STARVING FOR ATTENTION:
THE CRISIS OF CHILDHOOD MALNUTRITION
LETTER FROM THE EXECUTIVE DIRECTOR

Dear Friends,

In this issue of Alert, we focus on the neglected crisis of childhood malnutrition.

Last year alone, Doctors Without Borders/Médecins Sans Frontières (MSF) treated more than a quarter of a million malnourished children in 34 countries. As a medical organization, we know what infants and young children need to grow and develop. We know that when families cannot afford to provide the milk, eggs, fish, or meat that their children need, simple supplements or ready-to-use foods can mean the difference between life and death.

We also know that most food aid sent to developing countries is made up of poor quality foods—blends of soy and corn flours that carry little or no actual nutritional value. This food makes little difference for the 195 million children who suffer from malnutrition every year. It makes little difference for the three to five million children who die every year from causes related to malnutrition.

As staggering as the numbers is the fact that this crisis is so invisible to most of us, that so many children around the world are suffering and dying from a medical condition that we know is both treatable and preventable.

That is why MSF has been actively advocating for changes to food aid policies as well as to treatment and prevention protocols. That is why we partnered this year with the VII Photo Agency to document seven different responses to malnutrition in seven different parts of the world. The result is “Starved for Attention,” a multimedia exhibit that was launched in New York City this past June. The exhibit has already been shown in Europe and Canada and will reach other destinations in the coming months.

Some of the situations captured in the exhibit are shared in this issue of Alert—families in Bangladesh and India struggling to feed their children or a family in eastern Congo whose infant son is hospitalized in an MSF clinic. There are success stories from Mexico and the US and heartbreaking tales from Burkina Faso and Djibouti of young mothers doing all they can to keep their children alive.

We invite you to visit this exhibit at www.StarvedForAttention.org. We also invite you to sign our online petition asking international donor countries, including the US, to stop sending substandard food to children in need and to commit to providing them with the nutrient-rich food they must have to survive and thrive.

Thank you for your ongoing support, which enables MSF’s medical teams to treat hundreds of thousands of malnourished children across the globe and helps us raise our voices on behalf of the world’s most vulnerable children.

Sincerely,

Sophie Delaunay
Executive Director, MSF-USA
Inside a Doctors Without Borders/Médecins Sans Frontières (MSF) outpatient clinic for malnourished children in northeast India, Dr. Krishna Ashvalayan is trying fervently to convince a mother to keep her severely malnourished 12-month-old girl in MSF’s nutrition program.

The girl’s mother, Sela, however, is adamant; she wants her daughter’s name taken off the clinic’s list of patients. She insists that she simply cannot make weekly trips from her home village to the clinic for check-ups and supplies of nutrient-rich ready-to-use therapeutic food (RUTF).

Days she comes to this clinic in the town of Biraul, she explains, are days she cannot earn money harvesting wheat in someone’s field. And to get here, she has to leave her home early in the morning to catch the train that takes her into Biraul. If treatment takes too long, she risks missing the last train back, meaning she has to pay for a ride home on either a motorized rickshaw or a makeshift bus that costs far more than the two-rupee train ticket. What’s more, this daughter is not her only child. “I have six other children at home,” she says. “Who is going to feed them?” Underlying her skepticism is a sense that her child, who looks like most of the other children in her village, is not really sick.

**A DIFFERENT KIND OF EMERGENCY**

India is a complex country in which to launch a program that targets a condition that can be invisible, or at the very least, hard to detect. A year and a half after MSF, in cooperation with the local health authority, opened its program for children with severe acute malnutrition (SAM), 3,000 patients have completed treatment. These children are now more likely to develop physically and mentally at a normal rate, more likely to have healthy immune systems, and less likely to get sick and die due to diarrhea or influenza. But 3,000 is a tiny number in Bihar, a state with a population of 100 million—let alone India, which, according to UN figures, home to one in every three malnourished children in the world.

“This is a very strategic project where we can’t hope to meet the needs of all of the people,” says Dr. Gareth Barrett, medical coordinator for MSF in India. “But we do hope to demonstrate that there is a way to treat severe acute malnutrition.”

MSF is working in Darbhanga District, an area of Bihar that is flooded every year by monsoon rains and where an estimated five percent of children under five years old suffer from SAM. This is one of the poorest areas of India, a region that boasts few signs of the development found in a place like Mumbai. Much of Bihar’s population lives season to season, dependent on rainfall and good harvests. Schools and hospitals are few in number, and health care is limited. Nutritious foods are available, but they are expensive. People who cultivate fruits or vegetables, or get milk from their buffalos or goats, are more likely to sell these nutritious foods for income than to keep them for their family.
This has led to a pattern of nutritional insecurity—or a lack of consistent access to nutritious foods—that has become a fact of life for generations of Biharis. Dr. Barrett estimates that half of the state’s population has had their growth stunted. It is so common now that it has ceased to look unusual. And the phenomenon has become almost self-perpetuating.

“The child grows up to be stunted, gets married to another stunted child, the child born to them will be stunted,” says Dr. Krishna. “So this is a chronic process that has been happening since time immemorial.” And as Dr. Krishna learned when he was trying to convince Sela to keep her daughter in the program, it can be difficult to convince a parent that they need to bring their child to a clinic every week for care.

The impact goes far beyond physical stunting. Malnourishment can also delay a child’s mental development. Like physical growth, brain development also relies on the right balance of micronutrients. “We have a lot of mothers coming with a complaint of, ‘my child is two-and-a-half or three years old and is not walking. My child is three years old and is not speaking yet,’” says Dr. Krishna. “The reason being the child has not been getting the proper nutrients for its development.” For these kinds of cases, RUTF can play a vital role in rehabilitating the child. But it is critical for children to get the right foods within the first two years of life, and it is critical that mothers understand that in such circumstances, once their child is six months old, breastfeeding alone is not enough.

BUILDING A MEDICAL MODEL

MSF’s nutrition program in India stands in contrast to its emergency treatment of SAM in other places. This is not Ethiopia in 2008, when children were in immediate danger of dying and desperately needed emergency treatment. And this is not like one of MSF’s current projects in Niger or Chad, countries where children are caught in a potentially fatal cycle of seasonal hunger gaps. But the fact is that SAM among children five and under continues to be an ongoing problem with far-reaching consequences in India, and thus far it has not been effectively addressed.

“The population today is undernourished,” says Dr. Barrett. “There is no other way of saying that people don’t have access to a well-balanced diet. But until things do improve, there is a need to treat people. With severe acute malnutrition, people today are vulnerable to premature death and long-term damage.”

MSF runs one inpatient stabilization center for children who are severely malnourished and in danger of dying. Children are fed gentle therapeutic milk packed with micronutrients that their bodies can absorb until they are stable enough to receive RUTF and regular food. But 8 out of every 10 children in the program are treated as outpatients, receiving weekly consultations with a doctor and rations of RUTF. Mothers like Sela bring their children to one of three ambulatory therapeutic feeding centers on appointed days. If they miss a week or two, health educators are sent out to their homes to find out why and to convince them to come back.

While patients are being treated, health workers collect data. The idea is to refine this small pilot program so that it can soon serve as a highly effective and cost-efficient model that can be replicated by other organizations or health authorities throughout the country. “What we’re trying to do in India is treat children, but then take the results from that and share that with the Indian government, share that with other organizations,” says MSF nutritionist Jeanette Bailey. “And we’re trying to show that it’s very simple, that it’s absolutely possible, and that there’s no reason we can’t do this on a large scale.”

SUCCESS THROUGH WORD OF MOUTH

Health education at the clinics is designed to sensitize mothers to the nutritional needs of their children, along with other health and hygiene practices, and the necessity of continuing the treatment until their children are fully recovered. The team’s communications efforts only go so far, however. The best ambassadors for the program, as it turns out, are mothers of children who are in the program and who have completed treatment.

It has been several months since MSF teams finished screening children in the villages of the area it serves and directing the parents of malnourished children to come to the clinics. Yet a stream of new patients continues to show up seeking care. This is due to word of mouth, says Dr. Krishna, mothers talking to mothers and elders talking to young families, spreading the message through community networks.

With Sela, Dr. Krishna has tried every argument he could think of in an attempt to keep her in the program. It seems...
that he was unsuccessful, however, and she appears to be preparing to leave the clinic for the last time. Just then, Laila, another young mother from Sela’s village, whose child is receiving a consultation right behind her, chimes in. “You should stay in the program for the good of your child,” Laila says.

The other mothers in the rooms instantly begin echoing the sentiment, breaking down Sela’s resistance with their own conviction until, finally, Sela relents. “Okay, I will come back,” she tells the relieved doctor, making a seemingly simple decision that may very well have a profound impact on the rest of her child’s life.

MSF AND VII BRING YOU “STARVED FOR ATTENTION”

In June, MSF and VII Photo Agency launched “Starved for Attention,” a multimedia campaign that exposes the neglected and largely invisible crisis of childhood malnutrition. “Starved for Attention” aims to rewrite the story of malnutrition through a series of multimedia documentaries that seamlessly blend photography and video from some of the most accomplished and award-winning photojournalists working today.

VII photojournalists Marcus Bleasdale, Jessica Dimmock, Ron Haviv, Antonin Kratochvil, Franco Pagetti, Stephanie Sinclair, and John Stanmeyer traveled to malnutrition “hotspots” around the world to shed light on the underlying causes of the malnutrition crisis and innovative approaches to combat this condition. They captured frontline stories from Bangladesh, Burkina Faso, the Democratic Republic of Congo, Djibouti, India, Mexico, and the United States.

An estimated 195 million children suffer from the effects of childhood malnutrition; 90 percent of them live in sub-Saharan Africa and South Asia. Malnutrition contributes to at least one-third of the eight million annual deaths among children under five years of age.

Many families simply cannot afford to provide nutritious food—particularly animal source foods such as milk, meat, and eggs—their young children need to grow and thrive. Instead, they struggle to survive on a diet of little more than cereal porridges of maize or rice, amounting to the equivalent of bread and water.

You can be part of the campaign to rewrite the story of malnutrition by going to StarvedForAttention.org and signing the petition demanding that donor governments ensure that food aid fulfills sufficient nutritional requirements and that the 195 million malnourished children around the world get what they need to escape the deadly cycle of malnutrition.

The “Starved for Attention” campaign has been made possible with the support of LG INFINIA.
PHOTO ESSAY

STARVED FOR ATTENTION: SOME OF THE 195 MILLION STORIES OF MALNUTRITION

Go to StarvedForAttention.org to see all seven multimedia presentations.

BURKINA FASO
Jessica Dimmock followed Natacha, a Burkinabè mother who worked desperately to keep her children healthy. Burkina Faso 2009 © Jessica Dimmock/VII Network

BANGLADESH
The schools that Ron Haviv visited in Bhola were full of children like this little girl who frequently fainted in class. When he met her, she had not eaten in three days because her parents were not able to get enough work to feed her. Bangladesh 2009 © Ron Haviv/VII
DJIBOUTI
In Djibouti, in northeast Africa, nothing grows, nutritious foods are too expensive to buy, and much of the population has been displaced by poverty or conflict. Marcus Bleasdale captured the worry and affection mothers have for their children, many of whom are caught in a repetitive cycle of malnutrition.
Djibouti 2010 © Marcus Bleasdale/VII

MEXICO
In Oaxaca State, John Stanmeyer explored how the Progresa/Oportunidades program is helping impoverished Mexican families get the nutrient-rich foods their children need to grow and stay healthy.
Mexico 2010 © John Stanmeyer/VII
UNITED STATES OF AMERICA
Antonín Kratochvíl and Jessica Dimmock captured two different and contradictory examples of how the US deals with the nutritional needs of children. In Illinois, Kratochvíl documented the harvest of crops that would be sent abroad as food aid—an almost nutritionally worthless blend of corn and soy flours (right, US 2009 © Antonín Kratochvíl/VII).

DEMOCRATIC REPUBLIC OF CONGO
Franco Pagetti documented how people in North Kivu who are repeatedly displaced from their homes by conflict are forced to rely on food with little nutritional value. DRC 2009 © Franco Pagetti/VII
A veteran family physician with numerous Doctors Without Borders/Médecins Sans Frontières (MSF) missions under his belt, Dr. Cameron Bopp returned in July after several months in Africa. He served first as medical team leader in Chad and then as emergency coordinator in Malawi, which was in the midst of a widespread measles outbreak—one of several to hit the region in recent years after two decades of steadily decreasing case numbers (see back page and doctorswithoutborders.org for more information). Here he discusses his time in Malawi, during which he was tasked with overseeing the emergency response to the measles outbreak and setting up vaccination programs.

**PLANNING THE INTERVENTION**

Our original targets were the city of Blantyre, which was the epicenter for the Malawi measles outbreak in the south, followed by Chiradzulu, which also had a very high rate and is the home base for an MSF HIV/AIDS treatment program, and Mzimba, in the north, which had a fairly high attack rate as well.

But the window for trying to control the epidemic by responding early in Blantyre was closing. It took about six weeks from the time we made the original proposal to the time the Ministry of Health gave us permission to start the vaccination program. By then, it was rapidly spreading to the adjacent districts. So plans started being made for Lilongwe, the capital, which was coming on the screen.

Our strategy turned out to be perfect, in retrospect, I think. We vaccinated the three major urban areas in the country—Blantyre, Lilongwe, and Mzuzu, which is the regional capital in the north. They were also the places that, along with Chiradzulu, had the highest attack rates at the time we vaccinated.

**ON THE UPSURGE OF OUTBREAKS**

There’s going to be a lot of research done to explain this, but at this point, I think some of the big factors in Malawi are HIV, which increases the number of people who are susceptible to the disease, and the fact that, from what we were able to see from the government campaigns, protocols for cold chain and supervision of vaccinators weren’t really in place. This probably leads to people who on paper have been vaccinated but who aren’t really getting effective vaccinations. And I think a third thing is that after 10 or 20 years, the protection of previous vaccinations can start to wear off. Probably those three factors put together are accounting for what we’re seeing.

It was an eye opener for younger health care workers who’d never seen measles, who were misdiagnosing it, essentially, because they hadn’t seen it—the same way I did when I came across my first measles case. These were people in their early 20s, young nurses, medical assistants, and clinical officers. There were no real national protocols in place for measles outbreaks. There were also a lot of gaps in medications. So the initial case management was very satisfying because a little bit of teaching and the drug kits go a long way, both for better surveillance and better case management.

**WHO CONTRACTED MEASLES**

There were a lot more adults than usual in this epidemic. In Blantyre, which has the country’s highest HIV rate, adults represented one-third of all patients. After the vaccinations, the people who continued to come in with measles—because they weren’t vaccinated—were adults. And of them, at least of those hospitalized, a high percentage was HIV-positive.

Otherwise, it followed the usual patterns. The attack rates were highest in children aged 6 to 9 months and 9 to 11 months. But the number of cases in children aged 5 to 15 years was high enough that you had to vaccinate that entire cohort to achieve control.

Initially, people were coming in very late. In the early stages of any epidemic, when the population isn’t aware that there’s a serious outbreak going on, people come in in the late stages of pneumonia, the late stages of dehydration from diarrhea, later in the course of clinical presentation. That’s why the death rate is usually higher initially.

I’m not sure I’d say people were panic- icked, but there was certainly a lot of fear. I think that’s why we had such an enormously successful campaign. The social mobilization was almost the easy part, though you can never take that for granted because it’s too important. There was remarkably little national press coverage of the measles epidemic initially, but word did spread through local networks.

**ON THE ROLE OF THE EMERGENCY COORDINATOR**

The role evolves as the project evolves. Initially, it’s concentrated on set up and strategy, going in and opening a project. Once the teams are in, you’ve done the initial training, and you’ve made sure that the program is up and running, you switch to fine tuning.
You try to allow yourself time to look at the big picture, to look at the data, and make sure that things are happening the way they’re supposed to. 

You know it’s going well when your epidemic curves really start coming down. Initially, you look at your estimated vaccination coverage rates on a daily basis. You look at the consumption of needles and syringes and vaccines to make sure everything lines up, that there are no red flags. You want to make sure you don’t run out of supplies. But the big number is the percentage of people in each target group that you’re vaccinating. 

In Malawi, it was totally rewarding because we were doing 105 percent, 110 percent, 115 percent, wherever we were. That was partly because the census numbers were probably a bit behind, partly because we had people coming in from other districts to be vaccinated. 

The number of cases in the country was up to 33,000 the week I left, but it’s still a fairly small percentage of the population that gets measles. It’s not like there’s mass panic going on. It’s different than a meningitis campaign, where the mortality rate is pretty high and people are more afraid. In this, you really wouldn’t know from walking on the streets that there was an epidemic—although it’s not rare to come across someone in Blantyre who says they have lost a relative to measles. 

ON NEW WAYS OF RESPONDING 

MSF has been instrumental in showing that in a developing country, a measles epidemic can go on for months to well over a year. The original World Health Organization guidelines claimed that once a measles epidemic started, it was too late to do anything about it, and in terms of vaccinating you have to let it run its course. That was dead wrong. [Editor’s note: In 2006, MSF released a study that showed that rapid, wide-scale vaccination programs can reduce the toll inflicted by measles outbreaks even after they’ve begun, and the WHO has since changed their guidelines to reflect this.] And that’s one of the rewarding things about being a part of an organization like MSF: You know that your data is going to be put to use. It’s going to become part of a broader database that can lead to some clinical research, some epidemiological research that can help improve international policies. 

LOOKING BACK 

The two images that come to mind are, first of all, the epidemic curves, when we really started seeing the numbers go down and the joy that brought to the team and the Ministry of Health and everyone else. And the other thing is the enthusiasm and dedication of the expat teams, especially the first mission people. I told people when they came, “You can’t have a better first mission than a vaccination campaign. It’s short, it’s intense, but everybody has exactly the same goal in mind no matter what their piece is. And it’s really nice to be part of a group that shares something so intimately.”

The two expat teams performed fantastically, vaccinating 2.1 million children over a period of two months. We had challenges, but people rose to those challenges. They learned how to do problem solving daily, hourly, whatever was needed. There’s no way to overestimate how important experience is. It’s something that just can’t be taught. You learn it from people who have more experience than you and then ultimately you learn it with on-the-job training, being put in this position, having some successes and some mistakes, trying to learn from both and apply them better next time.
SITUATION UPDATE

HAITI: THE IMPACT OF DONOR SUPPORT

*The following was adapted from MSF’s report, “Emergency Response After the Haiti Earthquake,” available in full at doctorswithoutborders.org

In its aftermath, the January 12 earthquake in Haiti left not only millions of dazed, injured, and displaced people but also an extensive litany of challenges for the relief effort. Although Doctors Without Borders/Médecins Sans Frontières (MSF) was already in the country, the organization nonetheless saw its own structures damaged and was stretched to its limits by the extent of the medical needs. The organization’s financial resources were generously augmented by millions of individual donors, but the pressure on its medical, technical, and managerial staff was unprecedented.

Though the full scale of the damage took some time to reveal itself, it was clear from the outset that the medical needs were immense. Soon, though, MSF grew concerned that the funds pouring in from supporters old and new and earmarked specifically for this emergency threatened to eclipse what MSF could foresee spending.

MSF takes the expectations of its donors seriously and, given the uncertainty about its ability to use the amounts projected to come in, decided in the days following the disaster to discontinue active fundraising for Haiti. MSF continued to welcome donations but called upon donors to support the organization by giving to the Emergency Relief Fund, which allows MSF to respond rapidly to emergencies around the globe.

That decision has helped MSF’s ability to respond to other emergencies around the world and has not hampered its ability to respond to needs in Haiti. As of May 31, MSF had received around $122 million earmarked for emergency relief in Haiti and had spent nearly $71.5 million on assistance to the Haitian population. MSF projects that spending will reach approximately $120 million in Haiti by year’s end. Any remaining earmarked funds will support MSF’s ongoing commitment to the victims of the earthquake in 2011.

EXAMPLES OF ACTIVITIES

Among the large scope of MSF activities in Haiti, as of May 31, more than $14.6 million has been spent on surgical care for Haitians injured in the earthquake. At least $5.3 million was spent on maternal health services, which were already extremely limited before the earthquake struck. Roughly $11.3 million was spent on shelter and related items in an attempt to improve living conditions for some of the hundreds of thousands of people whose homes and livelihoods were destroyed. MSF also invested substantial amounts in other medical and relief activities, including primary care, mental health support, and provision of water and sanitation.

Operating such emergency health programs requires a range of investments. Given the devastation in Port-au-Prince and beyond, including the near-total destruction of many health centers and hospitals, nearly 30 percent of MSF’s expenditures as of May 31 were devoted to logistics. This involves, but is not limited to, the rehabilitation or construction of medical facilities and the ongoing maintenance of health structures, including water and electricity provision. Without this investment, medical staff would not be able to operate. A further 16 percent of MSF’s expenditures have been attributed to medical materials and supplies.

Because of the large number of essential emergency workers and vast amount of relief goods brought into Haiti, transportation accounted for 23 percent of the total spending. At one point, the MSF team totaled over 3,500 Haitian and international emergency personnel—doctors, nurses, logisticians, administrators, drivers, project coordinators, and others. At the
end of June, MSF still had more than 3,000 staff on the ground, over 90 percent of them Haitians. The costs related to employing personnel accounted for 28 percent of the money spent.

FUTURE NEEDS

One immediate challenge for MSF has been to create more robust medical facilities to replace those damaged in the quake and the tented structures that have been in use up to now—a process that is well underway. There are uncertainties around the speed of reconstruction and the extent to which other organizations will remain involved. There are concerns about the continued physical exposure of so many people in Port-au-Prince and about the potential for political and criminal violence, which could be exacerbated by frustration about the slow pace of progress, particularly around shelter for the displaced. All of this has reinforced the urgency of MSF’s planning and provision for the possibility of outbreaks of violence, disease, nutritional crises, and future natural disasters. MSF is immensely grateful to the millions of people around the world who have helped finance the organization’s relief work in Haiti. It is already clear that MSF will be making a very substantial commitment to Haiti in the years to come.

Top to bottom: Two girls carry water through one of Port-au-Prince’s many IDP camps, Haiti 2010 © Katrijn Van Giel; The post-operative services program in Tabarre, Haiti 2010 © Francoise Servranckx/MSF; A father and his newborn child at the Isaie Jeanty maternity program, Haiti 2010 © Kadir Van Lohuizen/NOOR
ON DOCTORSWITHOUTBORDERS.ORG

**MSF RESPONDS TO ETHNIC VIOLENCE IN KYRGYZSTAN**
At doctorswithoutborders.org/alert, see reports of MSF’s activities in Kyrgyzstan and Uzbekistan during and after spasms of ethnic violence in southern Kyrgyzstan killed scores and drove hundreds of thousands from their homes.

**HIV/AIDS GAP WIDENS IN AFRICA**
Watch a video that underscores the dangers millions living with HIV/AIDS face as some international donors cap and even reduce their funding for HIV/AIDS drugs.

**MEASLES OUTBREAKS HIGHLIGHT NEED FOR NEW OUTLOOK**
Read about MSF’s response to a wave of measles outbreaks, primarily in Africa, which poses a major problem and puts many lives at risk.

**ON THE MEDICAL/HUMANITARIAN FRONT**
In a new book, *Medical Innovation in Humanitarian Situations: The Work of Médecins Sans Frontières*, several authors examine the debates and controversies surrounding the obstacles to providing medical care in precarious situations in the field—from developing logistical capabilities to improving the treatment of cholera, sleeping sickness, HIV/AIDS, malaria, and malnutrition. Edited by Dr. Jean-Hervé Bradol, the volume examines how MSF has dealt with the incongruity of practicing conventional medicine in situations that often require unconventional approaches.

Dr. Bradol, a former president of MSF-France, has served as an MSF field physician in contexts ranging from refugee camps in Thailand—where he coordinated the introduction of a new treatment for multidrug-resistant malaria—to the Rwandan genocide. Most recently, he spent several months in Haiti as a field physician. Currently he is director of research at the MSF Center for Reflection on Humanitarian Action & Knowledge (Centre de Réflexion sur l’Action et les Savoirs Humanitaires, or CRASH). See www.msf-crash.org for more information, including how to order the French version of the book. An English version is forthcoming.

**MSF FRONTLINE REPORTS: A WEEKLY PODCAST FROM MSF**
Frontline Reports now brings you weekly updates from MSF projects around the world.

**July 26, 2010**
In June violent clashes between Uzbek and Kyrgyz communities in southern Kyrgyzstan left hundreds dead and thousands wounded. Though the violence subsided, fears it could flare up again abound. MSF has implemented a three-point strategy for treating victims of the violence and preparing for another potential surge.

**July 21, 2010**
Only 10 percent of the 27,000 people working for MSF around the world are international field workers. The overwhelming majority are national staff working in their home countries. This week we meet a Ugandan doctor who began his career with MSF after seeing the organization’s work in his country.

**July 06, 2010**
In an area of northwest Nigeria rife with wildcat gold-mining operations, a wave of lead poisoning seems to have caused the sudden death of numerous children, leading MSF to treat patients for lead poisoning for the first time in the organization’s history.

From left: An Uzbek woman surveys her destroyed house in Osh, Kyrgyzstan, this past June, Kyrgyzstan 2010 © Alexander Gilyadylev; A patient listens to an adherence counselor describe the treatment for HIV and TB co-infection, Uganda 2010 © Brendan Bannon
WRITING ON THE EDGE:
November 18, 2010: New York City, New York
92nd Street Y

Award-winning photographer Tom Craig teamed up with MSF and a roster of highly acclaimed, widely traveled writers, directors, and actors to visit MSF projects around the world. Their accounts became the basis for the unique book, Writing on the Edge. Craig will discuss the process of documenting the humanitarian activities of MSF and will be joined by contributors to the book, including Damon Galgut, who traveled to Uganda with Craig, and journalist Hari Kunzru, who traveled with Craig to India. MSF-USA’s Deputy Operations Manager, Dr. Greg Elder, who oversees program activities in Uganda, Somalia, Ethiopia, Nigeria, and Haiti will also share his experiences in the field and the latest information on MSF projects around the world.

November 20-21, 2010: Miami, Florida
Miami Book Fair

Tom Craig, Hari Kunzru, and Damon Galgut will be repeating their discussion of Writing on the Edge at the Miami Book Fair. For details, please visit doctorswithoutborders.org.

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 $21.6 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.

GIFT ANNUITY RATES HAVE GONE UP!

MSF’s Charitable Gift Annuities make it easy to provide for our future as well as your own. When you set up a gift annuity for at least $5,000 with MSF, you will receive fixed payments for life and an immediate income tax deduction. Minimum age when payments begin is 65. We follow American Council on Gift Annuities suggested rates. For more information, including a personalized illustration of how a gift annuity can work for you, please contact Beth Golden, planned giving officer, at (212) 655-3771 or plannedgiving@newyork.msf.org.

WORK WITH MSF

Between July and December 2010, MSF will hold recruitment information sessions in the following cities:

Boston, MA
Cleveland, OH
Denver, CO
Los Angeles, CA
New York, NY
Raleigh-Durham, NC
San Francisco, CA

All prospective medical and non-medical aid workers are welcome to join us for a presentation, film, and question-and-answer session to learn more about MSF’s field work. A human resources officer will discuss requirements and the recruitment process. Check doctorswithoutborders.org for dates, more information, and to register for these events. If none is convenient, please consider participating in one of our regularly scheduled recruitment webinars. Please note that there is, at present, a particular need for French-speaking applicants and orthopedic surgeons to work in countries such as the Democratic Republic of Congo, Chad, Niger, and Haiti, where some of MSF’s largest projects are located.

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MSF’s Charitable Gift Annuities make it easy to provide for our future as well as your own. When you set up a gift annuity for at least $5,000 with MSF, you will receive fixed payments for life and an immediate income tax deduction. Minimum age when payments begin is 65. We follow American Council on Gift Annuities suggested rates. For more information, including a personalized illustration of how a gift annuity can work for you, please contact Beth Golden, planned giving officer, at (212) 655-3771 or plannedgiving@newyork.msf.org.

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 $21.6 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.

A child gets attended to at Boost Hospital in Helmand Province, Afghanistan 2010 © Kate Ribet/MSF
Scores of people came to a Doctors Without Borders/Médecins Sans Frontières (MSF) facility in Malawi in May to get vaccinated for measles. Over the past two years, MSF teams have responded to increasingly frequent and widespread measles outbreaks in Africa. Previously, the World Health Organization’s Expanded Program on Immunization (EPI) had helped achieve a very real decline in measles cases and deaths. The WHO, in fact, had targeted measles for eradication by 2015. But in the past year, as limitations in EPI became clearer and resources were demobilized by donor nations and bodies that seem to believe measles is no longer a grave threat, the disease has seen a marked rise.

In the field, MSF focuses primarily on surveillance, patient care, and emergency immunization. Last year, working with ministries of health and other stakeholders, MSF immunized more than 1.5 million children and adolescents in response to measles outbreaks in 10 countries. In 2010, if current trends hold, the numbers could double.

Rapid interventions can mitigate the spread of outbreaks, but obstacles remain. MSF has been speaking out about the dysfunction inherent in the current approach to battling measles and the need, in collaboration with all stakeholders, to design a more effective response.