RESPONDING TO MALNUTRITION IN SOUTHERN ETHIOPIA
HUMANITARIAN ACTION

Dear Friends,

When Doctors Without Borders/Médecins Sans Frontières (MSF) speaks out publicly, it is always based on what our medical teams have witnessed first-hand. Our actions alone can never be enough to redress the injustices, atrocities, or neglect that bring patients to our clinics. But there are times when we believe our experience and medical perspective can help move others to rethink or scale up their activities to better assist the most vulnerable people in a crisis.

That is why we co-hosted an international symposium on nutrition with Columbia University in New York in September of this year. We brought together almost 400 nutrition experts, policy makers, representatives of leading UN and aid agencies, and community leaders from around the world. We asked: given recent advances in our understanding and treatment of childhood malnutrition, what can we do now for the 20 million children around the world suffering from malnutrition in its severest forms? And can we prevent children reaching this life-threatening condition to begin with—a condition that we see too often in our hospitals and clinics?

As a medical humanitarian organization, our concern is always for those most at risk. In addition to conflict-related emergencies, malnutrition primarily affects infants and young children struggling to survive in malnutrition “hotspots” around the world where it is a chronic, ongoing, and seasonal problem. This is what we are seeing in Ethiopia today, where our teams are treating tens of thousands of malnourished children in centers throughout the south of the country.

The symposium revealed a growing and encouraging consensus to put infants and young children first. If children receive the right balance of nutrients between the ages of 6 months and 2 years, they can avoid severe malnutrition and the long-term consequences of chronic malnutrition, which include stunting and poor educational development. To receive those nutrients, they must have animal-source foods, such as milk or eggs, in their diets. We must stop the current practice of sending substandard food aid to people in crises and send instead foods that meet the nutritional requirements of the youngest children.

When our medical teams encountered the pandemic of HIV/AIDS in our clinics, we successfully challenged the complacency that said it was impossible to treat people with HIV/AIDS in developing countries. Today we are challenging a different kind of complacency, one that has allowed too many young children to suffer—or die—from what is a treatable and preventable disease.

Thank you for your continued support. It is thanks to you that we at MSF are able to continue to bring medical care to tens of thousands of malnourished children, and to speak out on their behalf.

Sincerely,
Nicolas de Torrenté, PhD
Executive Director, Doctors Without Borders/Médecins Sans Frontières (MSF)
EMERGENCY DESK: SOUTHERN ETHIOPIA

MSF Responds to Severe Malnutrition

In May, Doctors Without Borders/Médecins Sans Frontières (MSF) emergency teams found extremely high numbers of children under age five who were severely malnourished in southern Ethiopia. By May 13, MSF had begun an emergency nutritional intervention that continued to grow along with the increasing numbers of patients.

Four months later, MSF was operating about 60 nutrition centers for patients with severe, life-threatening malnutrition—several centers with the capacity to treat those also suffering from additional, complicating factors such as malaria or pneumonia. And teams were expanding operations to include outpatient feeding sites for moderately malnourished children and their families.

As of late September, MSF had treated 28,000 severely malnourished and 21,000 moderately malnourished patients. The nutrition situation in some areas had started to stabilize, meaning the numbers of malnourished patients admitted into feeding programs had plateaued or had begun to decline. But that wasn’t the case everywhere. In Tunto town, in the Southern Nations and Nationalities People’s (SNNP) region, the MSF team was still having days when 2,000 hungry people were lining up outside the clinic doors.

A YEAR HARDER THAN USUAL

Ethiopia is no stranger to malnutrition; millions of people here receive food aid routinely, when it is accessible. But, a combination of economic and agricultural factors has made this year’s levels of under-nourishment reach rare heights. This can be seen throughout the Oromiya and SNNP regions where MSF nutrition centers have distributed 3,000 tons of food to 40,000 malnourished children and their families.

Zamane, a mother in the SNNP region who came to the MSF clinic in Tunto, watched her child die only two days before. She was there to try to get her surviving two-year-old into the nutrition program.

“My husband is a farmer,” says Zamane. “He grows maize and ginger. Maize is for the family; ginger is to sell. With the income of ginger sales, we normally can buy some additional maize from the market. But this year, the price of ginger is very low and at

Left: People line up at an MSF nutrition center in Tunto, Southern Nations and Nationalities People’s region. Ethiopia 2008 © Anne Yeeber/MSF
Right: In Shashemene, MSF staff treats a child for malnourishment. Ethiopia 2008 © Elena Torta/MSF
the same time, the price of maize has risen and has become too expensive. It has become difficult to buy maize to feed the family."

The rates of severely malnourished children reached approximately 11 percent and even 15 percent of all children under age five in some areas of the SNNP region; nutrition interventions should be started when the rate reaches 3 percent. An unusually large number of older children and adults are also being admitted to the program, another sign that the nutritional situation this year was more serious than previous years. Forty-year-old Twados, a farmer, came to the MSF center in Tunto after becoming severely malnourished and unable to help provide for his six children. He was admitted to the outpatient program where he received therapeutic food three times a day and was given food rations to share with his family.

"Without these rations, I'd have nothing to eat," Twados said. "Before, we could buy food at the market, but the prices have risen too much. Two times I received 50 kilograms (110 pounds) of food aid from the government, but you know, it's not enough for a family as big as mine. I hope that with the help of God, future harvests will be better and my life will improve."

"JUST THE TIP OF THE ICEBERG"

Every morning this summer, MSF staff in southern Ethiopia found long lines of people, sometimes up to 2,000, waiting outside the clinics. When the rains came, people stood grimly outside, many barefoot and shivering, some having come from distant regions where there is little if any aid. MSF medical staff performed "rapid screenings" with a MUAC, a medical tool that measures the circumference of the patient's mid-upper arm and indicates whether he or she is malnourished or in danger of malnutrition.

"The patients in MSF's care are just the tip of the iceberg," said Rosa Crestani, MSF emergency coordinator in southern Ethiopia. Other aid organizations are also in the region, working to meet the huge needs that still exist. "But many others are suffering. They have exhausted their food stocks, and right now they depend totally on food aid brought in from elsewhere."

At the start of this intervention, MSF's strategy was to treat only the most severely malnourished. These patients are given therapeutic, nutrient-rich, ready-to-use food until they are stabilized. But preventative measures also are necessary to have any impact on peoples' health and prevent moderately malnourished people from getting worse. In mid-July, MSF began setting up outpatient feeding centers for moderately malnourished children and their families, where they receive biweekly food rations of blended fortified flours and cooking oil. This is not the optimum product, but it was the only option available. In Siraro district, a comprehensive approach that includes therapeutic feeding and targeted food distributions had a measurable impact: over four weeks in July and August, the number of patients in MSF's programs decreased from 1,251 to 971.

While things seem to be improving in many places where MSF has been treating malnourished patients, the situation varies widely from area to area due to variations in climate and rainfall; and food costs remain prohibitively high. MSF teams continue to work in southern Ethiopia and are adapting their activities according to people's needs.

SOURCE: OCHA

EMERGENCY DESK – SOUTHERN ETHIOPIA
EMERGENCY DESK – HAITI

MSF Assists People Hit by Successive Storms

Between August 16 and September 1, Haiti was ravaged by Tropical Storm Fay, Hurricane Gustav, Tropical Storm Hanna, and Hurricane Ike. On September 4, a Doctors Without Borders/Médecins Sans Frontières (MSF) emergency team of medical staff, logisticians, and water and sanitation experts began arriving in the northwestern city of Gonaïves, which had been particularly hard-hit.

“It’s a mess—it’s not a town any more, it’s really a mess,” said Max Cosci, head of MSF’s emergency response. Areas of Gonaïves and other parts of the country remained inaccessible long after the initial flooding. As the storms and rains continued, flood waters forced people to live on the roofs of buildings with no access to food, clean water, or sanitation. Others locked to an estimated 150 overcrowded shelters and often lacked basic needs there, as well.

When the first MSF team arrived, health centers in Gonaïves were not functioning, and the team began cleaning out Raborateau Health Center, where MSF worked in 2004 after Tropical Storm Jeanne. Even before they found a place to work, however, the needs were obvious. “While we were looking for a suitable place, people started coming to us with their friends and family who had been injured in the storm,” Cosci said. “They were opening the doors of the ambulance and just putting in people with fractured limbs and open wounds.”

The following day, the MSF team performed 110 consultations, treated 49 injured people, and carried out 16 surgical procedures. When MSF medical staff had treated the majority of the wounded patients, they began to see people with conditions related to the dirty water that flooded large parts of the town, such as skin diseases, respiratory infections, and diarrhea.

As soon as they received water sanitation equipment, MSF staff established several clean water points in Gonaïves, and by late September they were providing 350,000 liters of water per day to approximately 150,000 people or half the city’s population. Staff filled water bladders and trucked them into areas without access to clean water, though the logistics of getting into some of the storm-affected areas were extremely challenging.

MSF also began holding mobile clinics, conducting consultations at the crowded and often unhygienic shelters. “One of the big problems is that there are no lavatories; they’ve been washed away,” said Cosci. “We cannot dig latrines because the ground is too waterlogged. We can only dig latrines in the small part of town that’s dry, but people will not cross the entire town to go to the toilet.”

As of late September, there were about 116 MSF staff in Gonaïves, and medical teams had performed more than 2,300 consultations through the Raborateau Health Center and mobile clinics. In cooperation with the Ministry of Health, MSF opened a referral hospital in Gonaïves for the treatment of more severe cases. Although the floodwater had receded, medical staff were concerned about what the future would hold. “We are starting to see things that really worry us, like bloody diarrhea,” Cosci said, “which could be the first sign of an epidemic in town.” MSF was also monitoring food security, which was already precarious before the storms, and treated some cases of malnutrition.

During exploratory assessments in areas outside of Gonaïves, MSF on September 30 reached Mamont, a town in the Arbonite region with a population of 17,000 who had been completely isolated for four weeks since the storms. The town was partially submerged, its roads cut off from major towns, and the residents were without clean water, food or medical care. MSF began providing emergency assistance in Mamont and called for other organizations to assist as well. On October 13, MSF denounced the ineffective response of international aid agencies in the areas of shelter and nutritional assistance. In the preceding days, some 10,000 people in Gonaïves were forced onto the rooftops of their flooded homes when authorities closed IDP shelters.

MSF staff hold a mobile clinic in Gonaïves. Haiti 2008 © Francois Servan-Schreiber/MSF
HUMANITARIAN ACTION

Famine and Ideology

"Famine we see on our TV screens from time to time is all the more intolerable because it seems a vestige of a long-ago age. But this is far from the case. During the 20th century famine caused as many deaths as did conflicts between nations. How many of us, indeed, are aware that one famine in Ukraine and the Northern Caucasus alone killed as many peasants as all the combatants killed during World War I?"

—From the chapter “Famine and Ideology” in From Ethiopia to Chechnya: Reflections on Humanitarian Action, 1988-1999, by François Jean

Doctors Without Borders/Médecins Sans Frontières (MSF) recently published From Ethiopia to Chechnya: Reflections on Humanitarian Action, 1988-1999, a collection of essays by François Jean (1956-1999) translated by Richard Swanson. Jean contributed enormously in the field and at headquarters to the evolution and direction of MSF for nearly two decades. After joining MSF in 1982 to establish medical and surgical projects in war-torn Lebanon, he went on to oversee emergency medical interventions in a variety of countries, including Chad, Pakistan, Sudan, and Chechnya. Throughout his time with MSF, Jean wrote prolifically about the difficulties and challenges faced by humanitarian aid workers in a shifting political landscape.

An MSF field worker examines the bodies of famine victims in 1985. Ethiopia 1985 © MSF

Learn more about François Jean; read From Ethiopia to Chechnya: Reflections on Humanitarian Action, 1988-1999 online; and order the book at doctorswithoutborders.org/alert
SITUATION REPORT – YEMEN

Dangerous Migration: Somali and Ethiopian Refugees Risk Everything to Leave

Every year, thousands of Somalis and Ethiopians risk their lives crossing the Gulf of Aden to Yemen. Hoping to escape the conflict and extreme poverty in their own countries, these desperate passengers are regularly abused and sometimes killed by the brutal smugglers they pay to get them across.

Boats made to hold a maximum of 30 to 40 people are crammed with 100 to 120 people, sometimes more. To keep passengers from moving, smugglers beat them with sticks, belt buckles, or knives. “We have a lot of patients with very deep cuts, sometimes on the head, sometimes on the arms,” says Doctors Without Borders/Médecins Sans Frontières (MSF) head of mission in Yemen, Alfonso Verdú. To avoid detection, when they get close to the Yemen shore, the smugglers often force the passengers to jump out of the boat into deep water, whether they can swim or not.

“They pointed at us with their weapons and forced us to jump,” says a 23-year-old Somali man who survived the violent journey that ended with at least 29 people dead on September 9 this year. “We were 120 people, overcrowded. The trip took two days. We did not receive food or water. Some of us were placed in the hull. Several people died because of asphyxia; some others were thrown overboard, among them two children. In order to intimidate us, they beat us heavily with their belts. One of the smugglers threw petrol on us and showed off his lighter.”

MSF has been working on the southern shore of Yemen since September 2007 to provide medical, psychological, and humanitarian assistance to these migrants, refugees, and asylum seekers. A network of people in the

“In order to intimidate us, they beat us heavily with their belts. One of the smugglers threw petrol on us and showed off his lighter.”

Refugees and migrants from Somalia and Ethiopia arrived onshore in Yemen last year. Yemen 2007 © MSF
communities along the 170-mile coast alert MSF when the boats arrive. Mobile teams are then sent to the coast to provide emergency medical and psychosocial assistance, food and water, and kits with clothing and toiletries. MSF has provided assistance to over 3,800 people so far this year.

AN ACT OF DESPERATION

Yemen has long been a country of origin, destination, and transit for refugees and migrants because of its proximity to the Horn of Africa and the wealthy Gulf states. Yemen itself, however, is the poorest country in the Arabian Peninsula and is struggling with deep poverty, unemployment, rapid population growth, and dwindling water resources. MSF provides medical care to people in the north of the country, which is gripped by fighting between government troops and the Houthis and the rebel movement.

Lacking safe and legal alternatives to leave their countries, refugees and migrants must use smugglers to cross the Gulf of Aden. Despite the known dangers of the trip, the numbers of those risking their lives to get to Yemen is increasing as more people flee the escalation of the conflict in Somalia and the drought affecting the Horn of Africa. During the first six months of 2008, more than 20,000 people arrived by sea in Yemen, more than double the number for the same period last year, and more than 1,000 people died or were missing, according to the UN High Commissioner for Refugees (UNHCR). The actual number of casualties is likely higher, as many bodies lost at sea are never found.

“We were expecting a massive arrival of refugees and migrants—the 2008 figures are double those of 2007. But it is clearly not only the numbers that are increasing: the violence has tripled since the beginning of September.”

This year, several boats arrived with passengers who had not been beaten, which gave Verdú’s team some hope. But that changed when MSF teams witnessed the 29 dead bodies washed up on the beach at Wadi Al-Barak in September. Survivors of the journey said 10 more people had died during the trip. “The horrific cases of 2007 are being repeated again,” says Verdú. “People have been through terrible things. One woman lost her three young children. A young Ethiopian witnessed his 70-year-old father being thrown into the sea at night and only recovered his dead body the next morning,” she says. “We were expecting a massive arrival of refugees and migrants. The 2008 figures are double those of 2007. But it is clearly not only the numbers that are increasing: the violence has tripled since the beginning of September.”

HELPING NEW ARRIVALS

In April, MSF opened a medical facility in a new UNHCR reception center in the coastal town of Alwar. Migrants stay at the reception center for a few days to recuperate from their journey. MSF gives them basic medical and psychological assistance, and they are registered by UNHCR before being taken to the Kharaz Refugee Camp.

About two-thirds of arrivals are Somalis; one-third Ethiopians. Yemen has been welcoming to Somalis, recognizing them as prima facie refugees, which means they don’t have to make a case for why they fled their troubled home country. Ethiopians that survive the crossing, however, face more challenges: they are considered illegal and are subject to deportation without regard to asylum claims.

MSF is urging the international community to do more to protect the migrants, refugees, and asylum seekers who arrive in Yemen and to provide more support. “To date, the humanitarian response has been inadequate,” Verdú says. “More international assistance is urgently needed and donor countries should commit themselves politically and financially.”
A total of 56 dead bodies washed up onshore on December 12 last year. Only about 50 people survived that crossing, which started out with an estimated 150 passengers. Yemen, 2007 © MSF

An MSF staff member administers first aid to a Somali refugee who landed on the shores of Yemen. Yemen, 2007 © MSF
FIELD JOURNAL – EASTERN CHAD

Treating Women and Girls with Fistulas

In 2007 a group of 11 women suffering from vesico-vaginal (VVF) fistulas approached MSF nurse Esther Moring and her medical team in eastern Chad, asking for treatment. At that time, Moring’s team was focused on performing war surgery, and the only MSF fistula project in Chad was in Bongor three days’ drive to the other side of the country. The sole Chadian surgeon treating fistula was located in the capital, N’Djamena, and limited funds meant he could perform no more than one repair per month, with a year-long waiting list.

In order to help those women and countless others with fistulas in eastern Chad, Moring and an MSF team initiated a pilot fistula surgery program based in the town of Abéché, near the border with Darfur, Sudan.

In January 2008, the program began admitting patients, including Sudanese refugees and Chadian women displaced by the ongoing Darfur conflict. These women are living in some of the most vulnerable conditions with little, if any, access to medical care.

Here, Moring describes what fistulas are and why starting this project was so important.

In Abéché, a woman undergoes surgery for fistula. Chad 2008 © Claude Mahoudeau/MSF

SURVIVAL IS ONLY THE BEGINNING

VVF is an abnormal opening between the vagina and bladder or the vagina and rectum, through which urine or feces leak continually. It’s usually a consequence of prolonged, obstructed labor where the baby cannot exit the womb, either because it’s in the wrong position or because the head of the baby is simply too big to pass through the mother’s pelvis. Usually, a woman develops a fistula trying for many hours, or days, to push the baby out, and the condition frequently occurs among young and adolescent girls because the girl’s body is too young and small to deliver the baby.

In the developed world, women experiencing these complications will have a C-section before it gets to the point where a fistula could occur. But in sub-Saharan Africa, usually, the baby will die during labor, before the
birth, and the mother will often die from complications such as sepsis or hemorrhage relating to a ruptured uterus, a life-threatening tear in the womb, due to the obstructed and prolonged labor. If the mother survives the prolonged labor, she is very likely to have a fistula from the relentless pressure of the baby's head during labor. It is thought that for every woman with such a fistula birth injury, up to eight others will have died during obstructed labor.

In addition to incontinence, there are other serious health issues that come with fistula, including neurological problems that make it difficult to walk, skin ulcerations caused by the continual leaking, renal infections, and major psycho-social problems stemming from the reactions of people around her to the smell caused by continual incontinence. Surviving means, in addition to the physical pain and burden of fistula, the woman will have an extremely hard life, as she will often be shunned by her own society and rejected by her husband. She may be completely isolated and have to beg for food. She will be unable to carry out normal activities such as going to the market, weddings or the mosque or church with other women.

**PREVENTION OF FISTULA**

Fistulas are preventable, but it requires skilled and trained birth attendants to follow pregnancies and detect problems early on and emergency obstetric care such as a C-section when necessary. Many women in sub-Saharan Africa have little or no access to such services. Births are traditionally at home with untrained people, and even when health care is available nearby, social mores can take precedence over the health of the mother.

Often the traditional birth attendant, or member of the family or community responsible for helping to deliver the baby, either doesn't think of going to a hospital or doesn't have the resources to pay for the ride there. In some parts of the region, custom requires a male elder to approve surgery, and medical professionals can meet with strong resistance, even when a woman is experiencing intense pain and suffering and even when her life is in danger.

A large number of those who die from obstructed labor or who survive with fistulas are between the ages of 10 and 18 and are of small stature. They might have been made to marry and become pregnant quite young, and because their bodies have not fully developed, they cannot deliver the baby. These are the women and girls who are at risk of such complications, and huge numbers of them die.

As the fistula program in Abéché grows, it will have a focus on prevention through training and outreach to traditional birth attendants and local community and religious leaders as well as concentrate on training Chadian health care staff in fistula prevention and management.

**BEYOND THE OPERATION**

Treating women with fistulas involves much more than an operation. When women arrive for treatment, they can be in very bad shape anemic, malnourished, and psychologically traumatized. It may take weeks in a hospital for them to get healthy enough to undergo fistula repair.

Post-operative recovery takes about three weeks, and close, meticulous care is very important because if the first attempt at repair does not work, subsequent attempts are much harder.

Recovery presents new challenges for the patient, both physical and otherwise. She must relearn how to control her bladder; and she also must find a way to reintegrate into society, return to her community and explain what happened to her, as well as develop a way to be self-sufficient. This could mean learning how to read and write, or learning a handicraft some way to earn an income. The program plans to help patients recover in this way, as well.

After a woman leaves the facility, strict precautions must be taken in order for her to fully recover. She should not get pregnant for six months, and MSF provides contraception for that time period. But if she does become pregnant, she absolutely must have a C-section in a hospital. Otherwise, a new obstruction during labor could be fatal, or it could end in more serious tears. It is difficult for staff to monitor a woman's progress after she leaves the facility, and the insecurity of eastern Chad makes it that much more difficult. So MSF is working with Chadian health care partners on finding new ways to do this.

**PATIENT STORY: ZENEA**

Zeneba married very young, which is common in this part of the world, and became pregnant when she was barely 15 years old. Her delivery was overseen by a traditional midwife; it lasted five days and the child was stillborn. She came to MSF's fistula repair hospital in Abéché to receive help.

"I had never been to a health center before giving birth," she said. "The hospital was very far away, and it was certainly very expensive. My husband wouldn't have wanted to go there."
CAMPAIGN FOR ACCESS TO ESSENTIAL MEDICINES

Taking the Plunge: Pooling Patents Could Help Get Urgently Needed New Medicines

A patent-sharing scheme that helped the United States build planes during World War II now could help drug manufacturers create new, urgently needed medicines.

When legal wrangling between patent holders of various aircraft components looked like it would permanently ground US planes by bringing manufacturing to a halt, just as the United States was preparing to enter the war, Congress pushed through the creation of a patent pool. The pool worked by placing all aircraft patents under the control of a new association, and manufacturers licensed the patents for a fee, which was paid to the original patent holders. The United States got its planes. Now UNITAID®, the international drug purchase facility, is taking up the same concept as a way to break down barriers to medical innovation and deliver the treatments that MSF patients and others in developing countries urgently need.

One example of how a patent pool for medicines could make a huge difference is in treating children living with HIV. Ann, a 15-year-old MSF patient in Thailand, tells her story:

“I was 10 years old when I started taking antiretrovirals (ARVs). I weighed just 11 kilograms (39 pounds). I had to take medication for TB and HIV at the same time. There were so many pills around 18 tablets a day that it was almost impossible to swallow them all. I was so sick I couldn’t move, I couldn’t eat, and my lips were stuck together. My mother used to sit with me for ages, getting me to swallow the pills one by one with glasses of water. Fortunately, I need to swallow far fewer pills now, but I still don’t like it. If I could talk to someone who makes the medicine I would ask if it could be just one tablet, twice a day.”

Since she first started taking ARVs, part of Ann’s wish has come true: there is now one pill for children that combines

Above: A child living with HIV prepares her drug regime in Prachinburi province.
Thailand 2004 © Joanna Wong / MSF
three anti-AIDS drugs in one tablet in a fixed-dose combination, which is used by many MSF projects. But children living with HIV have different needs and require different formulations, and this single option is not a solution. The vast majority of HIV-infected children are still left without proper treatment. Instead, their caregivers have to split up adult tablets or grind them into powder to try to roughly approximate a child’s dosage of ARVs clearly a risky business.

The problem is that making fixed-dose combination ARVs for children has not been a priority for most pharmaceutical companies. They make their money in industrialized countries where there are barely any children living with HIV anymore so there’s no market argument to develop the products. As well, to come up with a pill combining two or three component drugs, a manufacturer would have to negotiate with all the separate patent holders a potentially horrendously lengthy legal process even if the parties were willing to negotiate.

So that’s why the simplicity of the UNITAID proposal has been causing some excitement in the public health community. This is how it works: under a voluntary agreement, the holders of individual drug patents put their patents into a ‘pool.’ Then, the administrators of the pool license the use of the patents to any interested producers on payment of a royalty, which goes back to the original patent holder. There’s still work to be done on the terms of the licenses for instance, where the products can be sold and which diseases can be treated but since the negotiations with patent holders, license-issuing, and royalty payments are all carried out under one roof, the hope is that this streamlined process will encourage multiple drug developers to take the plunge.

Another advantage will be the reduction in the cost of medicines, as Ellen t’Hoen, director of policy and advocacy at MSF’s Campaign for Access to Essential Medicines, explains:

“Today, when you’re faced with a patent in a country, as a generic producer you have to wait 20 years until the patent term runs out. With a patent pool you can speed that up because as soon as the patent is in the pool, the generic company can go to the pool, pay the royalties, and develop a generic version of the product so you will get competition much earlier, and competition is the single most important force that drives drug prices down.”

The benefits of this scheme aren’t restricted to helping develop new medicines for children. It could also generate affordable, newer fixed-dose combination drugs for adults who need them. At the moment, the prices of new drugs are just too high. For instance, MSF pays between $613 and $1,022 for the newer World Health Organization (WHO)-recommended regimen for first-line AIDS treatment—a 7-to-12 fold increase compared to older first-line treatments, which are now available for $87 per patient per year.

But if the patents for these new drugs were put into the patent pool, the situation could be transformed as generic and other manufacturers come forward to develop new products. That’s why many donors and public health experts are behind the idea of the patent pool; they recognize that long-term treatment for HIV/AIDS cannot be supplied without major changes in the way we access medicines.

As a voluntary initiative, the buy-in from pharmaceutical companies is critical. So far, reaction from the industry has been cautiously positive. The main body, the International Federation of Pharmaceutical Manufacturers and Associations, has called the idea "very interesting," and individual companies have also said they would be willing to consider licensing patents to the pool depending on the nature of the licensing terms.

t’Hoen is optimistic about the future of the patent pool. She says it’s also very important that generic drug producing companies come forward to show their support for the idea. If it takes off, she says, the pool could bring huge benefits to both MSF patients and millions of other people in developing countries in need of new and affordable treatments.

“I think if the UNITAID patent pool succeeds, the effects could be really phenomenal, both in the area of access, namely bringing prices down, and in the area of developing desperately needed combinations and pediatric formulations. But success will depend on everybody collaborating.”

Find out more about the work of MSF’s Access Campaign at mfasaccess.org; and go to doctorswithoutborders.org/alert to find out more about UNITAID and the patent pool initiative.
MSF TREATS MALNUTRITION IN SOUTHERN ETHIOPIA
See video showing MSF operations inside a nutritional center in the Oromiya region of southern Ethiopia, where MSF began responding to a malnutrition crisis in May.

NO CHOICE: SOMALI AND ETHIOPIAN REFUGEES, ASYLUM-SEEKERS, AND MIGRANTS CROSSING THE GULF OF ADEN
Read an in-depth report featuring testimonies taken from survivors of the illegal crossing and information from the MSF staff who have assisted them.

A REFUGEE CAMP IN THE HEART OF THE CITY
This Fall, MSF brings its traveling refugee camp exhibit to eight cities in Canada and California. The tour will wrap up in San Diego on November 9, but will live on online. Visit the Tour Blog, featuring video of the tours and interviews with visitors and special guests in each city, as well as written entries from MSF field workers.

ON THE MEDICAL FRONT
"Assessing Antimalarial Efficacy in a Time of Change to Artemisinin-Based Combination Therapies: The Role of Médecins Sans Frontières," a recent article published in the journal PLoS Medicine, discusses MSF's role in conducting much-needed research studies on the effectiveness of newer drugs to treat malaria. It also addresses the subsequent effect of these field data on influencing national policy changes to artemisinin-based combination therapy (ACT) drugs. This article and others published in medical and scientific journals are archived on our MSF Field Research site.

PODCASTS
MSF at the International AIDS Conference, September 2008
In this special MSF Frontline Report, listen to stories from the 17th International AIDS Conference in Mexico. This August, MSF presented medical data from its HIV/AIDS projects around the world and discussed challenges to providing the best care. You'll hear about two key issues: the shortage of health workers in sub-Saharan Africa that is helping to keep the 70 percent of people living with HIV from receiving the care they desperately need; and the challenges to treating children with HIV.

SLIDESHOW
Refugees and Migrants Risk Their Lives to Cross the Gulf of Aden to Yemen
Thousands of people risk their lives every year crossing the Gulf of Aden to escape from conflict, violence, drought and poverty. During 2007, almost 30,000 took the dangerous voyage to seek relative safety in Yemen. These photos show people who arrived on the southern Yemen coast in 2007 and MSF providing assistance to them. This year's peak time for smugglers crossing the Gulf of Aden began in September and continues into October, due to climate and water conditions.
UPCOMING EVENTS & FUNDRAISING NEWS

MSF FEATURED IN “BATTLE IN SEATTLE” FILM
The film “Battle in Seattle”, which opened in theaters in September, dramatizes MSF’s advocacy effort at the World Trade Organization’s (WTO) 1999 ministerial meeting in Seattle. While recounting the protests at the WTO meeting, it also describes the actions of Dr. Bernard Pécoul, then director of MSF’s Campaign for Access to Essential Medicines, who urged the WTO to prioritize public health when regulating trade of essential medicines for diseases such as HIV/AIDS, malaria, and sleeping sickness. The cast includes Charlize Theron, Woody Harrelson, and Ray Liotta. More information is at battleinseattlemovie.com.

IN 2008 DOCTORS WITHOUT BORDERS MEDICAL TEAMS RESPONDED TO AN UNPRECEDENTED NUMBER OF CRISIS
This past year has been an extraordinary year for emergency response, and our medical teams plan to continue to respond where the humanitarian needs are greatest in 2009 and beyond. Natural disasters, food crises, and the long-term needs of our patients with HIV/AIDS and other diseases are not going to go away overnight, and we need your support more than ever to continue to deliver lifesaving emergency care.

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 $18,716,625 towards the initiative. To find out how you can pledge a gift over a three- to five-year period of time, please contact Mary Sexton, director of major gifts, at (212) 655-3781.

Rade Sherbedgia, left, plays Dr. Mario, a character based on Dr. Bernard Pécoul, former director of MSF’s Campaign for Access to Essential Medicines. Barbara Tyson, right, plays Anna in the film “Battle in Seattle”.

MSF recognizes these are extraordinary economic times. As a strong supporter of MSF’s work, please renew your giving so that we can enter 2009 knowing that the organization can continue our lifesaving work, responding immediately and effectively where people need us the most.
In August, MSF presented medical data from its HIV/AIDS treatment programs around the world at the 17th International AIDS Conference (IAC) in Mexico City. MSF experts and staff hosted press conferences and panel discussions on the challenges of treating children with AIDS and the potential benefits of a patent pool for medicines proposed by UNITAID. MSF also led “Mind the Gaps,” a special session on the critical shortage of health care workers in sub-Saharan Africa. Speakers gave presentations on how an exodus of health workers is affecting people living with HIV and the health care system.

“It is devastating to stand by and watch people growing sicker—and sometimes dying—as they wait weeks and even months before being treated simply because there are not enough health care workers,” said Dr. Mit Philips of MSF. Near the end of the IAC, health workers and organizations, including MSF, initiated a spirited rally to express the need for more health professionals in these countries.

You can watch the rally and view medical presentations, research papers, interviews with MSF staff, and photos on MSF’s Mexico 2008 IAC mini-website, at doctorswithoutborders.org/mexicoaidsconference2008/. 

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