

Fighting the good fight

Médecins Sans Frontières (MSF) is one of the most well-respected humanitarian organizations in the world. But it is not resting on its laurels. It is continuing to fight the good fight, speaking out about neglected crises and exposing abusers of the aid system. Unni Karunakara, international president of MSF, talks about what else can improve humanitarian work.



Unni Krishnan Karunakara was appointed international president of Médecins Sans Frontières (MSF) in June 2010. He joined MSF in 1995, when he was tasked with setting up a tuberculosis control programme in Jijiga, Ethiopia. In 2002, Karunakara joined MSF's Public Health Department in Amsterdam and three years later became medical director of MSF's Campaign for Access to Essential Medicines. Karunakara received degrees in public health from Yale University and Johns Hopkins University, USA. Since 2008, he has been assistant clinical professor at the Mailman School of Public Health, Columbia University, USA.

Interview by **Jyotsna Puri**.

What is the scope MSF's work and importance?

MSF is a medical humanitarian organization providing emergency medical assistance to populations affected by man-made and natural disasters. MSF was formed 40 years ago by doctors and journalists who witnessed disasters in Biafra and Bangladesh, and felt the need for an organization that could act quickly and independently to bring medical care to people in times of great need.

MSF was a departure in the humanitarian field. First, it was a *medical* humanitarian organization. At the time, medical assistance was just a small part of the overall humanitarian aid package. Second, MSF assumed the role of bearing witness to the plight of those affected. Today, it still often speaks out about neglected crises, and inadequacies or abuse of the aid system.

More than 20,000 volunteers work for MSF in over 60 countries today. Wherever possible, MSF works with local governments, ministries of health and civil society. Engaging with ministries of health is important to keep them involved and implicated in any activities or services provided because ultimately they are responsible for their citizens' health.

In your view, what are the pressing issues that require research to improve the work you do?

One critical area that MSF has been concerned about in the past decade has been access. A decade ago, we launched the Campaign for Access to Essential Medicines. This campaign has advocated for more R&D in neglected tropical diseases such as Kala-azar, sleeping sickness and Chagas disease.

These are parasitic diseases that almost exclusively affect the poorest in developing countries. MSF currently treats Kala-azar patients in India, sleeping sickness patients in the Congo and Chagas patients in Bolivia. Typically, big pharmaceutical companies ignore these diseases because there is no profit in them. Consequently, there has hardly been any R&D for effective medicines and diagnostic tools for these illnesses.

We are also promoting the development of better treatment models, medicines and diagnostic tools for the 'big three' diseases: malaria, tuberculosis and HIV. You may be surprised to hear that HIV is a neglected disease. Although

there are hardly any children with HIV in the developed world, more than 300,000 children are born with the virus in Africa each year. Paediatric HIV, therefore, is a neglected area that has had very little R&D.

As the free market has failed to address the needs of the poor, it will be up to governments to formulate R&D priorities that cater to the needs of their population and to involve the universities and medical research institutes. Public private partnerships such as the Drugs for Neglected Diseases initiative (DNDi) can also play a major role in developing appropriate medicines. Any medicine that is developed should be field-adapted – in other words, robust, with few side effects, easy to use and heat stable – and affordable. It is also important to develop appropriate delivery systems by translating scientific advancements into appropriate models of care. Much work needs to be done on implementation research in this context.

Can you give an example of this?

Let's start with HIV/AIDS. At the turn of the century, there was not a single patient in sub-Saharan Africa receiving treatment through the public health system. The cost was a major factor. It was also widely believed that patients would be unable to adhere to a life-long treatment.

MSF's many programmes have since shown that it is possible to treat patients in Africa, often with better adherence rates than programmes in developed countries. One important innovation was the development of generic fixed-dose combinations of antiretroviral drugs that made it easier for patients to take their medication on time. Generic competition from pharmaceutical companies in India and elsewhere also helped to bring down the prices sharply, allowing ministries of health to scale up treatment with the help of the Global Fund, for instance. Today, more than four million Africans are receiving treatment for HIV/AIDS.

Another example is sleeping sickness, a parasitic disease transmitted by the tsetse fly in sub-Saharan Africa. The only drug available to treat the disease was melarsoprol, an arsenic derivative. The toxicity of this drug resulted in very poor treatment outcomes. This disease was completely neglected until the 1990s. A newer drug called eflornithine became available but required intensive round-the-clock nursing and

intravenous infusions, making it very difficult for treatments to be scaled up.

MSF initiated a clinical trial in the Congo in 2002, basically because no one else was doing that kind of research. It resulted in a new combination therapy called NECT (Nifurtimox-Eflornithine Combination Therapy) that improves outcomes, cuts down hospitalization and is therefore scalable. This illustrates the need to carry out more clinical and operational research for specific populations in countries where they live. This should result in the development of specific health-care solutions that fit their circumstances.

Where should research go in the next ten years?

I think research should focus on field-adapted, affordable and accessible models of care. Fixed-dose combinations, oral formulations of medicines that do not need to be refrigerated and point-of-care diagnostic tests that can be administered by minimally trained health-care workers have helped to scale up treatment.

A different area for research concerns the delivery of humanitarian assistance. The natural disasters in Haiti and Pakistan made 2010 a very intense year for humanitarian agencies. The current humanitarian system is increasingly unable to effectively respond to the needs of populations affected by large emergencies.

In my article, 'Haiti: Where Aid has Failed', published in the *Guardian* on 28 December 2010, I argue that the inadequate response to cholera in Haiti – coming on the heels of the slow and highly politicized flood relief effort in Pakistan – is a damning indictment of an international aid system whose architecture has been carefully shaped over the past 15 years. While the capacity to coordinate – usually the responsibility of the government or a designated UN agency – is definitely an issue, the capacity of agencies that are being coordinated to deliver efficient aid is at least as important.

All humanitarian agencies need to accept that the current system is broken, and that a better model that facilitates the timely delivery of humanitarian aid urgently needs to be put in place. Failures and successes in coordination should be documented and analyzed to better understand how aid can be delivered effectively in the future. ■