FOOD IS NOT ENOUGH: How Millions of Malnourished Children Could Be Saved
Dear Friends,

There is good news for the millions of acutely malnourished children living in warzones or the “malnutrition hotspots” of the Sahel and Southeast Asia. Highly nutritious ready-to-use foods (RUF) are revolutionizing the treatment of acute malnutrition. These specially formulated products—dense in nutrients and containing milk protein—do not require refrigeration for storage and can be eaten without being cooked. As a result, many more acutely malnourished children, who can now be treated at home, can be reached. This is a rare and exciting breakthrough: a medical innovation adapted to the needs of poor patients in developing countries, raising the prospect of saving many of the five million children under five years old who die from malnutrition-related causes each year.

In October, Doctors Without Borders/Médecins Sans Frontières (MSF) initiated a campaign to immediately increase the provision of RUF to the estimated 20 million young children worldwide who are suffering from severe acute malnutrition. Production of RUF will have to be scaled up and programs changed. MSF also called for expanding the distribution of RUF to moderately malnourished children rather than using fortified blended flours that have questionable impact. Currently, major health and donor organizations, such as UNICEF, World Health Organization, and the US Agency for International Development, limit the use of RUF to only the most severe cases and support blended flours for supplementary feeding.

MSF didn’t reach this conclusion easily. Years of treating hundreds of thousands of acutely malnourished children in Niger, Chad, and other countries has demonstrated the amazing potential of RUF to save children on the brink of death and, by intervening early, prevent the onset of acute malnutrition. This issue of Alert looks at MSF’s experience in addressing the challenge of acute childhood malnutrition, as well as our advocacy efforts to shift the paradigm.

No amount of medical innovation, though, is going to be enough to assist the hundreds of thousands of acutely malnourished children in Niger, Chad, and other countries has demonstrated the amazing potential of RUF to save children on the brink of death and, by intervening early, prevent the onset of acute malnutrition. This issue of Alert looks at MSF’s experience in addressing the challenge of acute childhood malnutrition, as well as our advocacy efforts to shift the paradigm.

Thank you for your continued support of MSF and your belief in our principles of independent and impartial medical humanitarian action for people affected by armed conflicts, epidemics, nutritional crises, and natural disasters around the world.

Sincerely,

Nicolas de Torrenté, PhD
Executive Director, US Section of Doctors Without Borders/Médecins Sans Frontières (MSF)
On October 10, Doctors Without Borders/ Médecins Sans Frontières (MSF) called for increased and expanded use of nutrient dense ready-to-use food (RUF) to reduce the five million annual deaths worldwide related to malnutrition in children under five years of age. RUFs have transformed the way malnutrition can be addressed today meaning most children in need can be given the care they require. Yet much more needs to be done to make these lifesaving products available to address the crisis of malnutrition, particularly in the malnutrition hotspots of the world.

“It’s not only about how much food children get, it’s what’s in the food that counts,” said Dr. Christophe Fournier, president of MSF’s International Council. “Without the right amounts of essential nutrients and vitamins in their diet, young kids become vulnerable to disease that they would normally be able to fight off easily. Calls for increased food aid ignore the special needs of young children who are at the greatest risk of dying.”
Severe acute malnutrition in early childhood is common in large areas of the Horn of Africa, the Sahel, and South Asia—the world’s “malnutrition hotspots.” The World Health Organization (WHO) estimates that there are 20 million young children suffering from severe acute malnutrition at any given moment and MSF estimates that only three percent of them had access to RUF in 2007.

**LIFESAVING PRODUCTS TAILORED TO NEEDS OF YOUNG CHILDREN**

RUFs contain all the necessary nutrients, vitamins, and minerals that a young child needs. This dense therapeutic food, which has milk powder, sugars, and vegetable fats, can be produced and stored locally and transported easily, and requires no refrigeration, making it ideal for use in hot climates. It allows a child to recover from being malnourished and catch up on lost growth. Being easy to use, mothers, instead of doctors and nurses, are the main caregivers, meaning far more children at risk can be reached.

“In Somalia we are giving acutely malnourished kids packets of ready-to-use food and we see them gain weight and begin thriving within a couple of weeks,” said Dr. Gustavo Fernandez, MSF head of mission in Somalia. “RUFs are practical to use in places like Somalia where security is very bad. General
MSF has been treating malnutrition with therapeutic RUF since the first products became available in the late 1990s, and in 2006 treated more than 150,000 children with acute malnutrition in 22 countries.

CALLING FOR WIDER ACCESS

MSF is calling for donor governments and UN agencies to urgently speed up the introduction and expansion of RUF. But it will require governments to change their food-aid programs to incorporate newly developed products that have the nutrition needed to cure malnourished children. An estimated $1.05 billion will be needed to reach the most vulnerable.

“Unfortunately, sometimes, the problem of malnutrition gets hidden under the big discussions on eliminating poverty or eliminating hunger,” says Dr. Milton Tectonidis, nutrition specialist for MSF’s Campaign for Access to Essential Medicines. “What we do know is that the countries which have managed to control malnutrition and mortality were forced to introduce specially designed food for young children and it includes enriched milks or fortified baby foods. The places that still have high rates of infant malnutrition and high rates of infant mortality are the places where these foods are not available”

USING EARLY TREATMENT TO PREVENT MALNUTRITION

Currently, WHO, World Food Program, and UNICEF guidelines state that therapeutic RUF should only be distributed to severely malnourished children. Given its nutritional benefits, RUF has the potential to address malnutrition at earlier stages and is far more effective than the fortified blended flour used in most supplementary feeding programs. MSF has launched a pilot program in Niger using a modified RUF as a supplement to prevent children from becoming acutely malnourished.

“Instead of waiting for kids to get gravely ill we decided to act earlier,” said Dr. Susan Shepherd, MSF medical coordinator, Maradi, Niger. “We are piloting a program that gives RUF to all children under three in at-risk communities so that they get the nutrients that are missing in their normal diet.”

Through this early treatment program in Niger, MSF is providing mothers with small containers of a RUF, called Plumpy’Doz, as a supplement to their children’s normal diet. Three teaspoons of the supplement mixed into a child’s regular meal of millet adds essential micro- and macro-nutrients and 250 calories. Early results from this ongoing project, which is reaching more than 62,000 children, indicate that RUF is significantly more effective than the traditional approach of supplying fortified flours and cooking oil to mothers of young children.
On August 8, 2007, mothers and their children lined up at a Doctors Without Borders/Médecins Sans Frontières (MSF) distribution point in the Guidan Roumdji district in Maradi, Niger, to receive their monthly ration of the ready-to-use food supplement Plumpy’Doz. Three teaspoons of the supplement mixed into a child’s regular meal of millet each day adds essential micro- and macro-nutrients and 250 calories.

An MSF aid worker determines whether a child is malnourished by measuring the circumference of his mid-upper arm. In 2006, half of the children in this district aged six months to three years suffered from acute malnutrition and were admitted to MSF’s therapeutic feeding program in Maradi. In 2007, it was thus decided to provide all children under three years old with ready-to-use-food (RUF) supplements with the objective of keeping children healthy and staving off acute malnutrition.
A mother receives a one-month supply of Plumpy’Doz for her child. During this year’s seasonal “hunger gap” – the roughly five- to six-month period before harvests, when food stocks are typically leaner – MSF provided Plumpy’Doz for approximately 62,000 vulnerable children. This year, during the critical hunger gap, the number of severely malnourished children admitted to MSF’s intensive care ward in Maradi was much reduced.

MSF Featured on CBS’s 60 Minutes
To watch the program and learn more about MSF’s efforts to combat malnutrition visit:

www.doctorswithoutborders.org/news/malnutrition/
After 15 years of fighting, a dramatic surge of violence between rival armed groups has made the Somali capital, Mogadishu, and the surrounding areas so dangerous that civilians in need are afraid to seek treatment at hospitals and health centers. Moreover, some health facilities are located in the midst of heavy fighting, and others are closed or without adequate staff and supplies.

“There is a lack of functioning health facilities that is absolutely shocking today in the capital,” Dr. Christophe Fournier, MSF’s International Council president, said in an August 20, 2007, press briefing. “Within six hospitals in the capital that MSF has assessed, the number of doctors who are still at work has decreased from 53 at the beginning of the year, to only 13.”

Prompted by months of deep frustration at the inability to provide desperately needed medical care to people in Mogadishu, MSF issued the press release to urge...
all parties involved to respect the population’s need for medical treatment and the need for medical staff to work unimpeded. And, in November, MSF reaffirmed its grave concerns for the remaining population inside the capital.

“People are terrified but most have little choice except to wait and hope that the violence does not come to them,” says Colin McIlreavy, who heads MSF’s programs in Mogadishu and the northern city of Galcayo and Mogadishu. “In Mogadishu now there is no safe place to go.”

The high levels of insecurity often prevent wounded civilians from receiving medical assistance. MSF staff have been unable to help individuals who have been wounded by shrapnel or bullets during fighting at night. Some have bled to death as it was too dangerous to move them to hospitals. Former residents of a densely populated suburb near MSF’s clinic described armed men marching through the streets emptying houses, in some cases shooting unarmed people.

MSF staff estimate that fewer than 250 of the 800 hospital beds available in Mogadishu at the beginning of the year are still in service. From January to August, MSF treated 60,000 people as outpatients in and around Mogadishu, but untold numbers of people who need care, especially inside the capital, are not receiving it.
FLEEING ATTACKS

Stories from internally displaced persons (IDPs) who fled in recent months to South Galcayo, some 300 miles north of the capital, and who received treatment from an MSF-supported hospital there, are chilling. One man, a schoolteacher in his late 30s, described the conditions:

“I lived in Mogadishu for a long time and this time it was the worst fighting I had ever seen: many dead bodies on the roads and many women and children hurt in the fighting, just while walking in the street. People could not leave their houses. Since the fighting started, the gangs on the road increased. The journey here took three days, with militias and gangs frequently attacking our car. At one point, militia shot our car without telling us to stop; we were ready to give our goods, but they just shot instead. One passenger was killed and one was injured.”

REACHING PEOPLE IN NEED

Health workers trying to reach residents and internally displaced people in need of care are not spared. “We should be able to open emergency and surgical services in Mogadishu, send out ambulances to reach the sick and wounded, and bring them back for treatment,” says Dr. Fournier. “But, after months of trying, we still cannot even move about the city freely to assess the needs and provide the quantity and quality of care that we know is needed.”

On June 5, the driver of a car that MSF had rented was shot and killed and one staff member was injured when a passing convoy opened fire on the vehicle. On the roads, rape, robberies, and indiscriminate shootings have become common.

“I came to Galcayo by bus, and we had a lot of problems on the way,” recounts a 17-year-old woman who fled Mogadishu while seven months pregnant. “There were young men with guns stopping the bus. A group of them took four girls out of the bus and raped them. Those women told me that it was not the first time it happened to them. They did not go to the hospital.”

Given the area’s long history of violence, hundreds of thousands of people were already displaced before the recent upsurge; tens of thousands are new victims.

“I WAS SIX MONTHS PREGNANT WHEN I LEFT MOGADISHU”

A 27-year-old displaced woman at the MSF-supported South Galcayo hospital May 19, 2007

“I came from Mogadishu one month ago. I saw a lot of children and young boys killed and injured; the numbers were uncountable. People with guns just shoot.

Our house was hit and destroyed by an explosion. Some died and some fled to other places; we came to Galcayo. Now we don’t have a house and we have lost all our goods. We lost everything. I only have my daughter with me. I don’t know what happened to the rest of my family. I left without knowing where they went. I was told that my aunt and brother are dead; some of my family were injured and are now in a hospital in Mogadishu. I don’t know where my husband is; he didn’t leave Mogadishu because he’s sick, he has malaria.

I was six months pregnant when I left Mogadishu, but I lost my baby. I think I started to have problems while we were leaving in the car. I managed to get to South Galcayo hospital after 12 hours on the bus.”
Many IDPs subsist in bombed-out schools and hospitals, in deserted homes, or on patches of wasteland, says MSF’s McIlreavy. In these makeshift quarters, diseases are rampant, there is little drinking water, and conditions are miserable.

“We want to try and reach out to this group,” says McIlreavy, “which, probably more than any other group of people in Mogadishu, is facing very extreme medical needs. Earlier this year, there was a cholera outbreak—the cases were concentrated where there were IDPs—but we were unable to go there for fear that we may be accidentally or deliberately targeted while attempting to bring our medical aid.”

**RESPONDING TO MALNUTRITION**

In addition to the need for treatment of cholera, sexual violence, and gunshot wounds, and the need for obstetrical care, shelter, and water, IDPs from Mogadishu are suffering from a major malnutrition crisis. West of Mogadishu, in Hawa Abdi and Afgooye, where most people are now wholly dependent on external assistance, there is no regular food distribution and months-long food shortages have occurred.

A majority of the 1,700 weekly medical consultations carried out by MSF teams in both areas are for severe malnutrition, diarrhea, and acute respiratory tract infections, all related to precarious living conditions.

In early December, more than 250 severely malnourished children, including 80 who had to be hospitalized in intensive care, were admitted to MSF feeding centers. To meet the needs in this deteriorating situation, MSF teams have doubled their capacity from 20 to 40 beds in Afgooye, and are setting up a 50-bed pediatric unit in Hawa Abdi. The intensive nutritional care center in Hawa Abdi has increased its capacity from 20 beds in September to 80 today, and needs are increasing by the day.

Mortality rates among IDPs are extremely worrying. In Hawa Abdi, the mortality rate of children under five is more than twice the emergency threshold: 4.2 deaths per 10,000 people per day.
EPICENTER: SOUTHERN AFRICA

A Health Worker Shortage in Southern Africa Threatens Progress Against HIV/AIDS
The dire lack of health-care workers in southern Africa is threatening efforts to expand access to HIV/AIDS treatment. After seven years of providing treatment to people living with HIV/AIDS in southern Africa, Doctors Without Borders/Médecins Sans Frontières (MSF) teams are witnessing the effects of this critical shortage firsthand through its programs in Lesotho, Malawi, Mozambique, and South Africa.

Since MSF started its first antiretroviral (ARV) program in this region in 2000, the cost of life-prolonging medicines has dropped and new projects have begun and been scaled up. MSF instituted decentralized care to reach people outside of town centers and lower the strain on hospitals, while training non-medical workers to provide ARVs and counseling in their villages. But, as the availability of treatment in this region has grown, the number of health workers has not kept pace—and with tragic consequences.

Currently, more than 70 percent of people who need treatment for HIV/AIDS in sub-Saharan Africa are not receiving it. Many of these people are on waiting lists, and some die waiting—not because medicine is unavailable, but simply because there aren’t enough trained workers to administer it.

“In Thyolo district we are treating 7,000 people with HIV/AIDS,” says Veronica Chikafa, a nurse working with MSF in Malawi. “We need to increase this number to 10,000 by the end of the year, but our program is hitting a wall because there are simply not enough doctors, nurses, and medical assistants.”

MSF staff at projects in Lesotho, Malawi, Mozambique, and South Africa are frustrated by the consequences of this shortage every day—patients waiting for hours or turned away, months-long waiting lists that can make the difference between living and dying, an exodus of existing health workers and the dearth of new ones.

With so much at stake, MSF released a study, Help Wanted: Confronting the Health Worker Crisis to Expand Access to HIV/AIDS Treatment. In addition to reporting the facts and figures that constitute a crisis, its authors draw upon the experiences of MSF workers on the ground who are experiencing it firsthand.

OVERWHELMED STAFF

The World Health Organization has identified a minimum standard of 20 doctors to each 100,000 inhabitants in any given country. In Malawi, there are two doctors per 100,000 inhabitants; in Mozambique that number is 2.6; in Lesotho, it’s five. Compare that to the US, which has 247 doctors per every 100,000 people, or the UK, which has 222.

This scenario is played out in hospitals and clinics every day in southern Africa: nurses and other health workers come to jobs that often do not pay enough to live on; they
are overworked and forced to perform in substandard conditions; they see hordes of patients they cannot help or will not be able to give quality care; and they see their colleagues leaving for more lucrative positions overseas, in nongovernmental organizations, or in the private sector. And if all of these factors don’t lead to attrition, they can cause a severe lack of motivation.

“There is a workload where we have maybe hundreds of patients for just one nurse. So you can imagine - what kind of nursing can she give?” says Christina Chingi, a nurse in Malawi’s Thyolo Hospital, where MSF provides support alongside Ministry of Health workers.

In 2006, there were 50 nurses working at the district hospital in Chiradzulu, Malawi. This year, there are 28. Those who depart leave behind empty posts that are not easily filled, which in turn makes still more work for those who do stay, and allows for fewer patients to be treated.

“I am still trying to work with passion, but the conditions are demoralizing,” says Mpumelelo Mantangana, a nurse at the Ubuntu clinic’s TB/HIV co-infection program in Khayelitsha, South Africa, where MSF provides support. “The workload increases by the day. On top of that, since 2003, there are two vacant posts for professional nurses in this clinic. If it was not because I am motivated, nearly a militant supporting the ARV roll out, I would have left long ago.”

WAITING CAN MEAN DYING

In Thyolo district, Malawi, where the number of patients receiving ARVs nearly doubled in 2006 from the previous year, there are still 11,500 people who need them, but the clinics are full. At an HIV clinic in Maputo City, Mozambique, each clinical staff member conducts 30 to 40 consultations per day. In 2006, while the number of people in need of treatment continued to grow, there was a 30 percent drop in the number of new patients started on ARVs.

In Khayelitsha, South Africa, during the last six months of 2006, the rate at which the clinic was able to initiate new patients on ARVs dropped by 60 percent. Department of Health figures show that 35,000 people are on waiting lists for ARVs and a staggering one million are in need.

And, while health workers cannot work fast enough or in large enough numbers to treat people with HIV/AIDS, their own lives are being claimed by the disease. In Lesotho, Mozambique, and Malawi, death is the leading cause of health worker attrition, often HIV/AIDS-related.

EMERGENCY MEASURES ARE NEEDED

At its southern Africa projects, MSF is using strategies to cope with this situation, including the hiring of additional staff, supplementing pay, shifting certain clinical tasks from doctors to nurses, and training more lay workers, all of which have led to the ability to start more patients on ARVs. But, despite having significant resources for some projects, MSF’s efforts on the local level can only help so much.

In its report, MSF calls for the following fundamental changes in national and international policies and in donor government practices to be urgently implemented:

— Emergency retention measures such as improving salaries and working conditions must be developed at the national level.

— Work rules set by governments and professional councils must be made more flexible so tasks can be performed by staff.

— Donor government rules must be changed to allow funding for recurrent human resources costs.

— Spending limits must be lifted by ministries of finance and international finance institutions, such as the International Monetary Fund, to allow governments to increase salaries and the workforce.
MSF doctor and manager of the Lesotho project, Lesotho native Pheello Lethola examines an HIV patient who is being tested for TB. Lesotho 2007 © Molly Elliott/MSF

Patients wait in line to receive treatment in Thyolo. Malawi 2007 © Julie Remy

After waiting for more than four hours to see an MSF nurse at a clinic in Thyolo, patients start to get restless. Malawi 2006 © Julie Remy

At an HIV clinic in Lesotho, MSF nurse Patricia Nyoni, originally from Zimbabwe, tends to a patient. Lesotho 2007 © Molly Elliott/MSF
By Victor Garcia, MSF Project Coordinator

It isn't easy to talk about a conflict as complex as Colombia's or about the suffering it has brought to the civilian population for over 40 years, not to mention the enormous economic resources it consumes— and this in a country that is to a large extent prosperous, with abundant natural resources.

However, I will attempt to describe an average day at a health clinic run by Doctors Without Borders/Médecins Sans Frontières (MSF) in the Catatumbo region of Norte de Santander as part of the experiences I have had in one of the most conflict-filled and isolated regions in Colombia. I worked there for a year, from March 2006 to March 2007, coordinating an MSF team.

It is six in the morning. Today, I am getting up a little earlier than usual because we are doing a health clinic in Caricachabokira, and since we never know what we'll come across on the road, it's better to leave earlier.

Caricachabokira is a community inhabited by the Bari indigenous people. The Bari once lived in what is now Norte de Santander—a northeastern department (similar to a state) of Colombia—and a large part of Venezuela. They have seen their land reduced to just two small reserves: the one we’re going to today and another that is farther to the north in El Catatumbo. In Bari, Catatumbo means, “god of thunder,” and the frequent electrical storms here are truly spectacular, beautiful, and dangerous.

In this rural jungle region that is difficult to access, the Colombian government keeps watch only over a few villages that are on the coal highway or that have significant oil resources (Venezuela’s Maracaibo oilfield is not far away). The rest is the territory of the various guerrilla groups. There are also paramilitaries who, although officially demobilized, are said to be moving about the area.

Because this is a border zone that is quite rich in natural resources, it is a strategic area coveted by all the armed groups.

Our main reason for getting involved in this zone is that we have found many
people spread out across small villages who were living without any type of medical care. The closest hospital was, in many cases, several days away on foot, by boat, or by bus. Because of that, people diagnose and medicate themselves. Tuberculosis, anemia, leishmaniasis, malaria, hepatitis, and diarrhea are prevalent as well as mental health problems caused by the violence of the conflict. There were no others working in this area except Catholic nuns who live with the Bari and with whom we have always had a good relationship.

When I arrive at the office, the logistics team is already loading the material we’ll need during the week-long health clinic: medicine, laboratory supplies, portable refrigerators for the vaccines, food, and the electricity generator.

The highway is paved only as far as the oil refinery. The rest is a mud road with holes carved out by the rocking of trucks. In the rainy season, it takes us between 4 and 13 hours to travel 70 kilometers (44 miles). The access road is supposedly controlled by the government, but once on it, any group can stop you. We arrive at La Gabarra, a village on the banks of the river where the Bari should be waiting for us with their boats to take us up to the community.

La Gabarra has about 15,000 inhabitants who are heavily affected by the violence. It takes just one visit to see that something is happening, but nobody sees, hears, or says anything, as though the whole world were blind, deaf, and mute.

The village was a sort of remote port to which people would come to spend the money they earned from coca harvests, spawning an entire business of bars, pool halls, shops, organized crime, informers, and prostitution. There are also people who have tried to stay out of it, but that is difficult because coca seems to be everywhere. Today, the situation has improved somewhat with the demobilization of the paramilitaries, and the people seem to have a little more zest for life.

In La Gabarra, we’ve treated people with sexually transmitted and reproductive diseases, as well as mental health problems, because the aftermath of massacres and threats is often fear, depression, and anxiety. There is also group work with boys and girls to show them that another culture exists—not just the culture of violence. However, the people still live in fear of being pinpointed and accused of collaborating with one side or the other.

The river flows dirty and turbid. Every time I travel on it, I imagine that it is even dirtier underneath because of all the bodies that were thrown into it during the big massacres of 2002, when armed groups were fighting for control of the waterways.

After two hours of boating, we arrive at the community port where some Bari children are waiting for us. We must walk from the riverbank to the community carrying our things, and finally we arrive. Before the light fades, we hang our hammocks in a communal hut that the residents leave for us and have dinner. The light that remains is from candles or from the fireflies playing in the grass.

Beginning early the next day, the sick from neighboring communities begin to arrive at the health clinic. We offer free medical, dental, and psychosocial consultations and provide vaccinations. The triage is always: medical emergencies, pregnant women, the elderly, and children. There are many patients with TB, especially amongst the Bari population. If we diagnose someone who is sick with TB, we offer to accompany him or her to a city where we facilitate ongoing treatment through the national TB program.

Five days later, we have treated an average of 150 patients per day, and we return to the base to do the trip in reverse. The Bari accompany us with their boats. In La Gabarra, another team is waiting for us with the four vehicles, and again there is the muddy road. We get stuck, we get unstuck and we press on. Deep down, that is our rhythm too.

MSF’s programs in Colombia range from mobile to fixed medical clinics to provide access to basic health and counseling services. Colombia 2006 © Jesus Abad Colorado
FIGHTING IN EASTERN CONGO FORCES CIVILIANS TO FLEE

Democratic Republic Congo 2007 © Marcus Bleasdale

The latest spate of violence in the Democratic Republic of Congo’s North Kivu province has caused hundreds of thousands of people to flee their homes since August. Doctors Without Borders/Médecins Sans Frontières (MSF) has responded in many of the hardest-hit regions, but many people remain out of reach due to ongoing fighting between armed groups. MSF currently has projects in Rutshuru, Masisi, Lubero, Walikale, and Goma districts, with a total of 475 Congolese staff and 45 international staff in the province of North Kivu.

“In this latest round of fighting, which started in mid-August, we’ve seen another 100,000 to 150,000 people displaced on top of the already 300,000 to 500,000 people displaced,” says Jane Coyne, MSF’s head of mission in North Kivu. “The reality is that people who are displaced from their homes are living in really marginal conditions. We are now seeing more people living in camps than we’ve seen in North Kivu in the last 10 to 15 years. These people are living in small huts that are covered with plastic sheeting in an attempt to shelter themselves from the rain. They are unable to go to the fields to harvest their crops. Their access to food is almost completely dependant on the ability of aid organizations to reach them and distribute food.”

PERU: BRINGING RELIEF TO EARTHQUAKE SURVIVORS

Peru 2007 © MSF

MSF brought 12 tons of relief supplies to the Pisco region, on Peru’s Pacific coast south of Lima, following the 8.0-magnitude earthquake that struck on August 15. The earthquake killed at least 500 people, injured more than 1,000, and left thousands more homeless.

The team began by concentrating its efforts in Humay and Independencia, in the area hardest hit by the disaster, where health facilities had been destroyed and no other aid organizations had yet arrived. The team also discovered great needs in the town of Guadalupe, which had received no help 10 days after the disaster.

Within five days of the quake, MSF had provided 7,000 people in Humay with blankets, hygiene kits, and shelter materials, and had assessed water and sanitation facilities. Mental health professionals have also been working closely with the medical team to identify and help treat traumatized patients.
CAMBODIA: RESPONDING TO A MAJOR DENGUE OUTBREAK

Cambodia 2007 © MSF

This year’s Dengue fever season in Cambodia was particularly severe and an MSF team running an HIV/AIDS program in Kompong Cham province responded to the outbreak. With 35,000 cases and 190 deaths reported in 6 months nationwide, MSF teams were dispatched to the pediatric wards of Ministry of Health-run Kompong Cham and Takeo hospitals, two of the hardest-hit provinces, in order to help the Cambodian staff treat a large influx of patients.

Dengue is an infectious disease transmitted by the bite of a mosquito. Symptoms of dengue include muscle pain, intense joint pain, high fever, and nausea. Dengue hemorrhagic fever is the most severe form of the disease and is particularly lethal to children, causing bleeding and shock. There is no specific medicine for dengue, but early diagnosis and treatment for the symptoms can prevent complications and death. By mid-July the number of dengue admissions to Takeo hospital had decreased.

HAITI: MSF HOSPITAL ADDRESSES MASSIVE MATERNAL NEEDS IN PORT-AU-PRINCE

Haiti 2007 © Julie Rémy

Workers at MSF’s Jude Anne Hospital for emergency obstetric care in Port au Prince have delivered 10,000 babies since the hospital opened in March 2006. Original estimates for deliveries were projected at 300 a month. But in September 2006, the number of births reached 1,300—about one baby every half hour, and one-fifth of the babies born in Port au Prince that month. MSF established the hospital to address the great need for high-quality maternity services in the Haitian capital.

The large number of births at Jude Anne highlights the desperate need for the free and high-quality care offered at the hospital. This year, MSF is advocating for the government of Haiti and the international community to put the needs of pregnant women at the forefront of their agendas and to provide them with the care they need and deserve.

DRC: EBOLA OUTBREAK IS CONTAINED

DRC 2007 © MSF

On September 2, a week before an official declaration of an outbreak was made by the country’s Ministry of Health, a small MSF emergency team based in Democratic Republic of Congo (DRC) responded to reports of the disease. A lethal and highly contagious virus, Ebola can cause massive internal hemorrhaging and has no vaccine or cure. As of early October, 384 suspected cases had been reported in the region and 176 people had died, according to the World Health Organization. In an isolation unit opened by MSF in the hardest-hit part of West Kasai province, 32 patients were hospitalized. As of October 1, more than 80 percent of the people confirmed to be infected had died.

A 15-person MSF team trained national health workers, distributed medicines and protective material, and a medical team searched, in most cases successfully, for people suspected of being infected with Ebola. They also distributed drugs to 15 health centers.

No new cases of Ebola hemorrhagic fever have been admitted into MSF’s clinic in Kampungu, since October 4. By October 26, the 21-day incubation period for the disease had passed without further outbreaks, meaning the epidemic appears to be contained.
A woman smiles at her newborn baby, delivered by cesarian section at the Doctors Without Borders/Médecins Sans Frontières (MSF) surgical program in Mannar, Sri Lanka, in July. During December 2006 and January 2007, MSF opened three surgical programs in the public hospitals of Sri Lanka’s conflict-ridden areas. MSF teams performed an average of 450 surgeries per month in these hospitals in Point Pedro on the Jaffna peninsula, Vavuniya in the northern part of the mainland, and Mannar on the west coast of the northern mainland.

In Kilinochchi, MSF runs an emergency obstetrics program. In addition, a team is providing assistance to displaced persons in Batticaloa on the east coast. The surgical programs were initiated just several months after MSF had withdrawn for safety reasons from Sri Lanka, in October 2006, amid false accusations in the media that the organization was siding with the rebel group Tamil Tigers of Tamil Eelam.