caused by HIV or provide relief from symptoms, ARVs actually decrease the level of the virus in the body and contribute to the restoration of the immune system.

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## TREATING ONE PATIENT AT A TIME

*“So far, the patients I have seen on ARVs are doing quite well. The biggest change I see is the weight gain. HIV will waste you away to nothing. It is nice to hear when you ask, ‘How do you feel, any problems?’ They say ‘Yes, I was wondering if I could go back to work.’ Without ARVs, they would have been dead long before I arrived.”*

—Greg Goodyear, MSF physician in Homa Bay, Kenya

In the past year, MSF has increased the scope of its HIV/AIDS treatment programs and has provided clear evidence that treating AIDS in developing countries is possible and replicable on a much wider scale, even where the health infrastructure is severely limited. Yet there are serious obstacles—both real and perceived—to expanding this treatment. By tackling many of these challenges in its current programs, MSF is showing that these barriers are not insurmountable. Our medical teams now treat more than 6,000 patients living with HIV/AIDS in multiple projects in 16 countries, and we expect to be treating 10,000 by the end of 2003. Providing ARVs is only part of patient care, which also includes HIV testing and counseling, treatment for opportunistic infections, and prevention of mother-to-child transmission of the disease.



This young boy receives ARVs at an orphanage in Nairobi, Kenya. An estimated 16 million African children have already lost at least one parent to AIDS. That number is expected to reach 28 million in the next decade.

© Juan Carlos Tomasi 2001

We have also seen increased political attention to the need to expand care and treatment in the developing world. However, to advance treatment for the six million people who clinically require it, the costs must fall farther; treatment and monitoring must be simplified; international trade agreements must prioritize public health above the protection of commercial interests; and technical, financial, and political resources must be dramatically increased.

MSF has made a commitment to run each of its ARV projects for a minimum of five years and to guarantee treatment throughout the lives of our patients. The ultimate goal of our projects is to transfer the responsibility for providing treatment to local ministries of health. Clinical outcomes and anecdotal data are being tracked to monitor the progress of each patient and to document clinical and social benefits. Already the effects of treatment are evident: patients enrolled in our ARV programs gain weight, feel better, and resume productive roles in their communities and families.

*“I’m feeling very happy because I would have died without it. I got a very good response from the ARVs and gained a lot of weight. Even people can’t guess that I’m HIV-positive.”*

*“I feel such a difference between now and before the ARV treatment started. I am more hopeful and I even started to construct a house. I’m also trying to keep some small money for my children. I want to help other people, to relieve the ones with HIV/AIDS, and to prevent people from being infected.”*

—John, 39, a patient at MSF’s ARV project in Homa Bay, Kenya

## WORLD HEALTH ORGANIZATION CALLS FOR TREATMENT

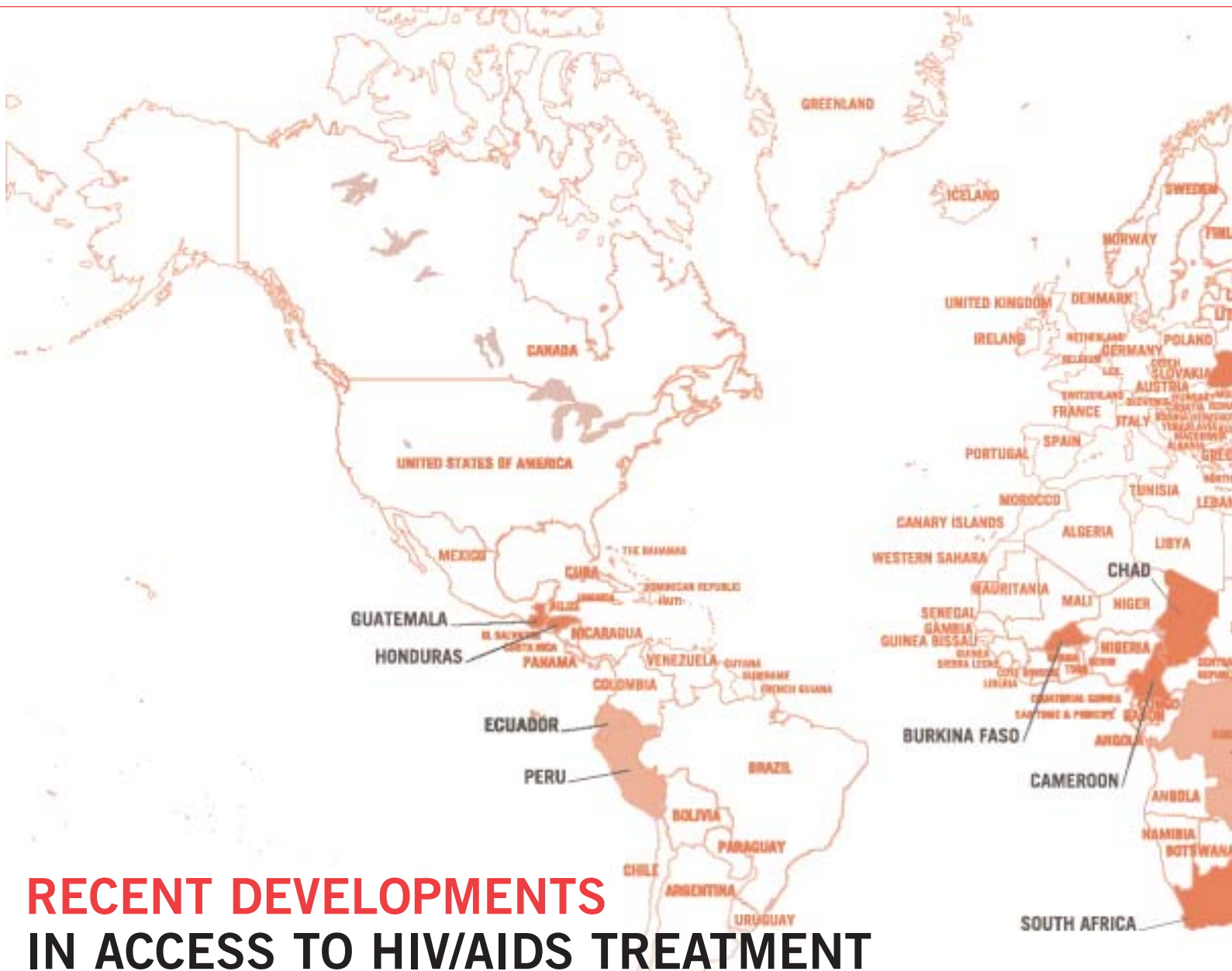
In September 2003, the World Health Organization (WHO) declared that lack of access to ARV treatment was a “global health emergency” and announced that it would release an emergency plan to expand access to ARVs for at least three million people by the end of 2005. MSF is encouraged by the WHO’s commitment and will provide its expertise and field experience to help advance this initiative. MSF has already published a series of reports documenting our experience in implementing ARV treatment programs, identifying sources and prices of AIDS drugs and diagnostics, and procuring AIDS drugs at the best possible prices. We will continue to monitor progress closely to hold the WHO to this ambitious goal.

## THE ROAD AHEAD

MSF is convinced that treatment simplification and the development of simple and affordable monitoring tools are vital to increasing ARV treatment, particularly in high-prevalence countries, a sentiment echoed by the World Health Organization.

Simplified treatment must first and foremost include the introduction of fixed-dose combinations of ARVs. By the end of 2003, 80 percent of the more than 10,000 patients who will be enrolled in our ARV programs in developing countries will be receiving their treatment in this form—one pill containing triple-combination therapy taken twice a day.

In addition, work must be done to determine pediatric dosages for ARV regimens. In general, few such regimens exist because of the relatively small market in wealthy countries. Furthermore, research is urgently needed to explore ways to adapt treatment to the reality of low-resource settings, for example, to identify ways to reduce dependence on lab tests designed to gauge the progress of the disease. Finally, there is a dire need to set a new research agenda and stimulate development of new AIDS drugs, diagnostics, and vaccines that are suited to the needs of people living with HIV/AIDS in poor countries.



# RECENT DEVELOPMENTS IN ACCESS TO HIV/AIDS TREATMENT

## NEW DEAL ON EXPORT OF GENERICS

On the eve of the 5th World Trade Organization (WTO) Ministerial Conference held in Cancun, Mexico, in September 2003, a compromise deal on the export of generic medicines was reached. The decision was said to make it easier for countries unable to produce drugs to procure less-costly generics. However, MSF believes that the complex rules of the agreement may actually hamper access. MSF has urged countries to make full use of the flexibility built into international trade rules to import or produce the most affordable medicines for HIV/AIDS and other diseases.

## CANADA MOVES TO CHANGE ITS PATENT LAW

In October 2003, Canada responded to a call by Stephen Lewis, the UN Special Envoy for HIV/AIDS in Africa, for wealthy countries to change their patent laws and start exporting needed generic medicines to treat HIV/AIDS and other diseases. If it goes ahead

with the plan, Canada would be the first wealthy country to implement the WTO decision, but MSF and others have cautioned that it must do so in the broadest and most flexible manner.

## THE FTAA IMPACT

All of the countries of the Americas, excluding Cuba, are now devising the Free Trade Area of the Americas (FTAA) Agreement, which will regulate many aspects of regional commerce. Draft proposals related to intellectual property rules are more stringent than those required by the WTO TRIPS Agreement and could have devastating consequences for people with HIV/AIDS and other diseases in Latin America and the Caribbean. MSF is advocating for the removal of all provisions related to intellectual property from the agreement, arguing that they will only lead to increased drug prices, decreased generic competition, and reduced accessibility of essential medicines.



**Current MSF ARV programs:**

- BURKINA FASO**
- BURMA (MYANMAR)**
- CAMBODIA**
- CAMEROON**
- DEMOCRATIC REPUBLIC OF CONGO**
- GUATEMALA**
- HONDURAS**
- INDONESIA**
- KENYA**
- LAOS**
- MALAWI**
- RWANDA**
- SOUTH AFRICA**
- THAILAND**
- UGANDA**
- UKRAINE**

**Future ARV programs:**

- CHINA**
- ECUADOR**
- PERU**
- ZAMBIA**
- ZIMBABWE**

**GLOBAL FUND FACES FINANCIAL CRISIS**

Created at the behest of UN Secretary General Kofi Annan, the Global Fund to Fight AIDS, Tuberculosis, and Malaria was launched two years ago to finance programs that combat these major killers in poor countries. After three rounds of grant disbursements, the Fund is facing a financial crisis because donor countries have not committed adequate financing. Although Annan called for \$10 billion annually, in part to help bridge the gap in access to treatment, the Global Fund predicts a massive shortfall in 2004. This shortage of funds will have concrete consequences in terms of the numbers of lives saved.

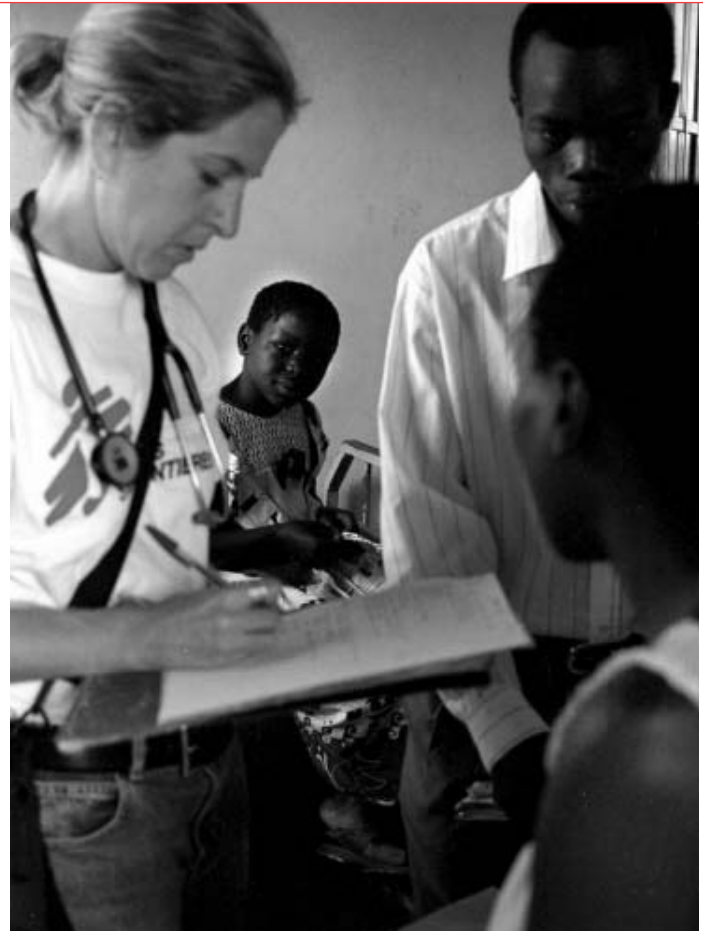
**UPDATE ON THE BUSH AIDS INITIATIVE**

During the 2003 State of the Union Address, President Bush announced an "emergency plan for AIDS relief," pledging \$15 billion over five years to fight HIV/AIDS. However, the President only asked for \$2 billion to be paid in 2004, rather than the \$3 billion expected, and only \$200 million of those dollars will go

into the Global Fund. None of this new funding has been allocated or disbursed as of this writing. MSF and others have strongly criticized this initiative, highlighting our concern that it will favor brand-name drugs over more affordable generics and lamenting the failure of the United States to contribute its fair share of funding to international initiatives.

**COST OF AIDS TREATMENT DROPS TO 36¢ A DAY**

In late October 2003, former President Bill Clinton announced that his foundation had negotiated with four generic drug manufacturers to reduce the price of ARVs to as little as 36¢ a day. Under this agreement, the price of one of the most commonly used types of triple-combination ARV therapy will drop from approximately \$300 per person per year to less than \$140 per person per year. In addition to reducing the price of AIDS treatment dramatically, the generic companies involved in this agreement are producing fixed-dose combinations, which can be taken in the form of one pill twice a day, and will be critical to scaling up ARV treatment.



# ENSURING TREATMENT SUCCESS: THE LESSONS LEARNED

Although MSF has been providing ARV treatment for only a few years, we have already learned valuable lessons about what makes a project successful.

## COMMUNITY INVOLVEMENT

People living with HIV/AIDS were the driving force behind efforts in the United States and Europe to gain access to treatment and to ensure that their voices were heard in setting policy. Now similar movements have taken hold in Africa, Asia, Latin America, and the former Soviet Union.

For example, since MSF began working in 1999 in Khayelitsha township near Cape Town, its work has been supported and greatly enhanced by the efforts of grassroots treatment advocacy organizations such as the Treatment Action Campaign (TAC). This organization has developed community-based educational programs and has drummed up strong public pressure on the government to commit itself to a comprehensive national HIV/AIDS plan that includes ARV treatment. TAC's

programs have led, moreover, to an increased understanding of the disease, which is helping to break the taboo surrounding HIV/AIDS.

## DECENTRALIZING CARE

While many developing countries have an abundance of people in need of treatment, these nations lack medical doctors to treat them. A number of countries are now finding ways to solve that problem creatively. For example, in Malawi, an estimated 850,000 people, or 10 percent of the population, live with HIV. In the Chiradzulu district in the southern part of the country, more than 5,000 need ARV treatment now. But there is just one public hospital—a 100-bed facility—to serve the whole district.

To reach the largest number of people, MSF is now helping to decentralize and simplify treatment so that care can be managed mostly by nurses. The MSF team makes rounds at 10 health centers, offering on-site HIV tests, managing opportunistic infections and ARV treatment, and providing counseling.



Left page, far left: This hospital waiting room in Malawi is overflowing with people living with HIV/AIDS. Eighty percent of the patients have an opportunistic illness linked to the disease. © Didier Lefevre 2002

Left page, right: An MSF physician charts the progress of patients receiving ARVs in Uganda. © Jake Price 2003

Above: An MSF nurse in Surin province in Thailand explains how to take ARVs during a home visit. © MSF 2003



Top right: Twenty percent of the children hospitalized at Malawi's Chiradzulu Hospital have HIV. This child arrived in a coma, also suffering from meningitis. © Didier Lefevre 2002



Middle right: A medical consultation with a patient at MSF's Homa Bay project in Kenya. © Andrew Njoronge 2002



Bottom right: In Mozambique, an MSF local staff member visits a woman living with HIV. © Francesco Zizola/Magnum Photos for MSF 2002

## PROMOTING GENERICS

International trade laws affect generic competition, and generic competition affects drug prices. MSF sees the availability of low-cost drugs as one of the key elements of scaling up treatment in all developing countries, because such drugs are, on average, two to five times less expensive than brand-name drugs, meaning that two to five times more people can be treated on a given budget. For that reason, MSF has become closely involved in international trade discussions about intellectual property rules that determine whether generic competition can exist.

## CENTRAL PROCUREMENT

Avoiding costly small purchases of ARVs can save countries huge amounts of money. Pooling purchases into a central procurement system has been shown by a number of countries to be a successful way to buy more medicines and treat more patients. For example, in Cameroon, where almost one million people are living with HIV/AIDS, a centralized public procurement system enables that country to buy quality ARVs at the lowest prices. In March 2001, thanks to both Cameroon's negotiations with pharmaceutical companies and the effects of generic competition, prices for first-line ARVs dropped from \$10,000 to \$277 per patient per year. By the end of 2002, approximately 2,500 patients had started ARV treatment at central and provincial hospitals.



## NEWS AND EVENTS

### MSF CALLS ON RUSSIAN LEADER TO HELP FREE ARJAN ERKEL

As world leaders convened in New York for the United Nations General Assembly in late September 2003, Doctors Without Borders/Médecins Sans Frontières (MSF) called upon Russian President Vladimir Putin to fulfill his obligation to ensure the release of Arjan Erkel, the MSF volunteer abducted on August 12, 2002, in the Russian republic of Dagestan. At a demonstration held outside of UN headquarters during a speech given there by President Putin, MSF volunteers, staff, and supporters also urged all UN member states to hold the Russian leader accountable for the resolution of the case.

In August 2003, the UN Security Council unanimously adopted a resolution on the safety and security of humanitarian aid workers, reiterating the responsibilities of host countries. Arjan Erkel, however, remains in captivity, and threats and violence to humanitarian workers in the region have increased. On September 12, a general warning about kidnappings brought humanitarian aid to a standstill in Ingushetia, home to 80,000 displaced Chechens.

“If the newly adopted UN resolution on the safety and security of aid workers is to have any meaning, President Putin must live up to his responsibility under international law to find and free Arjan and allow humanitarian assistance to reach those in need in the Northern Caucasus,” said Dr. Morten Rostrup, MSF International Council president.

### MSF EXAMINES ITS ACTIONS IN CONGO-BRAZZAVILLE

MSF-USA recently published *Civilians Under Fire*, a collection of articles that looks introspectively and self-critically at MSF’s operations during an acute phase of the civil war that devastated the Congo Republic (also known as Congo-Brazzaville). The publication sheds light on some of the important ethical, medical, and practical considerations that arise when organizations such as MSF make the decision to provide assistance to victims of rape, a group of people often overlooked by humanitarian organizations.

To learn more about the book or to order a copy, please visit the publications page on our website.

### ROUNDTABLE DEBATE ON HUMANITARIAN ACTION AND THE INTERNATIONAL RESPONSE TO CRISES

The tension between humanitarian action and political objectives has prompted concerns about a new approach to international aid called the “coherence” approach. Proponents argue that coherence enhances the effectiveness of each party’s work by ensuring that all interventions in a particular crisis are directed toward a common objective, such as maintaining peace or building security. Critics believe that coherence challenges the essence of humanitarian action. That is, coherence could lead to situations in which aid is selectively allocated to certain vulnerable groups depending on their political usefulness. And when political and humanitarian concerns conflict, humanitarian interests may be sacrificed.

MSF-USA participated in a one-day conference in New York on October 30, 2003, to discuss the impact the approach is having on humanitarian aid. The meeting, organized by the Carnegie Council, brought together UN staff, donor agencies, nonprofit organizations, and policymakers. MSF contributed to the debate by sharing its experiences from Angola. Papers presented at the meeting will be published in an upcoming issue of the journal *Ethics and International Affairs*.



**FRONTLINE REPORTS**

**MSF EVENTS IN NEW YORK FOCUS ON HIV/AIDS**

On December 4, Pulitzer Prize winner **Samantha Power** will talk with **Stephen Lewis**, UN Special Envoy for HIV/AIDS in Africa, **Eric Goemaere**, MD, head of MSF in South Africa, and **Johanna Ncala** of South Africa's Treatment Action Campaign (TAC). They will discuss how government promises of treatment could translate into lives saved and highlight the lessons that can be drawn from South Africa in expanding HIV/AIDS treatment throughout Africa.

The event will start with a reception at 6:00 pm, followed by a discussion at 7:00 pm at the New York Academy of Medicine, Hosack Hall, 1216 Fifth Avenue at 103rd St., New York. For reservations, call 212-847-3151.

Left page, far left: A boat displaying an MSF banner motors past the UN in September. © MSF 2003

Right top and bottom: MSF supporters, including the actor Patrick Stewart, call for Arjan Erkel's release during the UN demonstration. © MSF 2003

This page: Clients of MSF's AIDS project in Khayelitsha celebrate its second anniversary. © Eric Miller 2003

Throughout December, MSF-USA will host the exhibit, **Khayelitsha: Portrait of a Community in the Age of AIDS**. This poster exhibit features the work of South African photographer **Gideon Mendel**, who has documented people with AIDS in MSF's antiretroviral (ARV) treatment program in Khayelitsha, South Africa. For viewing details, call MSF at 212-847-3151 or visit our website.

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# HIV/AIDS TREATMENT IN GUATEMALA: THE NEED FOR COMMITMENT



In Guatemala, progress in the struggle against HIV/AIDS has not come easily. The cost of treatment is high, and a positive diagnosis for HIV/AIDS continues to carry a heavy stigma. Success is measured one patient at a time.

However, headway is being made. Just over two years ago, there were no Guatemalans receiving antiretroviral (ARV) drugs. Now there are 1,500, and the total is rapidly increasing in part because generic competition has cut the price of treatment to less than one-tenth of what it was in July 2002.

In any HIV/AIDS project, however, success depends not only on the price of drugs, but on many other factors including the work of trained counselors. If a person being treated for HIV/AIDS stops his or her treatment or takes it incorrectly, the same treatment may not work again. And if this happens too often, drug-resistant strains of the disease can develop.

One of the very first Guatemalans to receive ARV treatment was Carmen, a soft-spoken woman in her early sixties. As a former-patient-turned-counselor, she embodies the progress that has been made against HIV/AIDS in Guatemala. In the summer of 2001, Carmen weighed only 56 pounds. Today, at 134 pounds, she is a living testament to the effectiveness of ARV treatment.

"HIV lives with me and I live with HIV," Carmen says. "I have to take pills every day, but if I hadn't found treatment, I wouldn't be here."

Carmen now volunteers with Doctors Without Borders/ Médecins Sans Frontières (MSF) at Roosevelt Hospital in Guatemala City. There she counsels people who have just learned that they have HIV. Her optimism and personal experience with HIV/AIDS allow her to cut through the stigma and fear that surround the disease and to support new patients in adhering to their treatment regimens.

"For me the work is very satisfying," Carmen says. "When people find out they're talking to an HIV-positive person they open up completely."

When Carmen first arrived at the Roosevelt Hospital clinic, the waiting room was almost empty. "Now people are sitting on top of each other," she says. "Each day there are more people in this country infected, and more people who know they're infected. If the drugs become too expensive again, the clinic will be empty again, I guess."

Her advice to those newly diagnosed is simple and clear: "I tell them, 'You can live longer and you can improve your quality of life, but it takes devotion. It takes a commitment to the value of your own life.'"

MSF believes that governments need to make the same commitment to people with HIV/AIDS. Unfortunately, trade provisions sought by the US government threaten to reverse the progress made against HIV/AIDS in Latin American countries. Through regional agreements such as the Central American Free Trade Agreement (CAFTA) and the Free Trade Area of the Americas (FTAA), US trade negotiators are pushing regulations that would make drugs prohibitively expensive in Latin American and Caribbean countries by restricting generic competition.

*Guatemala is one of the 16 countries in which MSF medical teams are providing ARV treatment for people living with HIV/AIDS.*

Above: A woman living with HIV/AIDS receives her ARV treatment from an MSF volunteer at the pharmacy of Roosevelt Hospital in Guatemala City.  
© Juan Carlos Tomasi 2002

