Dear Friends,

There are people for whom living through a war is unimaginable. There are also people who have lived through so much conflict that anything else, over time, becomes equally unfathomable.

With tragic consistency, conflict has been a part of, or perhaps defined, life in the eastern parts of the Democratic Republic of Congo, or DRC, for a generation. The stories emanating from the region—and particularly North Kivu and South Kivu provinces—flash through the headlines every now and then, but it’s curious to see how little coverage is granted to people who have been enduring so much for so long. Conflict and its aftermath have killed millions in DRC. A rotating cast of militias battle each other and the national army, driving hundreds of thousands of people into the bush again and again. Children don’t get vaccinated and can’t get care for treatable diseases that prove fatal if unattended. Women are raped in staggering numbers. And hope dissipates with every new episode of violence and cruelty.

In this issue of Alert, we re-visit our work in eastern DRC, portraying the events of the past six months and their consequences by highlighting excerpts of reports we’ve issued earlier, photographs of people and our work in the area, and interviews with people leading our projects.

The needs are clearly immense, especially given the frequent outbreaks of disease in the region, and we are doing what we can to bring medical care to those who require it.

We also want to look at some other places and policies that could use more attention. One is the Trans-Pacific Partnership, a multi-country trade agreement being negotiated now by the US with 11 other Pacific Rim countries. Some parties to the process are insisting on including highly restrictive intellectual property clauses that could drastically reduce access to the low-cost medicines MSF and many other international health organizations rely on. We explain the issues here and ask for your help in protecting access to medicines for those who need it most.

Additionally, we have reports from Bangladesh and a “manifesto” for people who are living with drug-resistant tuberculosis. Part of our mission involves shedding light on communities and places that are not getting the medical assistance they need; that’s what this issue of Alert is designed to do.

We’re grateful for your interest in these places and for your support of our work. Were it not for you, these people and their needs would remain out of sight.

Sincerely yours,

SOPHIE DELAUNAY
Executive Director, MSF-USA
One afternoon not long ago, MSF surgeon David Lauter, a native of Washington State, received a patient in the hospital where he’s now working in Rutshuru, in Democratic Republic of Congo’s long-troubled North Kivu province. The patient, he wrote in a recent blog entry, had been shot and “had two holes in his upper leg. His smaller hole was the size of a US quarter, coming in the back of the leg at the mid hamstring and his larger hole was the size of my fist, coming out in the front just above his knee a bit to the outside.”

Years ago, back home, he’d treated people who’d been shot with handguns, but this injury was clearly caused by a weapon of a different order—a military-style assault rifle that was bigger and capable of both firing bullets at much greater velocity and causing much more damage. “Compared to gunshot wounds at home,” he wrote, “the ones in Rutshuru come with bigger holes and more tissue destruction.” [See pages 8 and 9 for his full post.]

One wishes this type of injury were as uncommon in eastern DRC as it’s been in Lauter’s experience. Unfortunately, that is not the case. Horrific gunfire injuries happen all too frequently in North Kivu—one day last November, MSF’s project in Masisi received 22 gunshot victims in a single four-hour stretch—and in neighboring South Kivu, too, and they take a deadly toll. Still, the wounds they inflict are just one of several nightmarish hallmarks of fighting that has been so pervasive over the past two decades as to become, astonishingly, almost routine.
Though it often disappears from the headlines for long stretches of time, the crisis in eastern DRC ruthlessly persists. Taking advantage of a weak central government that’s been unable to establish rule of law and various influences from outside the country—including internal factions of M23 clashed with each other in Rutshuru. Though M23 features heavily in these recent events, it is one of many armed groups fighting in the region, some of which are becoming increasingly identified with one ethnic group or another.

Goffeau makes a point of noting that “the Congolese are incredibly resilient. They never resign. It’s a matter of survival.” At the same time, though, the cumulative impact of many years lived under the gun is evident, he says. “Children don’t go to school, soil is not cultivated, houses are abandoned, access to health care is reduced, exposure to violence is high. Long-term consequences on health, mental, education, and overall wellness are inevitable.”

**MSF’S PROGRAMS IN DRC**

The common trope about DRC is that it is an incredibly poor but resource-rich country, a place suffused with valuable minerals that is nonetheless severely lacking in roads, infrastructure, education, and opportunities that don’t involve picking up a gun. All this contributes to catastrophic health indicators around child and maternal mortality, particularly in the embattled Kivus.

Given the vast array of needs in the country—which go far beyond conflict to include endemic diseases and outbreaks, maternal care, and, often, basic primary and secondary care—MSF’s operations...
in DRC are its largest and most resource intensive anywhere in the world, and they have been for most of the past decade. In 2011, MSF had almost 3,000 people working in DRC. In 2012, in the Kivus alone, MSF worked along with the Ministry of Health in eleven different hospitals—offering services ranging from surgery to pediatrics to mental health care—and ran forty health centers, nine health posts, and four reference centers. Teams also run mobile clinics and respond to emergencies ranging from outbreaks of diseases like cholera or measles to the manifold medical needs that arise when large groups are forced to seek shelter in crowded, under-resourced, and at times dangerous displacement camps.

The rampant insecurity has affected MSF personnel. Staff have been robbed, projects looted, mobile clinics suspended or proscribed. Additionally, members of the national staff, who make up the vast majority of MSF’s workforce in the country at any given time, have at times been forced to flee with their families when their homes have come under threat. During the fierce battles that broke out in Kitchanga in late February, for instance, “it was simply impossible for our team to leave base as the intensity of the fighting would not allow anyone to move around and reach the hospitals,” says Hugues Robert, another MSF head of mission in eastern DRC. “One hospital was also damaged by a mortar shell. Most of the wounded were taken to two medical facilities and to the UN’s peacekeeping base by relatives.” National staff members had to flee as well, he notes, adding that many of them “wound up spontaneously providing medical care to the wounded” in the locations where they found temporary sanctuary.

It is, to state the obvious, an extremely complex and difficult environment in which to work, and it requires balancing an understanding of what’s needed on the ground, medically speaking, with an understanding of ever-evolving security dynamics that can change very rapidly. “There’s a constant tension among the population,” says Robert, reached on the phone when he was in Mweso in mid-April. “Last weekend, there were a lot of rumors going around, for example, so people started to question whether they should stay and protect family members or move them somewhere else, to a safe place. No one feels secure.”

**DECEMBER 19, 2012:**
**DISPLACED BY VIOLENCE, STALKED BY ILLNESS**

More than 100,000 people are living in extremely precarious conditions in the area around Goma. Since mid-November, clashes between the DRC’s armed forces (FARDC) and M23 rebels have resulted in a massive new wave of displacement...

As the rebels advanced on Goma, displaced persons who were already in the Kanyaruchinya camp after M23’s July attack on Rutshuru moved to the camps west of Goma, swelling their numbers...

**JANUARY 17, 2013:**
**HIGH LEVELS OF SEXUAL VIOLENCE IN GOMA CAMPS**

People displaced by armed conflict around Goma are now suffering high levels of sexual violence in and around the camps where they have taken shelter...

Between December 3, 2012, and January 5, 2013, the MSF team working in Mugunga III camp, a few kilometers west of Goma, registered and treated 95 patients who were victims of sexual violence, with a notable increase in late December...

**JANUARY 31, 2013:**
**65,000 CHILDREN VACCINATED AGAINST MEASLES IN SOUTH KIVU**

In the past month, MSF teams in the Bunyakiri region of South Kivu Province have vaccinated more than 65,000 children aged 6 months to 15 years against measles. The campaign had to be briefly suspended in the north of the region due to the volatile security situation in an area where several armed groups are present and fighting is frequent...
MANY DIALOGUES AT ONCE

The atmosphere makes it necessary for MSF to maintain constant communication between and among teams in different projects, as well as with the leaders of the various armed groups in the area. MSF labors intensively to explain its purpose and approach—particularly its independence and impartiality—to the various groups, asking that they respect the sanctity of medical facilities and permit teams to cross front lines when necessary. According to Renaud Sander, an MSF project coordinator for the Masisi territory, “it takes constant effort to get acceptance from all the armed groups. Our identity as MSF makes a difference, and time after time, we stayed and continued providing care during the fighting, which helped us earn respect from the different actors.”

Though it doesn’t provide absolute protection, this has proven crucial to MSF’s efforts in the Kivus, making it possible to accomplish a great deal under extremely trying circumstances. In 2012, for instance, MSF conducted more than 15,000 surgical interventions and admitted more than 70,000 patients across its dozens of hospitals, health posts, and mobile clinics. Teams also delivered more than 36,000 babies and vaccinated more than 2.5 million children for measles.

There’s no understating the difficulties the people of the Kivus face, but even amid the worsening violence of the past year, MSF is not cutting back its efforts. On the contrary, while continuing to monitor the dynamics between the armed groups and preparing for fighting that seems almost certain to occur in the future, MSF is conducting exploratory missions into parts of the Kivus in which it’s not currently working, trying to see if it can address even more of the needs that exist on the ground.

Addressing all the factors at play in this conflict—or rather, these conflicts—will take many years, if not generations, but that’s not MSF's goal in DRC (or anywhere). MSF’s efforts are designed to maintain that balance between what is possible and what can be done safely, and to offer care to people who otherwise would go without, treating the gunshot victims that David Lauter tended to in Rutshuru, assisting births, tending to children with malaria, and caring for victims of sexual violence, all in hopes that they will survive the troubles of the day and be present should better days come.

Crises in the Kivus
Among the cases toward the end of the afternoon were two men in their early 20s with gunshot wounds, one in the arm, the other in the leg. They had been seen at another smaller hospital where their wounds were bandaged and splinted, then transferred to Rutshuru for definitive care. Ideally we would have x-rayed the injured extremities immediately but the x-ray machine was down for the day so they came to the OR for debridement [the medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue] and wash-out of their wounds without x-rays.

It’s been awhile since I’ve treated someone with a gunshot wound, though I saw my share during residency on the trauma service. There’s a significant difference between wounds from a handgun and a military rifle. The speed of a bullet as it leaves the barrel of a typical 9mm handgun is 300 meters/second compared to 900 meters/second for a military rifle. The force behind the bullet is in direct proportion to the speed of the bullet squared. This means that if a bullet from a Kalashnikov rifle is traveling three times faster than a bullet from a Glock 9mm handgun, it carries nine times the impact. Compared to gunshot wounds at home, the ones in Rutshuru come with bigger holes and more tissue destruction. The protocol here for treating gunshot wounds is based on the recommendations of the International Committee of the Red Cross (ICRC). It involves two operations, the first being debridement of all infected and dead material, leaving the skin edges of the wounds open, thus avoiding secondary infections that threaten life and limb.

The man with the leg wound had two holes in his upper leg. His smaller hole was the size of a US quarter, coming in the back of the leg at the mid-hamstring and his larger hole was the size of my fist, coming out in the front just above his knee a bit to the outside. After induction of anesthesia, we removed his splint, pulled the compresses that had been packed into the wounds, and surveyed the damage. There was a large cavity with torn muscle and bone fragments between the two holes. Almost all the bleeding had stopped. I could feel an abnormally rough texture to his femur bone but his leg felt structurally stable. I was comfortable that the main artery in his leg, the superficial femoral artery, was intact because it travels around the other side of the femur away from the damaged area, plus I had felt a good pulse in his foot before we started.

Using a scalpel I cut the bruised, dead skin from around both wounds so that I could better see into the cavity. I removed fragments of cloth and bone and cut away fat and torn, bruised muscle until I was satisfied that anything that would act as a source for bacteria to grow in had been removed. I rinsed out the cavity with saline and Betadine, put a loose dressing on both sides so that any infection could wick out, and wrapped the wound. With the help of the nurses in the OR, we put his leg in a plaster splint to immobilize it until he can get an x-ray tomorrow.

The next patient clearly had an open fracture of the upper arm because even with the arm immobilized in a splint, it didn’t look quite anatomically correct. I felt a strong pulse at his wrist, indicating no major arterial damage. It was harder to be certain about the three major nerves [the median, ulnar, and radial nerves] that travel through the upper arm. There is a quick examination to see if they are working, but it can be difficult to rely on when your patient is in pain, has received narcotics, and you don’t share a common language. After induction of anesthesia and the removal of his splint and dressing I could see he had a two-inch diameter hole through his mid-upper arm. By pulling on his arm I could see straight through to the other side. Needless to say, the exposure of his cavity was good. His humerus was broken with the two ends staring at each other 180 degrees apart and a visible gap. Without an x-ray it was impossible to tell how much of the bone, if any, was missing. I debrided skin and fat, cut away pieces of bruised and non-viable muscle with attached bone fragments and washed out the wound. There weren’t that many bone fragments so either he hadn’t lost much bone [good], or a big chunk had already been blown out [bad], or I had done an inadequate debridement and left dead bone fragments [worse]. I looked in the cavity to see if I could identify the ends of a transected major nerve but didn’t see any. If I had
seen one, I would tag it with a blue suture to help find it at the next operation when it would be repaired. Having completed the debride-
ment, I washed out the wound with saline and Betadine, checked to be sure there wasn’t any more bleeding, placed a dressing followed by a plaster splint, and we were finished.

Like all our patients with gunshot wounds, these two will come back to the OR in four or five days for re-evaluation. For smaller wounds without bone injuries or secondary infections, we close the skin at the time of the second operation [called delayed primary closure, or DPC, if you want to talk like a trauma surgeon]. For larger wounds, we wait until they are ready for a skin graft. For patients with open fractures who need an external fixture [our second patient will definitely need one to salvage his arm], it is placed at the time of the second surgery. Some readers may be interested in looking at the ICRC publication “War Surgery” [just Google search “war surgery ICRC” and you will find a downloadable PDF] which talks authoritatively about the treatment of high velocity gunshot wounds [some photos are not for the squeamish]. As well, it provides a readable [at least I thought it was readable, but then I’m a surgeon] overview of the tremendous variety of injuries that occur during war and natural disaster and the complexities of treating these injuries.

When I left home to come to Rutshuru, there was a renewed and vigorous debate in the US about the restriction of military-style rifles for personal ownership that began after the recent tragedy in Newtown, CT. The subject is a political hot potato involving powerful lobbies, heartbreaking tragedies, and passionate arguments on both sides. Regardless of where one stands on those issues, there is one indisputable fact: bigger guns make bigger holes. If you ever get shot, hope it’s with a handgun and not an assault rifle.

“I could see he had a two-inch diameter hole through his mid-upper arm. By pulling on his arm I could see straight through to the other side.”
So begins the DR-TB Manifesto MSF released in late March, signaling the start of a long-term advocacy campaign designed to bring greater attention to the disease, the people afflicted with it, and the dearth of effective, patient-friendly treatment and testing options.

Often thought of as a disease of the past, TB is still a present-day reality for millions of people worldwide, including growing numbers suffering from DR-TB and multidrug-resistant (MDR-TB) forms of the disease that do not respond to customary first-line drugs. In the best case, TB treatment is lengthy and arduous. For people with drug-resistant forms, it’s an even lengthier and more arduous regimen of daily injections for up to eight months and a cocktail of drugs that cause excruciating side effects ranging from nausea to hearing loss to psychosis. And it’s only successful 50 percent of the time.

Part of the problem is that the treatment hasn’t changed in nearly half a century. Today, two new drugs—bedaquiline and delamanid—offer new hope to people battling the disease. More research is needed to determine the best ways to use these medicines, but the prospect alone should awaken the medical community to the fact that less than 20 percent of people with MDR-TB receive any treatment at all. And yet the Global Fund to Fight AIDS, Tuberculosis, and Malaria—which provides about 90 percent of international support for TB—has recently reduced funding for the disease. “Right when TB should be the global priority, the trend we’re seeing is that it is being deprioritized,” said Dr. Manica Balasegaram, executive director of MSF’s Access Campaign. “This is unacceptable.”

Greater political and financial support is desperately needed. New diagnostics, new formulas of the drugs—particularly for children—and new approaches are needed as well. In March, MSF’s Access Campaign launched a new initiative, “Test Me, Treat Me: A Drug-Resistant TB Manifesto,” designed to bring together patients and caregivers, creating a collective voice that cannot be ignored. Excerpts of the manifesto follow, along with graphics and images from the campaign; the full text of the manifesto can be found at msfaccess.org/TBManifesto.

**MANIFESTO**

We, the people infected with drug-resistant TB (DR-TB), live in every part of the world.

Most of us were exposed and became infected with DR-TB because of the poor conditions in which we live. Undiagnosed, this disease spreads among us. Untreated, this disease kills. But in the countries in which we live, fast and accurate diagnostics, new formulas of the drugs—particularly for children—and new approaches are needed as well.

**ACCESS TO EFFECTIVE DR-TB TREATMENT**

81 out of 100 people with DR-TB don’t get effective treatment

Of the 19 treated, only 9.5 are cured.
diagnosis is rarely available, and only about one in five of us actually get effective DR-TB treatment.

Those of us “lucky” enough to receive treatment have to go through an excruciating two-year journey where we must swallow up to 20 pills a day and receive a painful injection every day for the first 8 months, making it hard to sit or even lie down. For many of us, the treatment makes us feel sicker than the disease itself...

Surviving this treatment itself is a huge challenge—one that many people cannot manage. But we have no choice if we want to live...

We, the medical staff who provide medical care for people with DR-TB, find it unacceptable that the only treatment options that we can offer people cause so much suffering, especially when the chance of cure is so low. We have no choice but to juggle combinations of largely ineffective and toxic drugs, while doing our best to manage the debilitating side effects and provide as much support and counseling as possible with limited resources...

The treatment is too long, too toxic, and too costly—the drugs alone cost at least $4,000 just to treat one person. We want to save many more lives, but we desperately need shorter, safer, and more effective treatment to do so.

We, the undersigned people with DR-TB and those involved in their care, here raise the alarm about the devastating toll this disease is taking on us, our families, and communities across the globe, and therefore make the following three demands:

1. We call for universal access to DR-TB diagnosis and treatment now.
2. We call for better treatment regimens: the TB research community, including research institutes and drug companies, must urgently deliver effective, more tolerable, shorter, and affordable DR-TB drug regimens.
3. We call for more financial support to increase DR-TB treatment, and a commitment to support research into developing better treatment.

We as patients and health care providers commit ourselves to:

- Encouraging each other to test for TB, take our treatment, and remain in care
- Protecting those people close to us from TB transmission
- Holding our governments accountable and pushing them to respond to the crisis
- Sharing our stories to improve TB awareness and reduce stigma in our communities

MUKHTAR KAMCHIBEKOV, Bishkek, Kyrgyzstan

In February 2011, he contracted TB but couldn’t afford to travel to Bishkek, Kyrgyzstan’s capital and largest city, for treatment. He suffered for months, unable to afford drugs and relying on his relatives, friends, and neighbors for support as his health deteriorated. “One day someone told me about the MSF project in Joosh village, in Kara-Suu District,” he says. “I decided to try and I went there. On the 29th of June I was hospitalized . . . I started to feel better with every day. In February I thought I would die, but thank god in June I became hopeful.”

WE NEED BETTER TREATMENT NOW

Current treatment takes:

2 years
240 painful injections
14,600 pills (20 per day)

Cost of treating standard tuberculosis
$19

Cost of treating drug-resistant tuberculosis
$4,000
As you read this, the US and ten Pacific Rim countries are negotiating a wide-ranging trade deal that could drastically curtail access to medicines in developing countries. The deal, dubbed the Trans-Pacific Partnership Agreement, or TPP, could involve additional nations—Japan has committed but won’t join negotiations until this summer—and is slated to be finalized this fall.

Leaked drafts of some chapters of the TPP, which is being put together behind closed doors, show that negotiators are pushing for extremely stringent intellectual property provisions that would undo safeguards for patients in poorer economies established by previous international agreements. If these provisions are enshrined in the final version, it will become much harder for TPP countries to produce or import low-cost, generic medicines that MSF depends on for its programs around the world. Generic competition was the driving force behind the 99 percent drop in price for HIV/AIDS drugs over the last decade, but many newer drugs for other diseases, not to mention second- and third-line HIV/AIDS drugs, are still priced out of reach of developing countries.

The US is proposing provisions in the TPP that are specifically designed to stifle generic competition, even though major global health initiatives that the US supports, such as The Global Fund and the US’s own PEPFAR program, all depend on generic medications. If the TPP is not revised, rising pharmaceutical costs could severely limit their ability to reach patients.

In 1995, the World Trade Organization’s TRIPS agreement imposed minimum intellectual property (IP) standards across the globe, including the obligation to grant patent monopolies for pharmaceutical products. The TRIPS agreement permits countries some leeway in overcoming IP barriers when they hinder access to medicines, and these public health safeguards have been affirmed numerous times since then. But multinational pharmaceutical firms and some governments are now trying to roll back these safeguards with far more restrictive IP rules, known as TRIPS-plus provisions, that enhance patent and data protections, extend monopolies, and obstruct price-lowering generic competition.

Defenders of access to medicines recently won a victory when India’s Supreme Court denied a legal challenge by Novartis that would have permitted the company to “evergreen” an existing drug. The TPP is the next big challenge, and it has potentially enormous ramifications for our field programs and patients. MSF is thus asking supporters to get involved by calling their elected officials and insisting that they protect public health and, when it comes to the TPP:

- **Remove harmful measures** that severely limit access to medicines in developing countries and instead include language that protects public health safeguards and balances commercial interests and public health.
- **Increase transparency** and conduct future negotiations with adequate levels of public scrutiny.
- **Fulfill previous US government commitments to access to medicines**, including several WTO and WHO agreements and the New Trade Policy, a hard-fought 2007 bipartisan commitment to exclude some of the most damaging IP provisions from trade agreements with developing countries, which the US Trade Representative has spurned in the TPP negotiations.
The US is proposing provisions in the TPP that are specifically designed to stifle generic competition, even though major global health initiatives that the US supports all depend on generic medications.

### MOST EGREGIOUS TRIPS-PLUS PROVISIONS

Provisions that negotiators are trying to include in the TPP

<table>
<thead>
<tr>
<th>Proposed Provision</th>
<th>Impact on Access to Medicines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LOWER STANDARDS FOR GRANTING PATENTS ON DRUGS</strong></td>
<td>The TPP would require countries to grant new 20-year patents for minor modifications of old medicines, even in the absence of improved efficacy for patients. Mandating this industry practice of “evergreening” lets pharmaceutical firms extend monopoly protection and delay generic competition.</td>
</tr>
<tr>
<td><strong>REQUIRE PATENTING OF SURGICAL, THERAPEUTIC, AND DIAGNOSTIC METHODS</strong></td>
<td>Such patents are considered unethical because of increased medical liability and costs and reduced access to basic medical procedures. The American Medical Association and the World Medical Association, among others, have expressed concerns on similar measures.</td>
</tr>
<tr>
<td><strong>PROHIBIT PRE-GRANT PATENT OPPOSITIONS</strong></td>
<td>Drug companies routinely file multiple patents on aspects of the same drug to stave off generic competition, but it’s a myth that every patent filed is valid. Pre-grant oppositions are a form of oversight that improves the quality of the patent system.</td>
</tr>
<tr>
<td><strong>REQUIRE DATA EXCLUSIVITY</strong></td>
<td>Drug safety regulators normally refer to pre-existing clinical data when approving generic drugs. Data exclusivity locks up this clinical data so generics can’t be approved, even when patents no longer apply or exist, which would also threaten the availability of biosimilars, the generic equivalents of newer biologic drugs.</td>
</tr>
<tr>
<td><strong>REQUIRE PATENT TERM EXTENSIONS</strong></td>
<td>Pharmaceutical patents last 20 years from the date of filing, but the TPP would allow companies to add years as compensation for administrative delays in processing drug approvals, further delaying generic competition.</td>
</tr>
<tr>
<td><strong>REQUIRE PATENT LINKAGE</strong></td>
<td>Drug regulators assess drug safety, quality, and efficacy; “patent linkage” would force them to determine patent status, too. Companies would then no longer have to defend patents and patent offices and courts would no longer mediate disputes. This would delay registration and undermine the compulsory licenses governments at times use to authorize generic production of patented medicines to address public health needs.</td>
</tr>
<tr>
<td><strong>REQUIRE NEW FORMS OF IP ENFORCEMENT</strong></td>
<td>This grants customs officials powers to detain shipments on suspicion of non-criminal infringements and impose arbitrary penalties, increasing unwarranted diversions of generic medicines and pre-empting attempts to balance commercial and public health interests in patent disputes. It also strips governments of the ability to define enforcement provisions, as allowed by international law.</td>
</tr>
</tbody>
</table>

We cannot stand by as this proposed agreement threatens to restrict access to lifesaving medicines. Join us in calling for a stop to the most harmful trade provisions ever for access to medicines.

Congress needs to know that the intellectual property terms in this agreement have a real cost in human lives—a cost that their constituents think is far too high.

**Call the US Capitol switchboard at [202] 224-3121 and ask your members of Congress [switchboard operators can help you identify your representatives based on your zip code] to make sure that the US Trade Representative withdraws demands that will harm access to medicines. Calling your members of Congress takes just a minute or two, and it’s one of the most effective ways to get their attention.**

Simply use these talking points to pass your message along to your member of Congress:

“I am from [your town/state] and I’m calling to urge Representative/Senator _____ to ensure that the US withdraws its demands for the Trans Pacific Partnership (TPP) agreement that will harm access to medicines.

I’m concerned about policies that the US government is demanding in the intellectual property, investment and pharmaceutical pricing chapters that could seriously harm the health of millions of people in developing countries by making it harder for patients, governments, and treatment providers like Doctors Without Borders to access price-lowering generic medicines.

I’m asking that Senator/Representative _____ shares with the White House and the Department of State the need for the US government to fulfill its commitments to protecting access to medicines in developing countries. Thank you.”

Once you’ve hung up, please call back and speak to your other members of Congress.

Thank you so much for supporting MSF’s efforts to ensure that treatments are accessible and affordable to anyone who needs them.

For more information on the TPP and access to medicines, please visit http://www.msfaccess.org/tpp/
**FILM: ACCESS TO THE DANGER ZONE**

Directed by Peter Casaer and narrated by Daniel Day-Lewis, this documentary provides a harrowing look at the challenges of delivering humanitarian aid during armed conflicts.

With dramatic on-the-ground footage complemented by interviews with experts from Doctors Without Borders, the International Committee of the Red Cross, and the United Nations, *Access to the Danger Zone* explores the strategies that Doctors Without Borders uses to save lives in Afghanistan, Somalia, Democratic Republic of Congo, and elsewhere.

To learn more about the film, or to find out how to host your own screening, email event.rsvp@newyork.msf.org.

---

**JOIN TEAM DOCTORS WITHOUT BORDERS!**

Join us for two major upcoming events in our ongoing endurance program, the Tri-Rock Lake Geneva Triathlon on September 14, in Williams Bay, Wisconsin, and the LA Rock ‘n Roll Half Marathon on October 27, in Los Angeles, California.

Participants receive exclusive Team Doctors Without Borders athletic gear, access to professional athletic coaching, fundraising coaching from our team of experts, and a race weekend experience including a chance to meet and mingle with returning Doctors Without Borders aid workers.

*We hope that you will join the team!* For more information visit events.doctorswithoutborders.org, email teamevents@newyork.msf.org, or call (212) 763-5708.

---

**DONOR PROFILE**

**SUSAN AND PETER LINZ**

“We’ve always wanted to give back to the world,” says Susan Linz. “At the same time, we love books.” After retiring from her community college teaching position, she and her husband, Peter—a former UC Davis professor—found a way to combine their passions: They opened Logos Used and Out-of-Print Books in downtown Davis, California, and began donating profits to Doctors Without Borders and Save the Children.

“We thought it would be nice to offer a place for people to come together,” Susan says. “We decided that this was an opportunity to serve the community. When people come into the store and find out that we give to Doctors Without Borders, they’re automatically very enthusiastic.”

Susan and Peter chose MSF because “we felt they were a charity we could feel proud and confident supporting,” she says. “Doctors Without Borders has a very good track record of the money going to the doctors and the medicines, all of the things that donors hope it will be used for!” In 2012 alone, Logos Books donated a combined $35,000 to MSF and Save the Children. You can learn more about Logos Books at http://logosbooks.wordpress.com/.

“[MSF] has a very good track record of the money going to the doctors and the medicines, all of the things that donors hope it will be used for!”
Doctors Without Borders/ Médecins Sans Frontières (MSF) works in nearly 70 countries providing medical aid to those most in need regardless of their race, religion, or political affiliation.