MILLIONS OF HIV/AIDS PATIENTS AT A CROSSROAD - Advances in Treatment Under Siege
HUMANITARIAN SPACE

Dear Friends,

HIV/AIDS was considered a high-profile emergency a decade ago, when MSF helped to establish some of the first AIDS programs in Africa. In many quarters, complacency has set in. But in the developing world, HIV/AIDS is an increasingly threatening emergency. As our lead story in this issue of Alert shows, shortages of appropriate drugs and diagnostics are now joined by new challenges. Funds for programs have dried up under the impact of a global recession, even though much-needed newer drugs are priced beyond the reach of most people.

Some of MSF’s HIV and AIDS patients are beginning to build resistance and fail on treatments, and clinicians have few, if any, options to offer them. The result could amount to a death sentence for many people in the countries where MSF works. If these patients lived in North America, they could expect to live decades longer given the diversity of drug regimens available. Little recognition of this emergency in the international community makes it even more important that MSF continue to be able to treat patients who we told years ago: “Take these drugs. They’ll save your life.”

There are many high-profile emergencies in the media right now, but the health care situation in Somalia is not one of them. Nearly two decades of conflict and violence have wreaked the national health system, driven out many of the country’s health workers, and displaced more than one million people. MSF is one of the few international organizations working to fill the health services vacuum, despite the enormous security-related challenges this involves.

In this issue of Alert you will learn about a hospital in the southern town of Jamaame, where dedicated Somali MSF staff run the day-to-day operations and a small number of international medical personnel based in Nairobi venture in as the security situation allows.

One new way you can help MSF continue to respond to these and other emergencies is by participating in an interactive campaign called “Be There First”. Read more on the back cover about this opportunity to support MSF while getting an inside look at the challenges facing those on the front line of an emergency response.

Sincerely,

Sophie Delatay
Executive Director
Doctors Without Borders/Médecins Sans Frontières (MSF)
EPICENTER

HIV/AIDS PROGRESS UNDER SIEGE

With a dire need for newer medications, a shortfall in funding and no increases on the horizon, the AIDS emergency in the developing world is far from over. Doctors Without Borders/Médecins Sans Frontières (MSF) spoke out at the International AIDS Society Conference held in July in Cape Town, South Africa, to push for urgent action.

TWO KINDS OF TREATMENT

"I'm so worried now because I don't know what is going to happen to me," says Thembisa Mchosa, a mother of two who lives in Khayelitsha, on the outskirts of Cape Town, South Africa.

Thembisa discovered she was HIV-positive in 2001 and began receiving life-extending antiretroviral drugs (ARVs) through MSF's clinic two years later. She responded well to treatment and was able to return to work and take care of her children. After showing signs of drug resistance, Thembisa was switched to a second set of ARVs. Again, she developed resistance. She now needs a third combination of ARVs to keep her alive, but the price of newer drugs puts them beyond her reach.

"If there's no such thing that can help me, I know that I'm going to die," she says. "And then who is going to look after my children?"

In the Khayelitsha clinic—one of MSF's longest-running HIV/AIDS programs—nearly one in five patients needs to switch to newer medications within five years of starting treatment. Of those who switch, one in four develops resistance again two years later.

This happens to people living with HIV/AIDS everywhere, not only in South Africa. But a third drug combination that could keep Thembisa alive is available only to those who can afford the treatment. The result is two kinds of treatment for HIV/AIDS: one for those living in wealthy countries, and one for those in the developing world.

In the US and other wealthy countries, HIV/AIDS now resembles a chronic condition, and patients generally have access to an increasing variety of medications when they develop
resistance to their current drug combination. In the US, Thembisa could live to around 70 years old. In Africa, where the majority of people with HIV/AIDS are, those in Thembisa’s position are likely to face a much earlier death.

ACCESS TO NEW DRUGS IS IMPERATIVE

“What we are seeing in Khayelitsha is what we will soon see throughout Africa if there is not a focused push for urgent change,” says Dr. Eric Goemuere, medical coordinator for MSF in South Africa.

In addition to having a lack of alternative drug regimens, the one ARV regimen that is affordable in most poor countries contains a drug that can cause serious side effects and is rarely used in wealthy countries. But unlike the first generation of HIV/AIDS drugs, prices for newer drugs are kept high up to 30 times the price of first-generation drugs by medicine patents that prevent the production of more affordable generic versions.

Some pharmaceutical companies are trying to stifle competition in generic drug production, for example, by challenging certain provisions of some national patent laws. In August this year, Swiss company Novartis launched a new legal challenge to eliminate a key public health safeguard in India’s patent law that currently opens the way for access to more affordable generic drugs.

Section 3(d) of India’s Patents Act, 1970, prohibits ‘evergreening’—the practice by pharmaceutical companies of making trivial changes to existing medicines in order to extend the period of their patent, thereby stifling the generics market and keeping drug prices high. Novartis’s challenge seeks to limit the effectiveness of section 3(d).

India has been a major source for generic drugs, and a main provider to MSF’s HIV/AIDS programs around the world.

HIV/AIDS TREATMENT AT A CROSSROAD

MSF was one of the first organizations to provide treatment for HIV/AIDS in the developing world, starting with projects in Thailand and South Africa in 2000. Today, MSF treats 140,000 people living with HIV in more than 30 countries. This has been possible in large part because MSF helped drive down the cost of first-generation ARVs, which are now available in generic versions.

New challenges to treatment in these countries are threatening hard-won and

COST TO TREAT AN HIV/AIDS PATIENT

First-line AIDS treatment for one year
10 years ago: $10,000
Today: $80

Reason: Medicines were not patented in countries including Brazil and India, allowing for affordable generic versions to be manufactured. Political pressure mobilized around access to medicines supported this dramatic reduction in cost.

Problem: Now, international trade rules have led to the patenting of many essential medicines in these countries. Less expensive, generic versions of newer HIV drugs will not be available at affordable prices for many years.

Result: People living with HIV/AIDS in developing countries have less access to the most effective drugs and to medication they need after they develop resistance to their initial regimen. Health and lives are at risk due to high costs.

One Solution:
Patent pools.
future progress—HIV/AIDS treatment is at a crossroad. And, not unlike 10 years ago, when many people said treating AIDS in Africa was impossible, there has been little action by the international community to meet these emerging challenges. This is why MSF has spoken out at the International AIDS Society Conference and elsewhere and continues to press funding bodies, donor countries, and others to act.

"Seeing a patient you have been treating since 2003, and now this patient is failing on her second combination, you feel you are a failure," says MSF nurse Mpumzi Mantangana. "We are feeling like our hands are tied. There is nothing we can say to Thembisa because it's she who needs answers from us."

THE NEED FOR POLITICAL WILL DURING AN ECONOMIC CRISIS

Four million people in developing countries receive ARVs, and at least six million more are in immediate need of treatment, but are not receiving it, according to UNAIDS. Extending HIV/AIDS treatment to everyone in need and offering them effective treatment with alternative drug regimens will require much more investment and political will. However, the international HIV/AIDS effort has been compromised by the reaction of world leaders to the economic crisis.

HIV/AIDS funding is stagnating and the prospect of universal access to treatment may be withering. This is evident through the developing world's two main funding sources for HIV/AIDS. The Global Fund to Fight AIDS, Tuberculosis and Malaria and the US President's Emergency Plan for AIDS Relief (PEPFAR) report, respectively, a $3 billion shortfall and no increase in funding.

In response to these dramatic political and economic changes, countries ravaged by HIV/AIDS are scaling back their ambitions: Tanzania reports significant budget cuts; some health care providers in Uganda say they do not intend to start new patients on treatment; and Botswana says it will stop enrolling new patients by 2016. This trend is likely to continue unless the international community reaffirms its commitment to universal access for effective HIV/AIDS treatment.

"It's a question of choice for national and donor governments," says Dr. Tido von Schoen-Angerer, director of MSF's Campaign for Access to Essential Medicines. "Will they give poor people just a few extra years of life or is the same chance for long-term survival as people with HIV/AIDS in rich countries?"

HOW A PATENT POOL WORKS

The international drug purchase facility UNITAID is working to create a patent pool for HIV/AIDS medicines. This mechanism would make it possible to access needed medicines more quickly and at more affordable prices.

Everyone wins: patients get access to affordable and effective drugs and the original producers are compensated.

HELP MSF PUSH FOR A PATENT POOL

Go to doctorswithoutborders.org to find out how you can write to the CEOs of the following pharmaceutical companies and ask them to put their patents in UNITAID's patent pool:

- GlaxoSmithKline
- Bristol-Myers Squibb
- Merck & Co.
- Gilead Sciences
- Boehringer Ingelheim
- Tibotec
- Abbott Laboratories
- Pfizer
- Sequoia Pharmaceuticals
FIELD JOURNAL

KENYA: PREVENTING MOTHER-TO-CHILD HIV TRANSMISSION

Nurse Colette Kerr returned to the United States in July after eight months with Doctors Without Borders/Médecins Sans Frontières (MSF) in Busia, a rural district in western Kenya, where MSF runs an HIV/AIDS project. Kerr oversaw the prevention of mother-to-child transmission (PMTCT) program for pregnant women and new mothers. MSF offers PMTCT interventions in over 30 projects, with 8,700 HIV-positive pregnant women having received preventive treatment and 8,800 babies having received post-exposure treatment in 2008.

Treatment providers continue to struggle to prevent newborn infections amid complex protocols and high numbers of patients who do not return for follow-up treatment. Despite the challenges, PMTCT programs such as MSF’s dramatically increase a child’s chances of being HIV-free and deliver essential support to HIV-positive mothers. Here, Kerr describes her experience in Busia.

When new patients come to the clinic for antenatal care, each receives a handful of tests—for malaria, for malnutrition—and then we ask, “Do you want to be tested for HIV?” Before testing, we explain that we can give medicine to help them live a long time with HIV and to prevent transmission to the baby. On hearing this, they almost always get tested. So we prick their fingers for a blood sample and wait 15 minutes. If two red lines appear on a patient’s test strip, she is HIV-positive.

The virus can be transmitted from an HIV-positive woman to her fetus or infant at three stages: during pregnancy, through the placenta; during delivery, when the baby comes into contact with the mother’s blood; or during breastfeeding. In the US and Europe, transmission rates are generally below two percent thanks to the widespread availability of antenatal care and HIV screening. Plus, antiretroviral drugs (ARVs) and infant feeding formula are easily accessible. In much of Africa, however, most women simply do not have access to these measures.

BRINGING CARE CLOSER TO PATIENTS

The people waiting at the clinic, like many others in Busia, earn their living by fishing, farming, or bartering. They have little income for transportation or health care. Without antenatal care, women miss the opportunity to be screened for HIV in a place where 15 to 20 percent of the population is living with the virus. If women don’t know their HIV status, they won’t receive ARVs, which can help
keep them healthy throughout their pregnancy and prevent them passing HIV to their babies.

MSF and the government have pursued a decentralized approach in order to make treatment adherence less of a hardship for the women. Since MSF began providing HIV/AIDS treatment at the Busia district hospital in 2003, the program has branched out to 10 rural health centers and into home-based care. Tiny, two-room government clinics in remote places provide PMTCT without electricity, labs, or pharmacists. MSF provides support with drug supplies, the transport of samples to labs, and personnel. In MSF’s Busia program, transmission of the virus to a baby occurs in less than seven percent of cases. Without any intervention, about 20 percent of babies born to HIV-positive mothers will be infected at birth, and more will be infected later through breastfeeding.

FAMILY SUPPORT

During a pregnant woman’s initial visit, a local nurse and a nurse acting as a mentor answer the patient’s questions and provide support. In follow-up appointments we administer ARVs and demonstrate safe feeding practices. Counseling patients on how to disclose their status to partners and families is critical. If a woman fears that attending clinics and taking two pills a day will expose her as HIV-positive, which can carry harsh consequences, she might default. Some husbands reject wives who test positive, though few of these husbands get tested themselves.

I think of one patient whose first child had died, and she didn’t know why. When she came to the clinic during her second pregnancy and tested HIV-positive, she joined the PMTCT program. But she feared telling her husband and family. She kept it a secret. The second baby got sick right away and tested positive. It wasn’t until then, for the sake of the baby, that she told her husband. She had to explain why the baby needed weekly hospital visits. Even though transmission wasn’t prevented, early diagnosis meant that we were able to start treatment before the child’s immune system deteriorated, before he developed opportunistic diseases or, even worse, before he died by the age of two as happens to half of all children born HIV-positive. Her husband didn’t leave her, but it was tough. He did not get tested.

LASTING IMPACT

We give newborns antiretroviral syrup at birth and a follow-up dose within the first month to further reduce the risk of transmission. Ideally an HIV-positive mother does not breastfeed. But in Busia formula milk is not widely available, safe, or affordable and there is fear that abstaining from breastfeeding could expose a woman’s status. MSF encourages HIV-positive mothers to breastfeed exclusively for six months and then abruptly stop when beginning other types of feeding. Other kinds of food may damage the lining of the baby’s stomach and intestines, making it easier for HIV in breast milk to pass into the baby’s tissues.

To help confront some of the practical challenges and stigmas, MSF runs monthly peer support groups at the clinics. These meetings serve as a venue for patients to see that they aren’t alone and that PMTCT is feasible for women like themselves.

“When I organize the lab results from the babies born to our HIV-positive mothers, the positives crush me, but each negative result feels like a graduation party.”

I remember one woman who had nearly graduated from the program. She had been devastated to learn that she is HIV-positive. In the months that followed, she absorbed all the information she could; she was so devoted to the pregnancy. She had twins. One died at birth and the other weighed less than five pounds. She came to the clinic every week for check-ups and supplemental food to make sure she had good milk. The baby got sick a few times, but when I last saw him, at five months old, he was growing strong and healthy.

At seven months we run a test to confirm a baby’s status. If it is positive, we immediately enroll the child in the HIV/AIDS program and start administering drugs. If the baby is negative, we tell the mother that she doesn’t need to bring her baby anymore and we enroll her in the program.

When I organize the lab results from the babies born to our HIV-positive mothers, the positives crush me, but each negative result feels like a graduation party. I just think, the women’s hard work and sacrifices paid off. It’s the only reward I need. And in the end, the program counts for much more than good test results. The awareness-raising activities demystify HIV and help chip away at the stigma for the whole community. And mothers receive the tools they need to live positively, receive treatment, and provide the best care for their babies regardless of HIV status.
SITUATION REPORT

JAMAAME, SOMALIA: “THOSE PEOPLE HAVE NO OTHER PLACE TO GO”

Intense fighting among various armed groups claimed the lives of hundreds of civilians and displaced thousands more in Somalia in the first half of 2009. The gap between the country’s critical needs and the level of humanitarian response continues to widen, mainly due to aid agencies’ extremely limited capacity to deliver assistance in a highly insecure and volatile environment. In spite of a series of attacks, abductions and other security incidents, Doctors Without Borders/ Médecins Sans Frontières (MSF) manages to maintain a presence in half of Somalia’s 18 regions.

The town of Jamaame, in a remote area of southern Somalia’s Lower Juba region, is one area where MSF has been able to provide ongoing medical services. Starting as a temporary response to severe flooding in March 2007, the Jamaame project has evolved into a primary and secondary health-care program with a small hospital serving some 60,000 people from the town and surrounding areas, including the nearby city of Kismayo.

“It’s a relatively isolated area and that provides us some security,” says Javier Roldán, MSF’s Jamaame project coordinator based in Nairobi. “But it is still dangerous to work, with many different armed groups in the area and very few other aid workers. We can be quite vulnerable.”

As the largest health-care provider in the area and one of the few non-governmental organizations in Lower Juba, MSF serves outpatients and inpatients who travel great distances to receive treatment. Priorities include nutritional care for the region’s malnourished children and maternity care—an essential service given Somalia’s extremely high maternal mortality rates. During the first seven months of 2009, MSF saw some 30,000 outpatients for a variety of health issues and more than 600 children in the nutrition program. More than 1,100 inpatients were admitted to Jamaame hospital during this same period.

FLASH VISITS BY INTERNATIONAL STAFF

Unlike most MSF programs that are run by teams made up of both international and national staff, day-to-day operations in Jamaame fall to locally hired staff whose dedication endures despite considerable risks to their safety. Kidnappings and killings of foreign and local aid workers—including the killing of three MSF staff in Kismayo in 2008, and the kidnapping of two MSF staff in Bakoel in April of this year—have forced MSF international staff to support the project from a base in Nairobi and to make only short visits to the project when security allows.

“Neutrality and impartiality have been essential to our work in Somalia,” says Roldán. “We show through our principles that we don’t take any part in the politics of the country. This

MSF ACTIVITIES IN SOMALIA, SEPTEMBER 2009

Ongoing activities

MSF is the main provider of free medical services in all of central and southern Somalia. At the end of June, 1,407 Somali staff, supported by 94 international staff in Nairobi, were working to provide primary healthcare, treatment for malnutrition, health services and support to displaced people, surgery, water, and relief supplies in nine regions of the country.

Emergency response

In March, MSF vaccinated 26,463 children against measles in Belet Weyne. Early this year, MSF treated 869 people in Jilib and Marere in the Lower Juba region, and 61 north of Mogadishu, for cholera and responded with mobile medical clinics and water distribution when people were displaced by an outbreak of violence in the Guri El area.

For more information go to doctorswithoutborders.org
allows us to take a step further than some others."

"The most important thing is for the community to see what we’re doing and what we’re providing for them," says Benoit Leduc, operations manager for Somalia. "The respect we gain is our main form of security."

Basic services, from health care to education, have been lacking for nearly two decades in Somalia. Violence has surged in several parts of the country in recent years and huge numbers of people have been displaced. According to the United Nations, 200,000 have fled the capital, Mogadishu, in just the last few months; there are now more than 1.3 million internally displaced Somalis and 3.2 million in need of humanitarian assistance.

**VIOLENCE HAS DRAINED HEALTH SERVICES**

Health workers are among those who have fled the violence, and drugs and other medical supplies have dried up. One of the main challenges for MSF is to recruit doctors and nurses in the absence of a functioning educational system. "We call it a lost generation because a whole generation has not had access to basic things like education and have known nothing other than war," says Roldan.

There was a ray of hope this year with the graduation of 20 doctors from a university in Mogadishu—the first batch of new physicians in two decades. There is a desperate need for such skills throughout the country, and the Lower Juba region is no exception. MSF’s team in Jammame is fortunate to have found three qualified Somali doctors. The nearest hospital in the region is run by a nurse.

In Jammame, MSF has also trained community health staff to relieve doctors and nurses of some of their tasks. When and if security allows, MSF would like to improve obstetric care and increase epidemiological monitoring. For now, these plans are on hold. Still, Roldan says the locals appreciate what MSF provides: "The hospital is always full and these people have no other place to go."
PHOTO ESSAY

INSIDE JAMAAME HOSPITAL, SOMALIA

All photos by Javier Roldan

About 13,000 people live in the town of Jamaame, but its hospital, run by Doctors Without Borders/ Médecins Sans Frontières (MSF), attracted 30,000 outpatients, many from surrounding areas, during the first seven months of 2009. There are few health care options for Somalis and very few international organizations present. Before MSF arrived in Jamaame, the population relied on traditional healers and shops that sold drugs.

Malnutrition is widespread because food is scarce and what little exists is hard to obtain. MSF’s nutrition program at Jamaame served more than 600 children from January through July.

Here, three generations of Somalis wait in the women’s outpatient ward of the hospital. Those who grew up over the last two decades have known nothing but violence and war in their country.

See more photos from Jamaame at:
doctorswithoutborders.org/alert
Mother-and-child health care is a priority at Jamaame hospital. Somalia has one of the highest rates of maternal mortality in the world at 1,600 deaths per 100,000 live births, according to the United Nations.

Below: A woman holds a cup of oral rehydration solution, used to treat people suffering from diarrhea and other complications. Water is the source of many health problems because most people get their drinking water from the Juba River or from shallow wells.
**BOOK EXCERPT**

**SIX MONTHS IN SUDAN**

In his memoir, Six Months in Sudan: A Young Doctor in a War-Torn Village, physician James Maskalyk recounts his first Doctors Without Borders/Médecins Sans Frontières (MSF) assignment in Abyei, Sudan. He and his team provided emergency medical care to the local population in this oil-rich region, which at the time was contentiously disputed. The book began as a popular MSF blog called Suddenly...Sudan.

In this excerpt from Six Months in Sudan, which was recently published in the US, Dr. Maskalyk describes his first emergency call, received on his first morning in Abyei.

Paola and I pass the military compound. Inside, some soldiers are washing their camouflage uniforms. A goat has climbed to the top of a mound of rubble, and another circles him, waiting for his turn to be king. In the corner of the compound, facing the juncture of the road I’m on and the approach to the hospital, sits a howitzer. I duck underneath its barrel, which appears to be aimed towards the great nothingness that surrounds Abyei, and turn left onto the hospital’s driveway.

In it sit three cars. One of them, a white Land Cruiser, is ours. The other two are military green. A crowd is gathered at the small entrance.

Paola pushes past and I follow. Inside the hospital, people are milling, pushing, yelling, straining to see what they can of the action. A little girl sits on the ground between angles of legs, crying.

I don’t know the hospital yet. It seems huge. I don’t know where I am supposed to be. There’s Bev. Her eyes are wide, her thin frame tight with stress. She is hurrying towards me.

“What’s going on?” I ask.

“Bloody rollover. Military truck ran into a car, then turned on its side. Six soldiers in the back. They’re mostly just banged up, but one of ’em’s got a big gash on his arm. Sandrine is in the tent with a civilian who got run over. I’m
crowd control," she turns away.

I edge through a group of women, babies on their hips, and walk towards the tent. On my way, I glance into the tiny emergency room. It is filled with soldiers.

In the tent, a man is lying on a cholera bed, grimacing. Sandrine is bent over him, listening to his lungs.

"What’s up?"

“Oh, James. Sorry to get you, but there’s just too many people. Mohamed is in the emergency room with one of the others, and this guy, I don’t know. I think he got run over. I started an IV and I’m giving him a bolus. Pressure’s okay."

His shirt is off, but his pants are still on. Coarse tread marks march over his thighs.

"His lungs are good? What about his belly?" I ask.

"Seems okay."

I feel his abdomen. It is soft. I put one hand on each side of his pelvis and push down. He screams.

"He’s probably got a pelvis fracture. We should cut his pants off. You log-rolled him?"

"Not yet," Sandrine answers.

"Let’s do that. We should give him some morphine first."

We turn him on his side, one person holding his neck steady, two others pulling him over. I feel along his spine. As I get down lower, he shouts in pain.

"Maybe a lumbar fracture too," I say. "Seems to be moving his feet okay. That’s good."

"Transfer?" she asks.

"I don’t know. What do you think?"

"We can."

"Maybe it’s all from his pelvis, I don’t know. It feels stable, but if not, the guy needs to be in traction or have surgery. Is there an orthoped at that other hospital, whatever it’s called?"

"Heglig," Sandrine says. "I don’t think so."

"X-ray?"

"Yes."

"Well, it’s probably worth a transfer, then," I say.

"Okay. We’ll do it."

"Are you cool here, Sandrine? Should I go help Mohamed?"

"Yeah. That’s a good idea."

She leaves tomorrow. She is an infectious-disease specialist and has been here three months. Today she is on call. Yesterday we were both pulled in so many different directions, we had little chance to speak.

On a nearby veranda, two of the roller victims are lying on the ground, each attended to by soldiers in green fatigues. They are moving. I consider that a positive sign and walk past them to the emergency room.

It is full. I can barely squeeze myself inside. On each of the two beds lies a soldier. One of them has a clean piece of gauze on his head. I pull it aside. An abrasion. I turn to the other bed and see Mohamed holding a cloth firmly down on the upper arm of the second patient. He in the other doctor in the mission, recently graduated from a medical university in Khartoum. He is young, brown skinned, with a smile full of bright, white teeth.

"Mohamed, you okay?"

"Oh, James. How are you, man?" he says, grinning.

"He takes the cloth away, and blood starts shooting from a large gash in the patient’s upper arm in a thin, red stream.

"Okay, okay. Got it."

"I think it was the glass from the windshield," Mohamed says.

I feel the pulse in his wrist. It’s strong. "Hey, can you ask him to wiggle his fingers."

A flicker.

"Make a fist."

A bit.

"Thumbs up."

Nothing.

"Ask him if he can feel me touch his hand."

No.

"Radial nerve. His arm is fractured?"

"Seems so."

"Any other injuries?"

"No, I don’t think so," Mohamed replies.

"Well, I guess we’ll have to wash it out and sew it up. Splint it. I’ll look for the nerve, I guess. We have ketamine, right?"

"Yes."

"If you get me some, I’ll start. It’s going to take a long time."

It does. Over an hour. His arm is broken in half. Thin spicules of bone keep snagging my glove, ripping it. I can’t find the nerve, can’t see enough of the bone to trace its route. I am reluctant to cut any farther. Sweat drips down my forehead and into my eyes. My stomach cramps, and it makes me feel nauseated. I wash out the wound, cut away the black pieces of crushed tissue, sew his triceps together, then close the skin. Lastly, with Mohamed’s help, I put him in a long arm cast.


Go to doctorswithoutborders.org/alert to read
Suddenly… Sudan, the blog that preceded the book.
ON DOCTORSWITHOUTBORDERS.ORG

SOMALI REFUGEES IMPERILED IN KENYA
At doctorswithoutborders.org/alert, see a photo slideshow that shows how MSF is assisting Somali refugees in Dadaab, Kenya, where more than 270,000 displaced Somalis face alarming shortages of food, water, and shelter in severely overcrowded camps.

AIDS EMERGENCY IS FAR FROM OVER
Watch a video that looks inside MSF’s HIV/AIDS treatment program in Khayelitsha, South Africa, where patients are in dire need of alternative drug regimens but the costs of new drugs are prohibitively high.

ON THE MEDICAL FRONT
A study by MSF resulted in the World Health Organization adding a new combination drug therapy for sleeping sickness (human African trypanosomiasis) to its essential medicines list. The study, conducted in the Republic of Congo and the Democratic Republic of Congo, compared nitifurtinom-eflornithine combination therapy (NECT) with eflornithine only, a typical treatment for sleeping sickness. The results showed NECT to be as effective, safer, easier to administer, and more protective against drug resistance than a traditional single-drug treatment, according to research published in July in The Lancet. Sleeping sickness is a fatal parasitic disease affecting 70,000 people in sub-Saharan Africa.

PODCASTS
September: The new Frontline Reports format brings you emergency updates from MSF projects around the world as well as in-depth coverage of how we help boost nutrition during Burkina Faso’s hunger gap and our work in Nigeria to help women injured during childbirth to overcome physical and psychological problems.

August: Hear about the new challenges in treating HIV/AIDS in developing countries. And listen to a report from Ingushetia, where MSF offers mental health treatment to civilians living in a state of fear.

July: Hear how MSF’s program for victims of sexual violence has helped one 17-year-old in Guatemala, where a startling 10,000 cases are reported each year. Also listen to an interview with an MSF water and sanitation specialist returned from Bangladesh, where survivors continued to struggle two months after Cyclone Alla struck.

HELP REDESIGN ALERT - TAKE OUR ONLINE SURVEY
The Alert newsletter will be undergoing a redesign for 2010 and we want feedback from our readers on the substance, style, and impact of our stories, photos, and current design.

Please take a short, 10-question survey at doctorswithoutborder.org/alert. This is an anonymous survey on what you value the most and the least, and what you would change or add. Your participation will help make Alert a better source of information about MSF activities.
UPCOMING EVENTS & FUNDRAISING NEWS

WORK WITH MSF
Recruitment information sessions will be held in these cities between October and December 2009:
Burlington, VT; Atlanta, GA; Chicago, IL; Minneapolis, MN; Washington, DC; Seattle, WA; Denver, CO; New York, NY

All prospective medical and non-medical aid workers are invited to a presentation, film, and question-and-answer session to learn more about how to become part of MSF's field work. A human resources officer will be on hand to discuss requirements and the recruitment process. For dates and details, and to register for these events, go to doctorswithoutborders.org.

FOR OUR FUTURE AND YOURS
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. Minimum age when payments begin is 65. We follow the schedule of rates recommended by the American Council on Gift Annuities.

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.

BOOK RELEASE:
A NOT-SO NATURAL DISASTER
MSF is pleased to announce the publication of Niger 2005: A Not-So Natural Disaster, edited by Xavier Crombe and Jean-Hervé Jezequel and published by Hurst & Company, London. This book examines the malnutrition crisis that struck Niger during the "hunger gap" months of 2005, a period when MSF treated 60,000 malnourished children, from a variety of perspectives. Nutrition experts, academic researchers, and aid workers share their analysis of the historical, sociological, and political roots of the crisis and the implications for future aid responses. For more information on this book, go to doctorswithoutborders.org.

THE PHOTOGRAPHER
A photo exhibit based on the highly praised graphic novel The Photographer: Into War-Torn Afghanistan with Doctors Without Borders will be on display in November at the Freedom Tower in downtown Miami during the Miami Book Fair. Go to www.doctorswithoutborders.org/thephotographer.

DR. JAMES ORBINSKI TO GIVE PUBLIC READING
Former MSF International Council President Dr. James Orbinski, who accepted the Nobel Prize on the organization's behalf, will read from and discuss his recently published book, An Imperfect Offering: Humanitarian Action for the Twenty-First Century at Harvard Book Store in Cambridge, Massachusetts, on October 21. Dr. Orbinski's talk will be followed by an audience Q&A.

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 $20 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.
BE THERE FIRST WITH DOCTORS WITHOUT BORDERS

Doctors Without Borders/Médecins Sans Frontières (MSF) invites you to participate in an exciting online fundraising event like no other. The MSF 'Be There 1st' campaign is an interactive experience that simulates the work of our MSF Emergency Response Team. As the 'crisis' unfolds, you will receive personal updates from staff who have worked with MSF in the field, and weekly situation reports based on MSF's previous humanitarian interventions. At the end of the campaign you will walk away with a clear picture of how MSF quickly mobilizes the extensive human and medical resources necessary to mount an emergency response, and the challenges our staff and patients face during a crisis.

Visit BeThere1st.org to build or join a team and create your personal fundraising page. We will provide you with all of the online tools you need to recruit your fundraising team and ask your friends, family, colleagues, and extended community for support. As you work to raise funds for MSF, you will see how your donations are immediately put to work to assist the men, women, and children we treat.

Our ability to be there first depends on independent funding from donors like you. Your support for 'Be There 1st' will benefit our Emergency Relief Fund, which allows MSF to dispatch our teams at a moment's notice to medical humanitarian crises. Through your generosity, MSF will continue to respond more swiftly to emergencies and continue to improve the quality and effectiveness of the medical care we provide in more than 60 countries around the world.

It's easy to make a difference. Visit BeThere1st.org to join the campaign and the growing community of supporters who make it possible for MSF to be there first when an emergency strikes.