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DISPATCHES

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Médecins Sans Frontières is a leading independent organisation for emergency medical aid. In over 70 countries world-wide, MSF provides relief to the victims of war, natural disasters and epidemics irrespective of race, religion or political affiliation. MSF was awarded the 1999 Nobel Peace Prize.

MSF nurse Christine Mwongera talks with a young patient's mother in MSF's health centre in Huddur

War returns to Somalia

When war broke out in Somalia just before Christmas last year, few people expected the Islamic Courts Union, which controlled much of the country, to collapse so quickly. Within two weeks, the whole landscape had completely been turned upon its head. By early January 2007 the Transitional Federal Government, backed militarily by neighbouring Ethiopia, was suddenly in control of much of the territory previously occupied by the Islamic Courts.

For MSF teams working in Somalia, this sea-change could mean new authorities, new partners and new relationships to forge; and potentially even greater problems than usual in ensuring the safety of MSF staff whilst continuing to provide essential health care for the population.

In Huddur, the regional capital of the Bakool district, MSF established a health centre in an old French military compound in 2000. Following this, four health posts have also been set up, reaching out to local communities and providing better medical coverage in the region. The project offers essential health services to the 215,000 people living in the Bakool region: treatment for kala azar, known as 'black fever', and tuberculosis; feeding for malnourished children; mother and child health care and basic medical care for a range of conditions that would go untreated and claim many lives without MSF's presence.

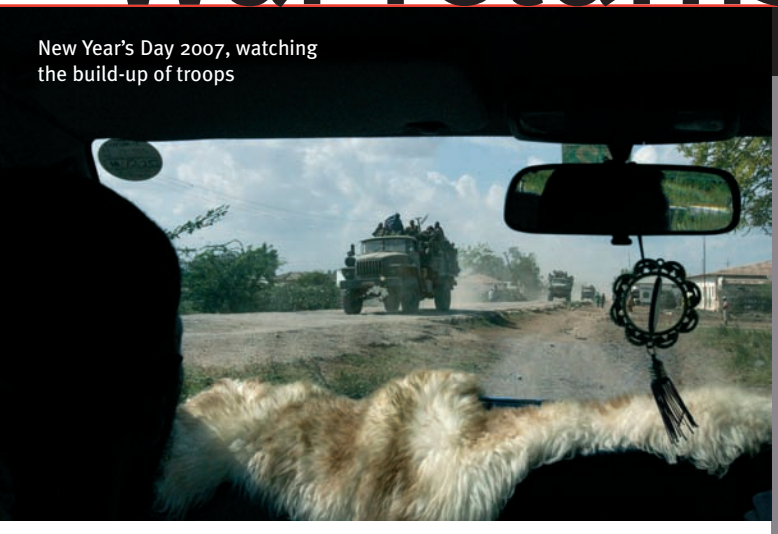
Huddur also happened to be one of the towns on the frontline between the Transitional Federal Government and the Islamic Courts; tension had been building for months.

"There had been a lot of rhetoric from both factions in the previous weeks," explains head of mission David Michalski, "but it was hard for us to judge when, or even if, it was going to come to a head. The Huddur project is one of the largest medical facilities in the country and it was imperative for us to try to keep it running at its full capacity for as long as possible. When we started to see a military build-up in early December, we knew that conflict was on the horizon, but we still held out a small hope that full scale fighting would not erupt."

The airstrip at Huddur doubles up as the local football pitch

"I wanted to get them out as quickly as possible but landing at night on these dusty unlit airstrips is risky"

War returns to Somalia



New Year's Day 2007, watching the build-up of troops

Photo © Juan Carlos Tomasi

I like my job with MSF a lot...

...but it is tough. I have no choice but to be on call 24 hours a day. With people coming from so far away, there are urgent cases all the time, and regularly wounded people from clan fighting are coming in. After dark, the expats cannot leave the compound as it is not safe for them, so I have no choice but to go then and help out at the hospital. Sometimes my children complain that I have to leave all the time....

Dr. Amin, a senior member of MSF's national staff team

MSF IN SOMALIA

Somalia's last president, Siad Barre, was ousted in 1991. For 16 years, the Somali people have been without a functioning central government and public health services.

MSF has been providing medical care in Somalia since 1986 and focuses its efforts in the central and southern parts of the country, long plagued with insecurity and violence. Despite a desperate need for health services, in this area there are few international NGOs present on the ground. Maintaining close contact with the Somali people in the areas where it works, MSF's medical teams can operate in places that would otherwise be inaccessible because they are extremely unsafe.

Somalia has one of the world's highest prevalence rates of tuberculosis, the fatal and neglected tropical disease kala azar is killing thousands, and there are regular outbreaks of measles and other epidemics. Much of the region is prone to drought and for thousands of children malnutrition is a serious risk. Furthermore, repeated fighting among a host of armed factions has resulted in an exodus of displaced people, and every year many people are injured by gunshots.

MSF's presence shows that it is possible to provide basic health services in Somalia. Even so, MSF is often forced to suspend activities due to violence or threats of violence against its staff and patients.

"The Bakool region had always ostensibly been under the control of the Transitional Federal Government" continues Michalski, "but by a few days before Christmas, there were all sorts of rumours flying around that the Courts were coming to take over, or that the Ethiopians were going to invade to stop the Courts' advance. We were worried about being on the front line of a serious confrontation."

On 22 December, the tension even became too much for the local authorities and they left town to seek refuge in the bush, leaving the MSF team with no-one to assure security.

"A reliable partner who is able to provide security is a pre-requisite for working in Somalia and this was deeply worrying," says Michalski. "I had no choice but to pull out the international staff as quickly as possible as a precaution."

With Huddur no longer safe to land, the MSF team left by road at dawn the next day. At the nearby Wajir airstrip, they were evacuated by a small Cessna Caravan plane to the Kenyan capital, Nairobi.

"I wanted to get them out as quickly as possible but landing at night on these dusty unlit airstrips is risky at the best of times. We have to balance all the risks and then decide the most prudent form of action," says Michalski.

In Huddur, the hospital was kept running by the team of over 80 Somali staff. Covering all the day-to-day functions in the hospital – surgery, hospital management, nursing etc – the national staff are at the core of the MSF's operations, with more than 10 Somali staff in Huddur for each international staff member.

"Expatriates provide training, supervision and skills that are otherwise impossible to find in Somalia, but our national Somali staff form the backbone of our operations. For short periods of time, MSF's work can be managed from the co-ordination office in Nairobi, and the national staff, who are less obvious targets, can maintain a continuity of medical service in the hospital," continues Michalski. "Unfortunately in situations like these, the international staff stand out so much that they can become a target."

"...our national Somali Staff form the backbone of our operations"

As it was, the Huddur international staff watched from Nairobi as the Transitional Federal Government took town after town with ease. By the first days of January, the Courts had taken flight and their remnants were hunkered down in the densely forested areas of southern Somalia near the Kenyan border.

On 3 January, only 10 days after the evacuation, Michalski and a skeleton team of a nurse, a logistician and a field coordinator, were able to travel back to Huddur.

"Most of the pre-war administration were still in place so it was a question of re-affirming the old agreements," he explains. "Nothing is ever simple in Somalia, but it's a relief to be up and working again so quickly."

At the date of writing, the MSF team in Huddur is back up to full strength.

To find out more about MSF in Somalia, please visit www.uk2.msf.org/dispatches/

"There were all sorts of rumours flying around... We were worried about being on the front line of a serious confrontation."

Mothers with children queuing for a nutritional screening in the small village of Istorte. MSF checks children for malnutrition and refers the severe cases to MSF's therapeutic feeding centre in Huddur

The 2005 nutritional crisis in Niger attracted the world's attention – and a massive international aid response. When the world's cameras are turned elsewhere, however, it is easy to forget that Niger's food shortages are a cyclical and ongoing problem. In 2006, a year with reasonably good harvests, MSF still found itself treating over 73,000 children with acute malnutrition. A new approach means that many more patients can be treated and with remarkable results.

A foil-wrapped miracle

The hunger gap

Acute malnutrition is not confined to sudden, abnormal incidents such as wars or droughts. In Niger, a cycle builds around the 'Hunger Gap', when last year's harvest has been exhausted and the next is still awaited. People living in poverty do not have enough money to buy food and many people, if they have not done so in previous years, are reduced to mortgaging or selling their possessions, deepening the burden of debt. During those five to six months, from May to September or October, thousands of children become malnourished. They don't have the appropriate food, in quality and in quantity, to meet their nutritional needs. The main victims of malnutrition are the youngest children, under three years old.


Because it is in sealed packs, the food can be given to children at home without risk of contamination © Anne Yzebe

Until very recently, MSF found treating widespread acute malnutrition difficult. MSF used highly nutritious enriched milk for severe cases in special Therapeutic Feeding Centres and flour based foods for moderate cases in Supplementary Feeding Centres; but it was clear that we could treat more patients with less disruption to livelihoods by taking our activities into the community, rather than relying on a hospital setting. The treatments we used to use, however, need to be administrated under medical supervision in order to respect the precise dosage, to avoid bacterial contamination and to guarantee monitored storage conditions.

A new ready-to-use therapeutic product

For several years now a new type of 'wonder-food' has been in use for treating children with severe acute malnutrition. Ready-to-Use Therapeutic Foods (RUTFs) are vacuum-packed sachets of high energy milk- and peanut-based paste, enriched with essential micronutrients. They are airtight, the food doesn't need to be mixed with (potentially dirty) water, they have a long shelf life and they can be easily transported and distributed. Furthermore, they taste good, like sweetened peanut butter, which is extremely helpful in encouraging malnourished children to eat enough. Used extensively by several aid agencies in Niger in 2005, it is clear that RUTFs are extremely effective.

One of the essential benefits of these packaged foods is that they can be used in a community setting. This makes it much easier for a patient's family. They can collect a weekly or fortnightly supply from an outpatient clinic and can give the treatment at home. This means parents avoid having to spend long periods (generally several weeks) with their infant at a feeding centre. In Niger, the vast majority of the children MSF treated in 2006 never had to be hospitalized. They see a medic every week to check their improvement and get more medicines if needed and they eat the therapeutic product twice a day at home. The average time of recovery is about a month.

MSF continues to run permanent medico-nutritional centres which are now used, however, almost exclusively for children who need medical care because of a severe disease associated with malnutrition. Dr Sylvaine Blanty explains how effective RUTFs can be in helping children return to their families: "In other malnutrition treatment programmes, children remain hospitalised until they have recovered. Here, once they are doing a little better, they go home and just go to a health centre near their village once a week until the treatment is completed. That's much better for both the child and mother. The doctor provides the initial treatment, but then it is the mother's responsibility to feed the child the therapeutic food."

This was the case for two-year-old Fatima who spent more than two months at an MSF inpatient centre with her mother and older sister. She had fought for her life since the age of one month. She had tuberculosis and, after starting treatment, quickly gained weight. Two months later she was able to leave the inpatient feeding centre and, thanks to RUTFs, she could continue her follow-up care by making regular visits to one of MSF's outpatient feeding centres.

Using MSF's MUAC (Mid-Upper Arm Circumference) bracelets, one can tell whether a child is malnourished (yellow), moderately malnourished (orange) or severely malnourished (red)

WASTING AWAY

Malnutrition is defined as an imbalance between the body's supply of nutrients and the body's demand for energy. When a person cannot take in sufficient nutrients to meet their needs, the body begins to waste away. In medical terms two degrees of 'acute malnutrition' are identified. Patients with moderate acute malnutrition are substantially under-weight and at risk of dying – patients with severe acute malnutrition are even more under-weight and at particularly high risk of death.

Children under three years old are the most vulnerable because they are growing rapidly and have a hard time fighting off disease. A deadly cycle can emerge when lack of food and disease combine; acute malnutrition makes children more susceptible to infection and, on the other hand, diseases can prompt an already undernourished child to stop eating and drinking, throwing the child into a state of acute malnutrition.

MSF's Dr Sylvaine Blanty explains how weak some of these children are: "When I approach a child and he looks at me, I know he's doing better. When I come close and he has the strength to cry, I'm pleased. If he agrees to eat, that's a key first step and if he asks for food, that's wonderful!"

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Changing how malnutrition is treated

In Niger in 2006 MSF set about seeing whether packaged RUTFs could be used to provide treatment in a far more extensive way. Instead of just using RUTFs for children with severe acute malnutrition, the teams used them to treat moderate acute malnutrition as well.

MSF's Dr Defourny explains: "We first used [RUTFs] on a large scale in 2005 with children who had reached a severe stage of malnutrition. The results were very positive, leading us to ask whether we should use this effective product sooner, without waiting for a child to slip into a state of severe acute malnutrition. We began doing so in early 2006. This is a new practice because the food that most aid groups give those children is an enriched flour that requires water for preparation."

The results were extremely encouraging. There were more than 73,000 admissions and the cure rate was over 90%. What's more, fewer than 2,000 children in the treatment area were admitted with severe acute malnutrition, substantially fewer than the team were expecting. This indicates that treating moderate acute malnutrition with therapeutic foods really works in preventing degeneration into severe acute malnutrition and death.

"This product is more effective than enriched flour," continues Dr Defourny. "Children gain weight more quickly and the treatment lasts for three to four weeks, rather than two months. [...] there are fewer children in a serious condition than in the past."

The price must come down

Outside of major crises like the 2005 disaster, child health care in developing countries rarely includes the systematic treatment of malnutrition, even for the most severe cases. Milton Tectonidis, an MSF nutritional specialist, maintains that "what would be most effective from a medical point of view is to insist that therapeutic food for severely malnourished children be integrated into the regular services offered in the health care system."

But the actual price of the ready-to-use nutritional products is a major obstacle to widespread use. "From the food aid agencies' point of view, the price would have to be cut in half, or by two-thirds, if the product is to be accessible to the majority of those who need it," said Dr. Jean-Hervé Bradol, president of Médecins Sans Frontières in France.

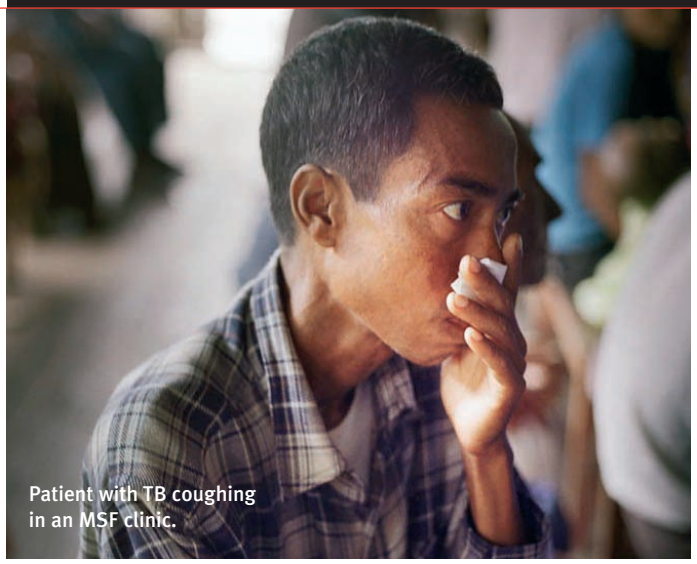
A concerted international effort needs to be made to bring down the cost of ready-to-use therapeutic products and they should be adopted as part of the standard health services of governments with malnourished populations. While children are at risk, however, and until there are other options for them, MSF's presence in Niger is invaluable.

To find out more about MSF in Niger, please visit **www.uk2.msf.org/dispatches/**

Around the world, some 11 million people are living with both HIV/AIDS and Tuberculosis (TB). Diagnosing when someone has both diseases at the same time, as well as providing treatment, is tricky even in the rich world. So imagine the obstacles in Myanmar (formerly Burma), a country where MSF's task is made doubly complicated by poverty and the difficulty of negotiating with the military authorities to get unfettered access to patients. Despite these challenges, Dr Kalpana Sabapathy, MSF's HIV coordinator in Myanmar feels that "our project is really a positive story – we are saving people."

Photos © Chris de Bode

A deadly combination



Patient with TB coughing in an MSF clinic.

MSF has five crowded clinics in the outskirts of Yangon, the former capital, where the staff try to keep abreast of more than 15,000 consultations each month. These general health clinics deal with all sorts of medical problems for free, including HIV treatment. The clinics are therefore particularly popular with HIV/AIDS patients. Furthermore, of those Burmese patients who do receive antiretroviral treatment (which is a very small proportion of the people who need it), 80% receive it from MSF.

Despite the clinics' popularity and success, however, one of MSF's local Burmese doctors is growing increasingly concerned about TB: "TB is the most challenging disease in our country. There are a lot of malnourished people living in poor conditions and there's a high TB prevalence. Because people living with HIV/AIDS have a weakened immune system, TB is radically on the increase."

Together HIV/AIDS and TB are a deadly combination. HIV/AIDS weakens the immune system, causing patients to develop opportunistic infections they can't fight. TB is one of the most common and is the main cause of death among people infected with HIV. MSF's Head of Mission in Myanmar, Dr Frank Smithuis, sums up the problem: "About 50% of the HIV/AIDS patients we care for also have TB. If we only treat one disease, the other may still kill them".

Correct diagnosis is one of the biggest hurdles to treating this pair of diseases. Whilst the HIV/AIDS test is relatively simple and effective, testing for active TB is tough, particularly in HIV-positive patients and children. Complicated laboratory techniques exist in rich countries that allow doctors to be almost sure of a diagnosis. In Myanmar this is more difficult. Dr Sabapathy explains: "When patients have both diseases, often weight loss can be the only symptom. But of course weight loss can be a symptom of other diseases. We have to rely on our clinical judgement and the available basic tests like sputum and X-ray. But they only reveal TB in the lungs and it can be situated anywhere in the body. Sometimes it feels like we are shooting in the dark."

Once diagnosed, treatment is possible, but patients face many difficulties in sticking to their treatment because they have to take so many pills each day. "Treating both diseases simultaneously is difficult. Three antiretroviral drugs plus four drugs against TB, it becomes a lot," continues Dr Sabapathy. Depending on the strain and the patient, TB treatment can last anywhere between two and eight months, with some drugs to be taken on an empty stomach and some after food.

Many of MSF's patients are extremely poor and their illness frequently leads to a loss of work. MSF usually pays for transport to the clinic and food to guarantee the proper course of treatment - so important not only in treating the patient, but also in avoiding the creation of drug resistant strains of TB. To this end a support group, the Phoenix, has been created by patients with MSF's support.

"I live only 1,500 metres from the MSF clinic, but it takes me almost one and a half hours to get there – I have to stop at least ten times," says Chet*, a 32 year old TB patient, three weeks after also testing positive for HIV. "I feel very weak but I don't have the money for transport. I know that being on antiretroviral treatment requires motivation, but I am ready to take that responsibility and I am sure that I can be cured. My life is in the hands of the doctor..."

*names changed to protect patients' identities

Multi-drug resistant TB

A further and deeply worrying issue is the emergence of multi-drug resistant (MDR) TB. If a patient stops taking their treatment before the end of the treatment period, or takes less than the required dose, their strain of TB can become resistant to the drugs used to cure it. The infection can then be passed on to others in its new drug resistant form. Drugs do exist for treating MDR TB, but the treatment takes much longer, is very costly and can have a lot of side effects.

"Today we had a patient who had TB treatment in the past from the [Government] National TB Programme," says Dr Sabapathy. "She is heavily pregnant. We did tests and they show that she is resistant to all the drugs we are able to use. Her husband also has drug resistant TB. We're very concerned about the risks for her baby, assuming it is alive when it is born... If she has it, her husband has it, other relatives or neighbours or friends etc will have got it. For us MRD TB is a growing fear and frustration..."

Volunteer making clothes at the Phoenix centre

The Phoenix – a support group of volunteers

Phoenix is an association of Burmese volunteers living with HIV/AIDS who offer practical, emotional and financial support to HIV-positive patients in need of treatment. MSF is one of the main supporters of the association.

The volunteers go to remote areas to offer people information about HIV/AIDS and where to go to get treatment. They give people money to pay for transport to the MSF clinics and regularly visit patients at the clinics, ensuring they have enough food (without adequate nutrition, the drugs won't work). They take particular care of patients who are alone, often having been rejected by their families.

Homeless patients or those coming from far away can eat and stay overnight at the Phoenix centre in Yangon. The centre organises many activities and there is a sewing room where patients may make clothes to sell at market, making some money for themselves and Phoenix projects.

"I was a sailor before," says Than*, Phoenix founder and volunteer. "After the boat company dropped me because I was HIV-positive, I started working with Phoenix. I don't want to hide that I am HIV-positive, I want to be an example."

To find out more about HIV/AIDS and TB, please visit **www.uk2.msf.org/dispatches/**

MSF UK volunteers currently in the field

Angola Philippa Farrugia *DOCTOR* Lourdes Cuellar *BIOMEDICAL SCIENTIST* Bangladesh Chris Hall *LOGISTICAL COORDINATOR* Megan Powell *LOGISTICIAN* David Cook *LOGISTICIAN* Caroline Forwood *DOCTOR* Burundi Rob Delaney *WATER & SANITATION EXPERT* Fiona Bass *NURSE* Gareth Walker *LOGISTICIAN* Paul McMaster *SURGEON* Timothy Boole *FINANCIAL COORDINATOR* Tara Brady *DOCTOR* Cambodia Christopher Peskett *NURSE* Central African Republic Clara Van Gulik-Mackenzie *MEDICAL COORDINATOR* Gina Bark *HUMANITARIAN AFFAIRS OFFICER* Emma Fuell *MIDWIFE* Joanna Knight *FINANCIAL COORDINATOR* Anupam Goenka *DOCTOR* Megan Craven *NURSE* Chad Elin Jones *NURSE* Anna Halford *LOGISTICIAN* Christophe Hodder *LOGISTICIAN* Babak Kianifard *SURGEON* Colombia Caroline Brant *PROJECT COORDINATOR* Simon Midgley *MENTAL HEALTH SPECIALIST* April Baller *DOCTOR* Congo Brazzaville Katherine Yarrow *DOCTOR* DRC Dawn Taylor *WATER & SANITATION EXPERT* Matthew Arnold *WATER & SANITATION EXPERT* Elaine Badrian *NURSE* Colin Beckworth *NURSE* Gail Leeder *FINANCIAL COORDINATOR* Laura Andres *MIDWIFE* Nicola Fenn *NURSE* Henry Gray *LOGISTICIAN* Ed Ramsay *LOGISTICIAN* Judith Kendell *ANAESTHETIST* Sally Tillett *NURSE* Ethiopia Rosemary Davis *NURSE* Karen Kennedy *LOGISTICIAN* India Luke Arend *PROJECT COORDINATOR* Monica Arend-Trujillo *DOCTOR* Candy Barrett *NURSE* Indonesia Sue Miller *MIDWIFE* Ivory Coast Susan Chadney *NURSE* James Seddon *DOCTOR* Ross Ferguson *PROJECT COORDINATOR* Alexis Gallagher *FINANCIAL COORDINATOR* Carolyn Lomas *DOCTOR* Jordan Maria Siemer *ADMINISTRATOR* Kenya Alyson Froud *MEDICAL COORDINATOR* Kathleen Roberts *NURSE* Liberia Nicky Shellens *ADMINISTRATIVE COORDINATOR* Pawan Donaldson *PROJECT COORDINATOR* Lucy Shoubridge *FINANCIAL COORDINATOR* Alison Cook *DOCTOR* Malawi Bibiana Angarita *BIOMEDICAL SCIENTIST* Bryn Button *LOGISTICAL COORDINATOR* Claire Hughes *LOGISTICIAN* Morocco Huw Price *DOCTOR* Mozambique Emma Cartmell *DOCTOR* Myanmar Michael Patmore *BIOMEDICAL SCIENTIST* William Baylis *LOGISTICIAN* Aster Ayana *DOCTOR* Jacqueline Dallimore *NURSE* Anthony Solomon *DOCTOR* Georgina Russell *DOCTOR* Sabina Ilyas *DOCTOR* Sarah Hichens *DOCTOR* Pakistan Luis Francisco Neira *MEDICAL COORDINATOR* Palestinian Authority Sakib Burza *MEDICAL COORDINATOR* Russia Solveig Hamilton *MEDICAL COORDINATOR* Emma Bell *REGIONAL INFORMATION OFICER* David Overy *LOGISTICIAN* Sierra Leone Mesfin Senbeto *SURGEON* Anita Tierney *MIDWIFE* Ana Llamas *MIDWIFE* Georgina Brown *DOCTOR* Somalia Colin McIlreavy *HEAD OF MISSION* Joan Wilson *MEDICAL TEAM LEADER* Maria Dominguez *DOCTOR* Christine McVeigh *NURSE* Christopher Lockyear *LOGISTICIAN* Samuel Crawley *LOGISTICIAN* David Sweeney *LOGISTICIAN* Felix Over *NURSE* South Africa Nathan Ford *HEAD OF MEDICAL UNIT* Sudan Fran Miller *MENTAL HEALTH SPECIALIST* Stephen Cooper *LOGISTICAL COORDINATOR* Michael Hering *LOGISTICAL COORDINATOR* Harry Ingram *PROJECT COORDINATOR* Philippa Millard *NURSE* Ann Wiggins *LOGISTICIAN* Lianne Barnett *NURSE* Giles Hall *NURSE* Joseph Jacob *DOCTOR* Kathleen MacEwan *NURSE* Amina Aitsiselmi *DOCTOR* Kenneth Lavelle *LOGISTICIAN* Jonathan Henry *PROJECT COORDINATOR* Liza Cragg *FIELD COORDINATOR* Simon Burling *MEDICAL COORDINATOR* Mairi Macleod *LOGISTICIAN* Helen Austin *MEDICAL COORDINATOR* Gareth Barrett *MEDICAL TEAM LEADER* Hilary Bower *PROJECT COORDINATOR* Morpheus Causing *MEDICAL COORDINATOR* Anna Hess *NURSE* Nicole Hendriksen *NURSE* Marcus Wootton *NURSE* Janet Simpson *NURSE* Elizabeth Harding *NURSE* Joanne Booth *NURSE* Aisa Fraser *NURSE* FelicityTucker *NURSE* Sarah Maynard *LOGISTICIAN* Paula Brennan *PROJECT COORDINATOR* Sri Lanka Kate Janossy *ANAESTHETIST* Thailand David Wilson *PROJECT COORDINATOR* Paul Cawthorne *DOCTOR* Turkmenistan Joan Hargan *NURSE* Uganda Charlie McQueen *LOGISTICAL COORDINATOR* Margaret Othigo *BIOMEDICAL SCIENTIST* Vivienne Monaghan *NURSE* Zimbabwe Sandi Chit Lwin *DOCTOR*

DISPATCHES is a quarterly publication designed to keep our supporters updated on the work of Médecins Sans Frontières.

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Protesters in New Delhi calling on Novartis to drop its case

© Michel Lotrowska/MSF

Shutting down the pharmacy of the developing world

In a court case that could affect the lives of millions around the world, Swiss pharmaceutical company Novartis is taking the Indian government to court in an attempt to force a change in India's patent law. According to Dr Unni Karunakara of MSF's Campaign for Access to Essential Medicines, Novartis' legal action is an attempt "to shut down the pharmacy of the developing world."

Until now, India has been able to produce 'generic' drugs, affordable versions of medicines patented elsewhere. Many developing countries rely on India's affordable medicines, which include over half the AIDS drugs used in the developing world. Over 80% of the 80,000 patients in MSF's AIDS treatment programmes receive Indian generics.

The Novartis case came about when a patent for the company's cancer drug, Gleevec, was rejected. An element of Indian patent law states that patents should be granted only for drugs that are genuinely new and innovative; this aims to prevent pharmaceutical companies making trivial changes to existing drugs (a practice sometimes known as 'evergreening') in order to get them re-patented.

When Novartis failed to get a patent for Gleevec in India in 2006, it decided to challenge Indian law. There are an estimated 9,000 patent applications waiting to be reviewed by Indian authorities of which most are believed to be modifications of old drugs. If Novartis wins the case and India is made to change its law, many of these medicines could become patented, making them off-limits to the generic competition that has proven to bring prices down.

"We are increasingly seeing the tools we need to treat people being taken out of our hands," said MSF's Dr. Tido von Schoen-Angerer.

Over 300,000 people worldwide have signed a petition calling upon Novartis to drop the case. Join them and sign our petition at www.uk.msf.org

© Jonathan Torgovnik

Among the signatories of the petition are John le Carré; former President of the Swiss Confederation Ruth Dreifuss; Archbishop Desmond Tutu; former UN Special Envoy for HIV/AIDS in Africa Stephen Lewis; and Dr. Michel Kazatchkine, the new head of the Global Fund to Fight AIDS, Tuberculosis and Malaria

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West Malling
Kent
ME19 4BR

Please quote your supporter number (located on the top right hand side of the letter) and name and address when making a donation.

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Dispatches also gives our patients, staff and volunteers a voice to speak out about the conflicts, emergencies, and epidemics in which MSF works, and about the plight of those we strive to help.

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