SOMALIA: AN UNNATURAL DISASTER
Dear Friends,

Doctors Without Borders/Médecins Sans Frontières (MSF) brings lifesaving medical care to people caught in emergencies around the world—war zones, epidemic outbreaks, disasters, or less visible crises brought about by neglect. At the same time, we examine the causes of these situations as best we can, and speak out when we believe our perspective, based on our field experience, can improve the situation for those caught in life-threatening circumstances beyond their control.

In this issue of Alert, we share news and images of our response to the ongoing crisis in Somalia, where MSF has spent the summer trying to expand its services to meet the latest emergency to befall the country’s people. Simultaneously, we have been conveying our perspective on the genesis of this crisis through press conferences, op-ed pieces, interviews, and meetings with diplomatic officials and NGO colleagues. There is a drought afflicting the Horn of Africa, to be sure, but the current emergency, which has driven hundreds of thousands of Somalis from their homes in search of relief and threatens the lives of hundreds of thousands more, is not solely the consequence of a natural disaster.

As our International President, Dr. Unni Karunakara, explained in an op-ed originally published in The Guardian (UK) after he returned from Somalia, there are many other factors behind the crisis, among them the decades of bitter conflict, the wholesale destruction of the country’s infrastructure, rising food prices, and past failures to effectively mobilize and implement international aid and assistance. Saying this is just about drought or just about famine both absolves many parties of responsibility for what is happening now and encourages an approach akin to treating one symptom of a far more complicated disease.

We also look at projects in Libya, Ivory Coast, and Haiti, along with threats to the manufacture of affordable generic medicines and the surprising resurgence of measles, a disease once thought to be on the wane. Some of these situations are more complicated than others, but none is simple. And it is MSF’s goal to use the resources you so generously provide us with to first understand the reasons behind each crisis, and then to implement projects, communications campaigns, and advocacy efforts to bring assistance to as many people as possible.

Sincerely Yours,

Sophie Delaunay
Executive Director
Somali refugees in Kenya carry their malnourished children to an MSF feeding center. Kenya 2011 © Brendan Bannon

**SOMALIA’S ONGOING EMERGENCY**

Throughout the summer, waves of Somalis set out on desperate, arduous journeys, braving desert heat, hunger, and bandits to seek relief from a catastrophe remarkable even by the standards of this long-troubled country. The numbers of displaced reached into the millions. Some streamed into Mogadishu, the capital. Others crossed borders into Kenya or Ethiopia. Thousands died along the way. Even those who survived were not assured of respite.

MSF, which has worked in Somalia since 1991, has been trying to expand its programs in and around the country over the past several months. In some places, it’s been feasible to do so, but the severity of the crisis has been compounded by a host of obstacles particular to Somalia that prevent MSF and others from scaling up operations to the degree necessary. Given the sheer number of lives at risk, however, the efforts to reach as many people as possible continues.

**AN UNNATURAL DISASTER**

Somalia has existed in a near constant state of crisis for almost two decades, as warring parties and clans battled each other for control of territory and influence and foreign powers intervened for various reasons, albeit with little benefit for Somalis themselves. In the first half of 2011, the Islamist militia known as Al Shabaab held significant portions of territory, including much of the capital, and was holding off attempts by the Transitional Federal Government (TFG) and the African Union Mission in Somalia (AMISON) to dislodge it. Interwoven through this conflict were other disputes between clans, warlords, and other parties, and an international battle between Al Shabaab and western powers, most notably the United States, that further isolated the population and limited the ability of humanitarian organizations to access populations in need.
Somalia’s current crisis has been portrayed in many forums as a natural disaster, the result of a drought and subsequent crop failures. That is inaccurate—or, the very least, incomplete. There is indeed a drought in the Horn Africa. There is widespread malnutrition, too, much of it severe. But in many ways, this is an amplified version of the crisis that’s been affecting the country for two decades. The specific medical emergencies of the moment are symptoms of a larger disaster involving failures of governance, development, and policy that have left Somalis tragically vulnerable [see page 9]—which is why, when the drought did come, so many were convinced that their survival depended on getting themselves to a place where relief might be available.

**SEEKING RELIEF**

Thus began the exodus. There were indications of the drought in 2010, but, says Duncan Maclean, MSF’s director of operations for Somalia, “The signs of a major crisis were first seen at the Ethiopian and Kenyan borders, where thousands of Somalis started to leave the south of the country in June.” Quickly, the populations of the already overcrowded refugee camps in Dadaab, Kenya, swelled even further. The existing facilities could not accommodate all the new arrivals, and the United Nations, which ran the camps, was slow to find space for them. Some of the exhausted Somalis endured weeks or even months of living in ad hoc shelters on the outskirts of the camps, waiting to get registered as refugees and to receive the assistance they needed.

The UN did eventually establish new camps, but it was still a struggle to keep pace. In early October, an average of 6,000 Somalis were still arriving in Dadaab on a weekly basis. MSF was treating nearly 15,000 patients in its nutrition programs—inpatient, outpatient, and supplemental feeding—and had vaccinated more than 20,000 people for measles in the Dagahaley camp, where it had been running a hospital for the last few years. MSF was also providing primary health care and treatment for malnutrition to refugees who’d settled on the outskirts of Ifo, another camp, and was working at health posts in the more recently-opened Ifo 2 and Ifo 3 camps. Additional teams were working in the border town of Liboi, providing care to Somalis and local people in the area.
While the UN registered nearly 150,000 Somali refugees in Kenya through the first nine months of 2011, another 78,000 Somalis—including a frightening percentage of severely malnourished children—crossed into Ethiopia and found temporary refuge in camps there. MSF was performing health checks of new arrivals as they passed through a transit center and, as of late September, caring for nearly 10,000 malnourished children in the Kobe, Hiloweyn, and Malkadida camps. Teams were also vaccinating children for measles and providing primary care at health posts.

**TRYING TO EXPAND**

In Somalia itself, MSF expanded existing projects and is attempting to negotiate access to open new ones where needed. In the southern town of Marere, for instance, MSF is running nutrition programs and treating cholera and measles. In nearby Jilib, MSF has been distributing essential items to 1,600 displaced families and providing primary health care through mobile clinics. Teams in Galcayo manage feeding programs, care for malnourished children and adults on both an inpatient and outpatient basis, and tend to people wounded in fighting.

In Guri-El, in the Galgaduud region, MSF works in the 80-bed Istarlin hospital, which has a pediatric ward, a women’s ward, and an operating theater—and which has been running over capacity as malnourished patients continue to arrive. MSF is also running six mobile feeding programs and two health posts in IDP camps in the area. “Before the droughts, less than 20 percent of our patients were malnourished, but now the number is closer to 50 percent,” said Dr. Faiza Adan Abdirahman, who runs Istarlin’s pediatric department, in late August. “With malnourishment, come all manner of other diseases. Many of these children are suffering from watery diarrhea and pneumonia. We’re also seeing other problems and complications such as measles and renal and heart problems.”

Teams in Belet-Weyne were admitting three times as many malnourished patients to their nutrition program as they were last year at this time. MSF staff was also carrying out nutritional screenings in IDP camps in Dinsoor, in the Bay region, and running four health centers, nutritional programs, and pre-existing maternity and tuberculosis treatment programs in Jowhar, north of the capital.
On the outskirts of Mogadishu, MSF remains active in the Daynille Hospital, where more than 1,250 war-wounded patients have been tended to in the first nine months of 2011, and approximately 75 people are being admitted to the surgical department each week.

In Mogadishu itself, teams are screening new arrivals for malnutrition and other health problems, carrying out stabilization efforts and supplemental feeding programs, admitting patients when necessary, and vaccinating for measles where possible. According to MSF Emergency Coordinator David Michalski, displaced people “are everywhere in Mogadishu, some with just a few families and some with hundreds of families. Most of the vacant land in Mogadishu has been taken over by these densely-crowded camps.”

LIMITED ACCESS
Throughout the country, medical needs far exceed available health services. The displaced populations are living in precarious health conditions, their immune systems already weakened by poor nutrition. Many have never been vaccinated or exposed to infectious diseases such as cholera, pneumonia, dengue fever and malaria that are common in the city and especially potent in crowded camps with poor sanitation. The rainy season, which begins in October, could exacerbate their spread.

Deploying aid in this patchwork of shantytowns is particularly complicated. “Food distributions are still irregular and inadequate,” says MSF program coordinator Eymeric Laurent-Gascon. “Some of the displaced persons have
STORIES FROM DADAAB

A man, his pregnant wife, and his father sat in a hut made of sticks, cloth, and cardboard on the outskirts of Dagahaley camp. Two of the couple’s children had died in the past two days. They were unable to speak, so the grandfather told their story. “I was a farmer,” he said. “I used to keep some livestock but all the animals died over the last three years and the farm dried up. We wanted to feed the children but there was nothing.”

He continued: “We are worried … a new member to the family [means] we need to feed it milk. There is no milk for the child and it will very difficult for the baby to survive … the mother is weak.”

not received any food since they arrived and are relying on help from those around them. Several NGOs have set up dining halls with food purchased on local markets, but this has led to significant inflation. If prices continue to rise, the entire population of the city will soon be unable to feed itself without outside assistance.” What’s more, due to security concerns, teams can often only work for a few hours per day.

The inability to vaccinate more widely for measles is another major concern. Though reliable numbers are hard to come by, it’s possible that more children are dying of measles at this point than malnutrition. As of early October, more than 54,000 people had been vaccinated. “That sounds like a lot, but if we are to have any hope of stopping the epidemic, we’d have to vaccinate at least 10 times that number,” explains MSF medical manager, Dr. Andrias Karel Keiluhu. “Logistical and security constraints limit our goals.”

MSF hopes that its teams will soon gain more access to deliver medical care in more regions. MSF also hopes to be able to resupply projects by air and send in much needed technical staff. To achieve these goals—and to ensure the security of our personnel in the country, to maintain the integrity and independence of medical facilities, and to communicate the nature and purpose of our actions—MSF remains in constant dialogue with Al Shabaab. This is a significant challenge because of Somalia’s recent history, the geopolitical aspects of the conflict, the ever-evolving
nature of the context, and Al-Shabaab’s proclivity to view all humanitarian efforts as an extension of the military campaign against it.

“So in addition to the security constraints we face, some of which are inevitable when working in a conflict area, we are attempting to exchange with the appropriate interlocutors, and convince them of the pertinence of our medical activities,” says Mclean. “These initiatives have been periodically successful, although we are not satisfied with the scope of our intervention given the scale of needs. But for just this reason, we continue to persist.”
The current emergency unfolding in and around Somalia is being portrayed by many aid organisations and the media in one-dimensional terms, such as “famine in the Horn of Africa” or “worst drought in 60 years.” But only blaming natural causes ignores the complex geopolitical realities exacerbating the situation and suggests that the solution lies in merely finding funds and shipping enough food to the Horn of Africa. Unfortunately, glossing over the man-made causes of hunger and starvation in the region and the difficulties in addressing them will not help resolve the crisis.

I just returned from Kenya and Somalia and what I and my colleagues are seeing on the ground indicates a profoundly distressing situation. In Mogadishu, I met a young woman from the southern region of Lower Shebelle who is now living in one of the many makeshift camps appearing all over the city. She left home with her husband and seven children because of a bad harvest and because they could not afford food and water. Somewhere along her trek, she had to leave her husband and three children behind, as they were too weak to complete the five-day walk. Sadly, her story echoes those of thousands of other families in southern and central Somalia who have been ravaged by conflict for years and tipped over the edge by drought.

Malnutrition is chronic in many parts of the Horn of Africa and there needs to be a long-term international effort to ensure that nutritious foods are reaching the people who need them. Today, however, the most urgent needs are concentrated in southern and central Somalia.

The failed harvests exacerbated what was already a catastrophe. Somalia is the theatre for a brutal war between the Transitional Federal Government, strongly backed by Western nations and supported by African Union troops, and armed opposition groups, most notably Al-Shabaab. In a failed political landscape, it is this war, combined with the internecine rivalries of the various Somali clans, that has kept independent international assistance away from many communities. The Somali people are trapped between various forces who are depriving them of assistance either for their own political reasons, or in an effort to weaken their opponents. There is virtually no access to healthcare in vast tracts of land across the country.

Against the backdrop of conflict, where many agendas are at play, it is difficult for a medical humanitarian organisation like MSF to expand health services and have an impact. MSF has been working in Somalia for two decades and has projects in nine locations on both sides of the front lines – in areas under the control of the Transitional Federal Government and Al-Shabaab. We are doing everything we can to scale up our activities to meet the growing needs.

In refugee camps in Kenya and Ethiopia we have been able to provide medical and nutritional care for tens of thousands of people. But scaling up operations inside Somalia is slow and difficult. MSF is constantly being forced to make tough choices in deploying or expanding our activities. Without the ability to carry out independent assessments and provide assistance in what we believe to be the hardest hit areas, we will not be able to prevent the worst consequences of this emergency.

Humanitarian aid has come to be seen by all sides in the conflict as either an opportunity or a threat. In areas considered to be the epicentre of this crisis, Al-Shabaab, already suspicious of western agendas, has placed bans on foreign staff, on the supply of medicines and materials by air, and on vaccination activities. Even the temporary lifting of US restrictions on the provision of aid in areas controlled by Al-Shabaab is unlikely to improve access. Elsewhere, seemingly endless negotiations turn simple procedures like hiring a nurse or renting a car into projects that take up precious time at the expense of the rapid response that is needed.

In spite of our constant negotiations with all parties to the conflict to gain access, we may have to live with the reality that we may never be able to reach the communities most in need of help or that we will have to compromise some of our independence when we do reach them. Unless all parties remove the barriers that stand between organisations with the capacity to save lives and the people who rely on them for their survival, thousands more may continue dying preventable deaths.
Not long ago, it was tempting to think the battle against measles was being won. Stepped-up vaccination campaigns had driven the number of reported cases down to 32,000 in 2007, according to the World Health Organization, the lowest ever recorded.

Over the past three years, however, there has been a resurgence. In 2009, more than 30 countries experienced widespread epidemics. In 2010, 28 countries declared epidemics, reporting 223,000 cases and 1,200 deaths. In 2011, many African countries have experienced large-scale outbreaks, particularly the Democratic Republic of Congo (DRC).

MSF was a pioneer in the move to vaccinate widely for measles after epidemics had already started, saving many lives in the process. In 2010, MSF vaccinated more than 4.5 million children in Chad, Malawi, South Africa, Yemen, Zimbabwe, and other countries. Through August of this year, teams had vaccinated more than 3 million children in DRC alone.

Measles is prominent in South Asia and present in many other countries—cases are rising in the US and Europe as well—but it’s in Africa where the evidence is most striking. The data shows the urgent need for action but most countries that experience epidemics do not adequately mobilize resources and organize vaccination campaigns. They pay a heavy price, and the costs may well rise as case numbers continue to climb back towards previous levels.

In addition to its work in the field, MSF is calling for an effective outbreak response mechanism, backed by secure financial and technical resources, to be established immediately. “We know for a fact that there will be additional epidemics in the near future,” said Florence Fermon, MSF’s vaccination coordinator. “It would simply not be right to wait for them to occur. We need an effective system to anticipate and prepare for the coming outbreaks.”
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**MSF’s Response: 2010 (Source: MSF)**

4.54 Million People Vaccinated

188,704 Cases Treated

**Measles Vaccinations by MSF: 2004 - 2010 (Source: MSF)**
FIELD NOTES

IVORY COAST: TREATING SURVIVORS OF ONGOING VIOLENCE

Despite the ostensible cessation of the fighting that wracked Ivory Coast earlier this year, violence against civilians has continued in some rural regions, particularly in the southwest. In mid-September, for instance, up to 16 people were killed and 50 homes were burned in an attack on the town of Zriglo. “Within a few hours of the attack being reported, one of our teams managed to reach Zriglo,” said Tara Newell, head of mission for MSF in Ivory Coast. “But they only could count the dead and the burned houses. The population, including the wounded, had already fled.”

MSF clinics in the region continue to see a steady stream of civilians who’ve suffered gunshot or machete wounds or been the victims of sexual violence. Teams have also seen evidence of other violent killings, some of which targeted children. The fear of harassment, extortion, or worse at armed checkpoints strewn throughout the area prevents many who need medical care from seeking it, however. In September, MSF issued a press release that called for all parties to the conflict to refrain from violence against civilians and to ensure access to basic services, including health care.

LIBYA: AIDING THE DISPLACED, THE WOUNDED, AND MIGRANTS

Heading into the fall, MSF was providing a range of medical services in Libya’s capital, Tripoli, as well as in Zintan, Yefren, Benghazi, and Misrata. These services included surgical care, maternal care, post-operative care, hospital support, and mental health care.

MSF worked in Tripoli’s Central Hospital until patient numbers decreased and local health staff returned to their posts. An MSF surgical team continued to work in Tripoli’s Ben Ashour clinic, handling orthopedic cases and treating a backlog of patients waiting for secondary surgical interventions. MSF also provided care to approximately 1,200 migrants and refugees in Tripoli who sought refuge from attacks by armed men in two make-shift camps that lacked water, food, security, and sanitation.

Additionally, after many attempts, MSF was able to send medical supplies into
the town of Sirte, one of the last loyalist holdouts, where health care conditions had deteriorated badly. In October, MSF teams began supporting staff at Sirte's Ibn Sina Hospital and treating patients from the area who were transferred to Misrata's Qasr Ahmed Hospital.

**MSF FIGHTS MOVES TO LIMIT ACCESS TO GENERICS**

India is often referred to as the pharmacy of the developing world because the vast majority of medications used in poorer countries are manufactured by its robust generics industry. The multinational pharmaceutical company Novartis, however, is suing the Indian government to rescind a law that prevents drug companies from seeking new patents for drugs already in use by either slightly altering the formula or patenting them for use with a different disease. This would restrict the ability of generic manufacturers to provide affordable versions of medicines in the developing world.

Additionally, in talks with its partners in the Trans Pacific Partnership agreement—Australia, Brunei, Chile, Malaysia, New Zealand, Peru, Singapore, and Vietnam—the United States Trade Representative (USTR) abandoned its support for more open public health provisions in international law and demanded aggressive intellectual property protections for pharmaceuticals. A leaked USTR position paper revealed that the U.S. is pushing for measures that would delay the introduction of affordable generic drugs in developing countries.

MSF’s Access to Essential Medicines Campaign has been advocating in numerous forums for Novartis and the U.S. government to respect the public health provisions already written into international law and to allow public health concerns to take priority over profits.

**HAITI: MSF OPENS OBSTETRICS HOSPITAL**

On August 18, MSF officially inaugurated a new emergency obstetric care hospital in the Delmas neighborhood of Port-au-Prince, Haiti. Built to replace an obstetric care hospital destroyed in the January 2010 earthquake, the new 122-bed facility provides 24-hour free care for pregnant women experiencing serious complications, along with antenatal and postnatal care, family planning, treatment of sexually transmitted diseases, and counseling and testing for HIV.

Run in collaboration with the Ministry of Health, the hospital is staffed primarily by Haitian health professionals and support teams and also has its own laboratory, blood bank, and pathology department. More than 1,700 women have delivered at the hospital since it opened in March.

**SOUTH SUDAN: A RAMPAGE IN PIERI**

In late August, MSF teams in the South Sudanese town of Pieri treated more than 100 people who’d been wounded during an armed raid in that part of Jonglei State. It is believed that several hundred people were killed. Hundreds more were injured, including women and children who suffered gunshot wounds. Almost half the houses in the town were destroyed.

Two South Sudanese MSF staff members were killed, one of them along with her entire household. Another staff member buried 16 family members. The MSF compound and clinic were looted and some MSF facilities were burned down.

“We condemn this attack on our medical facilities and the killing of our staff in the strongest terms,” said MSF Head of Mission Jose Hulsenbek. The events were the latest chapter in a series of back-and-forth raids launched by rival tribes, a dynamic that used to focus on cattle raiding but has become far deadlier in recent years, at least partly due to guns flooding the region during Sudan’s long Civil War. Whatever the cause, Hulsenbek said, “This is totally unacceptable. Medical facilities should always be respected as places of neutrality, where patients and medical staff should have no fear of attack.”
This fall, MSF-USA traveled to New York, Philadelphia, Baltimore, and Washington, DC, to stage “Starved for Attention,” a free interactive exhibit designed to raise awareness about the global crisis of childhood malnutrition. This is a preventable, treatable condition that continues to affect 195 million children worldwide and contributes to at least one-third of the eight million deaths of children under five every year.

Initiated two years ago, "Starved for Attention" is an advocacy campaign that seeks to achieve key reforms of the international food aid system, to ensure that children receive the quality foods they need. The exhibit recreated an MSF field hospital just like those used to treat tens of thousands of malnourished children in countries such as Somalia, Kenya, Niger, Burkina Faso, and India. MSF medical staff and aid workers, veterans of malnutrition efforts in the field, guided visitors through a simulated clinic that featured photographs taken by the award-winning photojournalists of VII Photo and highlighted methods that have been proven effective in the battle against malnutrition—tools that must be scaled up worldwide. “Our hope is that visitors will not only learn about the underlying causes of malnutrition, but that they will join us in the fight against it,” said Sophie Delaunay, MSF-USA’s executive director.

Malnutrition is not merely the result of too little food. The first two years of life are a critical window when children need access to a diet of high-quality protein, essential fats, carbohydrates, vitamins, and minerals, in order to avoid impaired growth and development and increased risk of death from common illnesses. Yet most food aid does not include these essential ingredients. “Foods we would never give our own children here in the U.S. are being sent overseas as food aid to the most vulnerable children,” said Delaunay. “This double standard must stop.”

As of October 10, more than 130,000 people—including many who attended the exhibition—had signed a petition demanding that policymakers improve the nutritional quality of food aid.

For more information, and to see the photos and films, please visit starvedforattention.org
WORK WITH MSF
Between October and December 2011, MSF will hold recruitment information sessions in:
Atlanta, GA
Boston, MA
New York, NY
Salt Lake City, UT
All prospective medical and non-medical aid workers are welcome to join us for a presentation and Q & A to learn more about MSF’s field work. A human resources officer will discuss requirements and the recruitment process and an experienced MSF aid worker from the local area will share stories of life in the field. Check doctorswithoutborders.org/events/public for more information and to register. Or please participate in one of our regularly scheduled recruitment webinars.

Please note that there is an urgent need for operating room staff and for French-speaking applicants to work in countries such as the Democratic Republic of Congo, Chad, Niger, and Haiti, where some of MSF’s largest projects are located.

MSF-USA SPEAKING EVENTS:
(All are free and open to the public.)
Tuesday, October 18 – 8 PM
Sophie Delaunay, Executive Director, MSF-USA
“Humanitarian Action and the Politics of Compromise”
St Mary’s College, Auerbach Auditorium
St. Mary’s City, MD

Wednesday, October 26 – 12 PM
Sophie Delaunay, Executive Director, MSF-USA
“Doctors Without Borders: Managing Pediatric Challenges in Humanitarian Situations”
Yale University, Fitkin Amphitheatre
New Haven, CT

Thursday, November 17 – 6-8 PM
Duncan Mclean, MSF Director of Operations for Somalia
“Famine and Displacement in the Horn of Africa”
The New School, Kellen Auditorium
New York, NY

MAKE A PLANNED GIFT AND JOIN OUR LEGACY SOCIETY
By providing for MSF in your estate planning you will help ensure our ability to respond to the challenges we face now and in the future. Each year, many of our loyal supporters join our Legacy Society by naming MSF in a will or trust or as a beneficiary of a life insurance policy, financial account, Individual Retirement Account (IRA) or other retirement plan, charitable gift annuity or charitable trust. As a member of our Legacy Society, you will receive updates about our work around the world and be listed in our Annual Report. For information about MSF’s planned giving program, please call Mary Sexton, Director of Major Gifts, at 212.655.3781.

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 $23 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.

You can also learn more by visiting us online at doctorswithoutborders.org/donate/multiyear.
A girl selling food along the Congo River in Mbandaka, in Democratic Republic of Congo, listened this summer as an MSF health promoter explained that a cholera epidemic had been spreading along the river and had caused outbreaks in many of the towns on its banks. He explained how to avoid getting cholera, the symptoms to watch for, and what to do if one contracts it.

DRC's summer cholera epidemic killed hundreds of people and spread to the capital, Kinshasa. MSF emergency medical teams established a cholera treatment center in Mbandaka that was receiving around 20 new patients every day. DRC is also dealing with a massive and deadly outbreak of measles, for which MSF sought and recently received permission to launch a widespread vaccination campaign in Katanga.