Dear Friends,

Doctors Without Borders/Médecins Sans Frontières (MSF) was founded four decades ago by doctors and journalists returning from a devastating famine in Biafra, Nigeria, where thousands of children had been denied access to food during a brutal civil war. There was a need, they believed, for an organization that could both dispense emergency medical services and also speak out about the reasons why such treatment was necessary in the first place.

Forty years on, the same dual sense of purpose lives on. Several months ago, we sent teams to set up emergency medical programs to treat people caught in violence erupting in Libya, Bahrain, southern Sudan, and Ivory Coast. At the same time, we spoke out forcefully about the violation of health facilities in Bahrain, the need for NATO countries to attend to the people fleeing a war they support in Libya, and other matters affecting patients in the countries where we work.

This issue of Alert contains updates from these and other contexts, including excerpts of a journal kept by Delphine Chedorge, an emergency coordinator who led one of the teams charged with providing medical care during the fevered factional fighting that gripped Ivory Coast this past Spring.

At the same time, though, we want to share another crucial part of our work, which centers on gathering and analyzing data from our programs. By constantly reviewing our efforts, we can use the findings both to identify ways we can improve and also to demonstrate to a larger audience what works and what does not. In addition to informing us about what we could be doing better, this gives us the evidence we need to advocate on behalf of our patients, to call for changes where changes need to be made or new policies where new policies are required.

For example, on page 8, we highlight a study conducted in Niger by MSF’s epidemiological research center, Epicentre, that shows that providing children who are malnourished or at risk of becoming malnourished with supplemental nutritional foods and basic health care services can lower mortality rates by 50 percent. Additionally, starting on page 12, we share findings from a report authored by MSF’s Campaign for Access to Essential Medicines that cites recent research showing that treating HIV not only prolongs lives, it also helps reduce new cases. This combination of direct action, research and reflection, and strategic advocacy is an inherent part of MSF’s work, a core aspect of our efforts to better both our projects on the ground and the governmental and institutional policies that impact them. We can do this thanks to your support and our shared belief that people enduring the worst of circumstances should benefit from the best that medicine has to offer.

Sincerely,

Sophie Delaunay
Executive Director, MSF-USA
“TERROR AND CATASTROPHE” IN ABIDJAN: ONE WEEK IN IVORY COAST

In November 2010, Ivory Coast held elections during which President Laurent Gbagbo was defeated at the polls. Gbagbo refused to accept the results, leading to months of fierce fighting between his supporters and the supporters of the election’s winner, Alassana Outarra.

Doctors Without Borders/Medecins Sans Frontieres (MSF) returned to Ivory Coast in the midst of the conflagration, setting up projects in the west, across the border with Liberia—where fleeing Ivorian families were taking shelter—and in Abidjan’s Abobo Sud neighborhood.

In early April, a week before Gbagbo surrendered and the fighting began to subside, the MSF team at the Abobo Sud Hospital was isolated, unable to move or obtain additional supplies from outside. Team coordinator Delphine Chedorge kept a diary describing this tense period. Some details have been changed or deleted in the interest of security, but her entries, minimally abridged and edited, illustrate the dilemmas and difficulties the team experienced.

Among the groups mentioned are the Forces Nouvelles, the Ivorian rebel forces that backed Outarra; the United Nations Operation in Ivory Coast (UNOCI); and the French “Operation Licorne” forces, which support the UN peacekeepers.
MONDAY, APRIL 4

The Forces Nouvelles’ final offensive began around noon. The U.N. authorized the French Licorne forces to attack Gbagbo’s heavy weaponry, which had caused civilian injuries and was also used to attack the UNOCI. All afternoon, fighting was concentrated around Cocody and Angre, targeting the Ivorian national television network. We could hear it very clearly from our location in Abobo. It’s not far away and sometimes the noise came quite close.

Fighting continued all night, until Tuesday morning. The fighters were the only ones to bring wounded patients in—arriving in a steady stream. However, we think many of the wounded are not reaching any medical facility unless they are transported by Forces Nouvelles soldiers.

The fighters escorting the patients have now overrun the hospital. They are from the northern part of the country. They don’t know us and they are better trained than the local militias, but they don’t have any greater respect for us. They are armed and come and go freely in the units, the emergency department, and the screening area, and even try to take our food, saying they need it because they’re fighting. These never-ending daily discussions—intended to make sure the team is safe and that it can do its work—are exhausting. The prognosis for our anesthesia supplies: two days, maximum.

TUESDAY, APRIL 5

Gbagbo’s surrender was announced this afternoon. Cheers in Abobo, people firing into the air everywhere. Everyone is hiding in the hospital—a bullet flew through the doorway and others are exploding on the roof. Injured patients follow quickly. Fighters arrive with the wounded. One man shows up in handcuffs. He was taken when Gbagbo’s second wife’s house was attacked. He was visiting his brother, who worked there, and was beaten and stabbed. He is terrorized, but his wounds are not serious. The fighters didn’t have the keys to the handcuffs. When they left, we cut the chain with shears. The two cuffs are still there and we hid them under our food, saying they need it because they’re fighting. These never-ending waves of wounded people, many of them life-threatening emergencies. The surgical team is really upset. Phrase of the day: “nothing like a good friend to shoot at you” (as a large share of our wounded patients have been shot by friends).

THURSDAY, APRIL 7

Patients are showing up with their prescriptions for antiretrovirals and tuberculosis drugs. We’re starting to take care of them. In the end, the Licorne forces canceled the convoy. The Japanese embassy was attacked last night and the Licorne soldiers had to get seven people out. Two pick-up trucks were also attacked at the French embassy. Our team based in Zone 4 left to come join us but they did an about-face when they came face-to-face with snipers and burned-out shells of cars in Adjame. We’re hearing increasing numbers of accounts about bodies left in the street. Our MSF team is still not leaving the hospital, although a few more people are out in the street this morning. Nine wounded today, 75 hospitalized. There’s still a patient who needs an amputation.

A little truck arrived from Bouaké with the anesthesia kit and solutions. Unfortunately, there are no narcotics inside (no valium or morphine) and only 10 vials of lidocaine. That’s one day’s supply. Our surgeon just learned that his family may have been robbed again... He’s afraid and can’t get through on the phone, so he borrowed mine to check on security where his wife lives. I sent a car of fighters to buy some baby formula and diapers for a baby who was abandoned at the hospital in late March. There are no more rules here. MSF’s standard principles no longer apply. We’re just trying to treat our patients, almost any way we can. At the end of March, we were comparing Abobo to Baghdad. Today, Abidjan resembles Baghdad.
Mogadishu—chaos, multiple groups, clans, robberies. Terror and catastrophe for the people who live here. We are not seeing any light at the end of this tunnel and the stories people are telling us are worse and worse.

FRIDAY, APRIL 8

The market is a little more crowded and there’s a bit more variety, too (but nothing to get excited about). Abobo is the best-supplied neighborhood in Abidjan. The hospital pharmacist has returned. The electricity and air conditioning are back on in the pharmacy and we’re organizing things so that we can set up our pharmacy in there, too, freeing up the large recovery room that we’ve taken over. A steady stream of people with bullet wounds continues to arrive. Labor and delivery is working at full steam. We are also seeing a regular flow of ill people: wasting syndrome, end of life, chronic illnesses in a complete state of collapse that we can’t do anything about (including HIV, diabetic coma, and stroke). There’s malaria, too, which, fortunately, we can still treat.

Deaths, explanations to the families so that they can take their parent home. That’s hard, too. We don’t have an experienced doctor, either (our young physician is working all alone and pretty much lacking support, in spite of the supervising nurse who helps him a lot). Five deaths today, 29 admissions, including 20 bullet wounds. The total number of hospitalized patients is now 78. No more 450 ml blood bags (we have only 250s left); only two more Determine HIV tests (we’ve been out of the Unigold for several days); no adrenaline; still no more valium or morphine; two boxes of examination gloves; no more tramadol; no more Ace Bandages; no traction materials.

SATURDAY, APRIL 9

The market is bigger and there are more goods. This is our first outing—to the market and Anyama Hospital [in northern Abidjan]. There are roadblocks every few hundred yards, but the guards are not hostile. Everyone greets us. At the hospital, the bursar tells us that the market reopened 24 hours ago. Not many roadblocks. Life is almost normal. On the other hand, the hospital is deserted. There are seven medical staff, compared to the normal 157. Finally, four trucks with medicine and medical supplies have arrived! And the first MSF employees who will be working at Anyama Hospital, too.

MSF teams continue to work in Abidjan hospitals, in several locations in the west, and with Ivorian refugees taking shelter in Liberia.
PAKISTAN

On May 26, a suicide bomber killed 36 people and wounded approximately 60 more near a police station in northwestern Pakistan’s Hangu district, just a few blocks from the hospital where MSF’s team lives and works. Hospital staff and MSF’s team together treated 58 people in the immediate aftermath.

MSF has been operating an emergency room and a surgical department in Hangu since May 2010, serving a population battered by years of armed conflict between militant groups and government forces. Most of the surgeries in Hangu are performed on victims of violence, including people wounded by bullets, mortars, and knives.

On May 18, MSF also opened a 30-bed obstetric and gynecological hospital in nearby Peshawar, another area where pervasive violence limits access to health care, particularly for women. Pakistan has one of the highest rates of infant and maternal mortality in Central Asia. MSF’s hospital provides free, emergency OB-GYN care, including consultations, labor and delivery, surgery, and hospitalization.

BAHRAIN

The health care system in Bahrain has functioned effectively for many years, its performance boosted by well-trained professionals working in well-developed facilities. When demonstrations began in the tiny nation, however, and the state’s security apparatus started cracking down on protestors, those same health facilities became places to be feared.

Salmaniya Hospital in the capital of Manama, the country’s only public referral hospital, was occupied by the military in March. MSF also received reports that the military attacked health centers in other villages, shot tear gas into clinics, beat patients and staff, and shot at ambulances.

“Health facilities are used as bait to identify and arrest those who dare seek treatment,” said Latifa Ayada, MSF medical coordinator. “Wounds, especially those inflicted by distinctive police and military gunfire, are used to identify people for arrest, and the denial of medical care is being used by Bahraini authorities to deter people from protesting.”

Furthermore, MSF staff member Saeed Mahdi was arrested in May and held for more than a month, until he was finally released.

MSF visited patients who feared seeking treatment and made several public statements and released a report—”Health Services Paralyzed: Bahrain’s Military Crackdown on Patients”—calling on Bahrain to respect humanitarian space and the neutrality of hospitals, and to allow wounded people access to medical assistance, regardless of their religious sect or political beliefs.

SOUTH SUDAN

MSF has been responding to frequent outbursts of violence in South Sudan. This comes in the aftermath of last January’s overwhelming vote for independence and the subsequent struggle to define borders and claim territory, particularly in the oil-rich region around Abyei town.

Fighting broke out in the area on May 20, driving tens of thousands of people from their homes. MSF was forced
to suspend all primary activities in Abyei and instead set up mobile teams along the roads to provide the displaced with medical assistance, food, and relief items like plastic sheeting, mosquito nets, and shelter. And an MSF hospital in Agok, 24 miles south of Abyei town, treated 50 victims of the violence in the days that followed.

“We have seen thousands of people—mainly women and children—carrying bags on their heads, or sitting on mats on the side of the road, exhausted by hours of walking,” said MSF head of mission Raphael Gorgeu. “We are very concerned about the harsh conditions the displaced population has to endure on the roads.”

LIBYA

The conflict in Libya has forced MSF to adapt and interrupt its work in the country on several occasions. On March 15, teams were forced to withdraw from the eastern city of Benghazi, where staff had been delivering supplies and performing surgeries in three city hospitals. MSF then returned to Benghazi on March 24.

Blocked from entering the besieged city of Misrata, MSF first sent surgical kits to Libya’s third-largest city. After staging two boat evacuations of patients, MSF finally entered Misrata on April 18, providing surgical expertise and trauma training in a number of Misrata hospitals.

Teams also worked along the western border with Tunisia, providing medical care and psychological counseling to people displaced by conflict. Additionally, MSF began working in Zintan, southwest of Tripoli, on April 30, assisting the local emergency unit with large influxes of war-wounded patients. Shelling in the city—some of it very near the hospital where MSF was working—forced a temporary suspension of activities. But a smaller, scaled-down team returned to the city just days later.

Refugees and asylum seekers fleeing the conflict have also reached the Italian island of Lampedusa. MSF has been providing medical aid, psychological counseling and basic supplies since February, and has issued several calls for the Italian government, and other European nations, to take responsibility for the people fleeing the war, since those same nations support the NATO actions in Libya that are driving people out in the first place.
MALNUTRITION IN NIGER: A NEW TREATMENT MODEL SHOWS GREAT PROMISE

In Niger, the stretch from June to October is known as the “lean season,” a time during which the country faces recurrent and often severe food and nutritional crises.

In 2010, the crisis was particularly intense. By April, roughly half the country’s population was in a moderate or severe food security situation. Two months later, Nigerien officials estimated that one of every six children was, or would soon be, suffering from acute malnutrition. Among children between the ages of six months and two years, the ratio was one out of four. In MSF’s feeding programs in the country, up to 85 percent of children admitted for severe acute malnutrition were under two years of age.

A HISTORIC RESPONSE

In response, Nigerien officials, the United Nations, and local and international NGOs implemented a historic crisis response plan. More than 300,000 children suffering from severe acute malnutrition were enrolled in therapeutic feeding programs. Food distributions intended to prevent malnutrition were given to another 675,000 young children—almost one-third Niger’s infant population.

MSF, along with Nigerien partners Forum Sante Niger (FORSANI) and ALIMA/BEFEN (Bien-être de la Femme et de l’Enfant au Niger), treated 150,000 of the 300,000 children enrolled in therapeutic feeding programs with ready-to-use therapeutic foods (RUTF), a peanut-based paste that provides 100 percent of the energy and nutrients a severely malnourished child needs to recover. In addition, MSF and partners provided another 150,000 at-risk children with ready-to-use supplementary food (RUSF).

RUSF is also peanut-based and contains the milk and micronutrients necessary for the development of a growing child. Unlike RUTF, however, RUSF is designed to be supplemental, to complement breast milk and family foods a child is already getting. Its precise formulation, therefore, is adjusted depending on the age, diet, and location of those receiving it. The RUSF used by MSF in Niger was developed according to the typical needs of a young child growing up in the Sahel.

FIGHTING MALNUTRITION EFFECTIVELY

Malnutrition results from inadequate quantities of food and from unbalanced diets lacking in essential nutrients. It can stunt growth and weaken immune systems to the point that diseases such as diarrhea or malaria can be fatal. According to UNICEF, 195 million children suffer from malnutrition globally. Worldwide, it factors into more than 30 percent of the eight million annual deaths of children under five years of age—one third of which occur in west and central Africa.

And yet the most-widely used forms of food aid—a porridge made of fortified blended flours—are considered by most experts to be unsuitable for young children or children with moderate malnutrition. They do not deliver enough essential micronutrients and do not have the animal or milk protein essential for their growth.

Ready-to-use products have several advantages when it comes to treating malnutrition on a large-scale in a resource-poor environment. They are simple to use, require no preparation, and can be distributed in a way that allows mothers to take several weeks worth of supplies with them, rather than having to return frequently to a fixed-point clinic. They are also easy to store, and they can be produced in the countries and regions where they are used.

STUDYING THE RESULTS

During the 2010 nutrition crisis in Niger, Epicentre, MSF’s epidemiology unit, conducted monthly surveys among a cohort of several thousand young children in zones in which MSF and its partners were distributing RUTF and RUSF. Preliminary findings showed that mortality rates were 50 percent lower among those who received supplemental food and who received basic health care.

This confirmed for MSF the importance of nutritional supplementation in programs aimed at reducing infant mortality in the Sahel and in countries where malnutrition is endemic. Interventions designed to combat and prevent malnutrition have to address immune-weakening nutrient deficiencies and protect children from the diseases that can kill them.

“Providing young children with high quality nutritious foods has long been one of the foundational principles of successful malnutrition and child mortality reduction programs,” said Dr. Susan Shepherd, MSF child nutrition advisor. “We can save children’s lives today if the
appropriate resources are put behind similar interventions to those we deployed last year in Niger.”

**END THE “DOUBLE-STANDARD”**

Over the past several years, a scientific consensus has emerged on the importance of providing suitable food for growing children in countries where malnutrition’s toll is highest. A new generation of nutritional foods tailored to the needs of the most vulnerable children makes possible the establishment of a new standard.

In 2010, the World Health Organization began establishing guidelines for supplementary food formulations. Aid agencies such as UNICEF and the World Food Program have begun similar initiatives and are including quality, age-appropriate food supplements in their programs for young children. Some main donors, USAID and ECHO in particular, have recently provided financial support.

Despite the encouraging advances, however, international food aid continues to be largely comprised of enriched flours that contain no milk and are thus ill-suited to the needs of young children. This has to change, because, as MSF’s experience in Niger last year shows, a concentrated effort to provide suitable, effective food aid can quite literally be the difference between life and death.

To learn more, and to see documentaries on the topic of malnutrition by some of the world’s top photojournalists, go to starvedforattention.org

From top left: A child is measured for malnutrition; A mother receives supplemental food for her children; A child with ready-to-eat therapeutic food.
Niger 2010 © Yann Libessart/MSF
MY LIFE WITH HIV

Siama Musine lives and works in the Nairobi slum of Kibera. She is living with HIV and has been on antiretrovirals (ARVs) for six years. In 2005, MSF gave her and five other Kenyan HIV patients disposable cameras so they could document their lives. The resulting photo project, “My Life with HIV,” can be seen on doctorswithoutborders.org.

This past June, MSF checked back with Musine and the others to see how they’ve proven it possible to live an active life, with HIV, once treatment has been initiated.

“All photos: © Sven Torfinn

“People really want to know exactly how I’m living, what I’m doing,” Siama says. “I’m a community role model. It has made me to be more proactive and to be more assertive on how I am expressing myself. It has really changed me.”
Siama holds a photo taken before she began ARV treatment. “Sometimes if I talk to people about my status, and they look at me, they are just like, ‘Siama, you are lying to us. You look very healthy. You just look very beautiful.’”

She plans to soon move to a place she has built outside Nairobi, where she will keep goats. “When I was ill … my mother, she really didn’t want me to be part of the family. But nowadays we work together.”

Currently, she works as a health promotion assistant in a medical facility, providing support to people who test positive for HIV. “I remember when I was tested, the counselor who was there just told me to prepare myself for death. At that time, there was no education.”

When she can, Musine goes swimming to build strength and be with other people.
In early June, world leaders and global health officials gathered at the United Nations for a summit meeting on HIV/AIDS. Among the outcomes was a new treatment target, a plan to get 15 million people living with HIV/AIDS on antiretroviral (ARV) treatment by the year 2015. It’s currently estimated that 6.6 million people are on ARVs today. Doctors Without Borders/Médecins Sans Frontières (MSF) was one of several organizations calling—through advocacy efforts, through public communications, and through reports based on first-hand experience treating HIV in the developing world—for a massive scale-up of treatment. In that regard, the “15 by ’15” pledge was welcome news. But it is just one step in a much larger effort, one of numerous measures MSF believes necessary to ensure that funding for the effort is in place, that effective medicines are available to those who need them, and that the global health community adopts medical guidelines that give the greatest number of people the best possible chance at longer healthy lives.

The necessity, and the potential impact, of a massive scale-up has become even clearer with new research from the National Institute of Health showing that treating HIV/AIDS reduces by 96 percent the risk of sexual transmission of HIV—which is to say, treatment is prevention. That means scaling up treatment will benefit individuals and limit the number of new infections. “This opens up a whole new world where we not only treat the individual with ARVs, but we can aim to reduce new infections at the community level, too,” says Dr. Isabelle Andrieux-Meyer, HIV advisor to MSF’s Access Campaign.

LESSONS LEARNED

MSF began providing ARVs for HIV/AIDS in 2000 in Thailand, and the following year in Cameroon, Cambodia, South Africa and elsewhere. Today, MSF provides ARVs to more than 170,000 people in 19 countries. From the outset, the results were dramatic. “I remember when I first started treating people with antiretrovirals in Mozambique,” recalls Dr. Gilles Van Cutsem of MSF’s South Africa office. “People were so ill and weak as a result of their illness that they sometimes weighed no more than a few kilos and were often carried into the clinics by their grandmothers. But one year later, after starting ART, those same people were just walking into clinic to ask for their pills themselves. It was amazing.”

Chronic disease treatment is not a static process, however. Improvements can and must be made, new policies sought, new initiatives pursued. Based on its experience, MSF
has identified a host of measures crucial to continued and sustained progress against the disease. They include:

**Treat earlier:** Most people in developing countries are not started on treatment until their CD4 cell count, an indicator of immune system strength, drops to or below 200 cells per cubic millimeter of blood. By then, many are ill and at risk of opportunistic infection. MSF supports new World Health Organization guidelines that recommend starting treatment when CD4 levels drop to 350. Data from MSF’s programs in Lesotho showed that people who started between CD4 200 and 350 were 68 percent less likely to die, 63 percent less likely to need hospitalization, and 39 percent less likely to drop out of care, compared to people who began at CD4 200 or lower. (In the US, for reference’s sake, treatment starts when CD4 counts hit 500.)

**Better drugs:** In developing countries, the most commonly used first-line drug regimen contains stavudine (d4T), which can cause intolerable side effects. The WHO now recommends safer drugs such as zidovudine (AZT) or tenofovir (TDF), which MSF is moving towards using in all of its projects, and which has proven cost effective because there aren’t the same number of side effects to treat. Better drugs are also easier to take; fixed-dose combinations reduce the number of pills patients need, simplifying treatment and enabling better adherence.

**Prevent transmission to infants:** In wealthy countries, mother-to-child transmission (PMTCT) of HIV is below two percent. But in nations that lack the same services and protocols, PMTCT causes a significant portion of new infections. To lower the numbers, donors must support countries trying to institute HIV services alongside antenatal and maternity care, creating effective drug regimens for pregnant women. “We know how to stop the vast majority of babies from acquiring the HIV virus,” says Dr. Marianne Gale, an MSF pediatrician. “These babies don’t need to get infected.”

**Decentralize services:** Moving care from hospitals to health centers and community health posts—closer to patients’ homes—allows MSF to reach more people. “That way [we] reach all those people who normally wouldn’t get treated because they couldn’t afford the transport to a health clinic or couldn’t afford the time away from home and work,” says Dr. Marcella Tomassi from MSF’s program in Swaziland.

**Support community-based dispensing:** Enlisting patients to assist each other has also shown benefits. In Tete, Mozambique, for instance, members of patient-led “community ARV groups” take turns picking up and distributing medicines, decreasing traffic at understaffed health centers and significantly increasing adherence rates.

**Treat HIV and TB:** This is crucial given the high rates of often fatal co-infection in many countries. By integrating HIV and tuberculosis services in Khayelitsha, South Africa, MSF increased proper diagnoses of TB and halved the time it takes to get HIV and TB co-infected people on ART. In MSF’s program in Shiselweni, Swaziland, TB detection almost doubled after HIV/TB services were integrated.

**Shift tasks:** The WHO recommends “task shifting” to overcome health care worker shortages and bring treatment closer to patients. In many MSF programs, nurses and clinical workers start patients on treatment and lay counselors provide testing and adherence counseling. Reviews of programs in Malawi, Lesotho, and South Africa showed no decrease in the quality of medical care.

**Greater needs, dwindling support:** Having grown out of an international effort to fund HIV treatment, two bodies—the Global Fund to Fight AIDS, Tuberculosis and Malaria,
and the US Government-led President’s Emergency Plan for AIDS Relief (PEPFAR)—provide treatment to 81 percent of people now on ARVs. But for the first time in a decade, overall funding for HIV decreased in 2009. The Global Fund faces a shortfall of several billion dollars, while PEPFAR, facing its own funding reductions, is hinting at reducing support for some programs and handing over others to health systems that aren’t ready to administer them. Some countries with high HIV burdens are being forced to scale back treatment ambitions.

In Malawi, for instance, where MSF has worked for more than a decade and 63 percent of those in need have been started on ARVs, the government’s plans to further expand and decentralize treatment will be delayed due to funding gaps. Zimbabwe’s plan to implement new WHO guidelines is also being delayed. In Uganda, where 300,000 people badly need to be started on treatment, spotty funding has meant that only pregnant women can start treatment at the earlier CD4 threshold. And in the Democratic Republic of Congo, where only 17 percent of those who need ARVs get them and only two percent of pregnant women receive PMTCT services, the treatment initiation rate fell 18 percent in 2010.

The inescapable truth is that if treatment is delayed, denied, or not started, lives are lost. “If there is reduced funding, it will mean more people will die and we will have more orphans,” said Catherine Mango, a woman living with HIV in Kenya. Donor governments must therefore reaffirm prior commitments to support access to HIV prevention, care, and treatment. Developing country governments must respect commitments such as the Abuja Declaration on allocating at least 15 percent of GDP to health. Innovative funding mechanisms should also be explored and promoted; a proposed financial transaction tax, for example, could lead to millions in revenue with a miniscule levy on international bankers’ transactions.

On the research and development side, more affordable medicines will help get more people on treatment. Competition among generic manufacturers helped reduce prices dramatically and, according to PEPFAR, helped reduce costs by more than $300 million over four years. It must not be restricted through intellectual property measures and overly stringent free trade agreements. And pharmaceutical companies can keep costs down by joining the Medicines Patent Pool, which asks patent holders to make patents available to generic companies in exchange for a royalty payment—allowing for easier production of needed three-in-one fixed-dose combination pills.

THE NEXT DECADE: A CLEAR MISSION

HIV/AIDS has claimed more than 25 million lives over the past 30 years. We must meet the challenges presented by a global treatment scale up and we must fiercely reject any double standard in care—and the complacency that would allow us not to do more.

In the decade ahead, aggressive research and innovation is needed to develop more effective treatment strategies and simpler and better medicines and tools. With funding, dedication, and political will, it is possible to provide better drugs at lower prices; to develop drugs specifically suited for children with HIV/AIDS; to design more effective delivery mechanisms, such as long acting formulations that could be administered weekly or monthly; to develop simpler tests to measure CD4 levels or diagnose TB; and to take other steps to insure more people get the chance Luis Junior Mariquele of Mozambique got when he started treatment. “Antiretroviral drugs have changed my life from negative to positive,” he said recently. “Without these drugs I would not be on this planet.”
WORK WITH MSF:
Between July and September 2011, MSF will hold recruitment information sessions in the following cities:

Anchorage, AK; Los Angeles, CA; New York, NY; Portland, OR; San Francisco, CA; Seattle, WA; Washington, DC

All prospective medical and non-medical aid workers are welcome to join us for a presentation and question and answer session to learn more about MSF’s field work. A human resources officer will discuss requirements and the recruitment process and an experienced MSF aid worker from the area will share stories of life in the field. Check doctorswithoutborders.org/events/public for more information and to register. Or please participate in one of our regularly scheduled recruitment webinars.

Please note that there is an urgent need for operating room staff and for French-speaking applicants to work in countries such as the Democratic Republic of Congo, Chad, Niger, and Haiti, where some of MSF’s largest projects are located.

STARVED FOR ATTENTION ACTION KITS

Last year, MSF and VII Photo launched “Starved for Attention,” a multimedia campaign that exposes the grave crisis of childhood malnutrition. The exhibition has since been staged in cities across three continents, and now you, too, can be a part of the effort to rewrite the story of this largely invisible disease.

An estimated 195 million children worldwide suffer from the effects of malnutrition, with 90 percent of them living in sub-Saharan Africa and South Asia. In fact, malnutrition contributes to at least one-third of the eight million annual deaths of children under five years of age.

Order a free, specially designed, two-disc Action Kit to create your own event. You can screen documentaries and images collected by some of the world’s top photojournalists, inspire your community to join the effort, and collect signatures for the petition calling for better quality food aid that will be presented to world leaders at the G8 meeting later this year.

Check our website for details about this fall’s Starved for Attention special exhibition. And order your free action kit at starvedforattention.org/action-kits.php. The kit includes a DVD of the documentaries, background materials, outreach materials, fact sheets, and a copy of the petition.

GIFT ANNUITY RATES FOR AGES 75+ HAVE GONE UP!

MSF’s charitable gift annuities make it easy to provide for our future as well as your own. When you set up a gift annuity for at least $5,000 with MSF, you will receive fixed payments for life and an immediate income tax deduction. We follow the ACGA suggested rates.

For more information, including a personalized illustration of how a gift annuity can work for you, please contact: Beth Golden, Planned Giving Officer, at (212) 655-3771 or plannedgiving@newyork.msf.org.

STRENGTHEN YOUR COMMITMENT

MSF would like to thank all of our donors who have pledged to our Multiyear Initiative. With their annual commitments of $5,000 or more, these generous supporters provide MSF with predictable and sustainable funds, enabling us to respond effectively and rapidly to emergencies around the world and helping us to better plan for the future.

To date, we have received pledges totaling over $23 million towards the Initiative. To find out how you can participate, please contact: Mary Sexton, Director of Major Gifts, at (212) 655-3781 or mary.sexton@newyork.msf.org.

You can also learn more by visiting us online at doctorswithoutborders.org/donate/multiyear.
A mother and child rest in the pediatric ward of MSF’s hospital in the Bicentenaire area of Port-au-Prince. Active in Haiti since 1991, MSF has opened five hospitals, including this one, and fought a widespread cholera epidemic in the country since a massive earthquake struck in January 2010.

More than 3,000 staff are providing orthopedic surgery and post-operative treatment to earthquake survivors and emergency obstetric and neonatal care to mothers and children, among other services.

The cholera epidemic continues—after a mid-May spike in cases in Port-au-Prince and elsewhere in the country, MSF reopened cholera treatment units in several areas to relieve the pressure on existing facilities.