Dear Friends,

This past summer, a Doctors Without Borders/Médecins Sans Frontières (MSF) team conducting measles surveillance in Nigeria followed a rumor to a remote village where 40 children had died of a mysterious illness, and more were falling ill.

Team members immediately set up a medical program, calling for additional staff and supplies and then engaging in what amounted to medical detective work in order to learn what was killing these children. This grew into the organization’s first-ever response to an outbreak of lead poisoning.

The team acted in a way that both saved lives and illustrated the kind of leadership and flexibility we want in our operations: the constant questioning at both field level and at MSF’s international offices about how to respond to a given context, how to improve our work, and how to best serve people in need of urgent medical care.

This year, that approach has been absolutely necessary, as MSF, with your generous support, has contended with, among other things, natural disasters on a massive scale in Haiti and Pakistan, widespread disease outbreaks in Central America and much of West Africa, large refugee populations in countries like the Republic of Congo and Bangladesh, and conflicts in places such as Somalia and Afghanistan.

The stories and photographs in this year-end issue of Alert speak to this same flexibility and openness to innovation. We can’t solve every problem, but our capacity to adapt and seek out new approaches in ever-evolving situations has made possible some remarkable achievements in some very difficult circumstances.

In Somalia, for example, our 1,300 Somali colleagues are running medical programs in Mogadishu and beyond, with support from colleagues based in Kenya. In Pakistan, MSF teams treated tens of thousands of patients in all four of the country’s provinces after flooding swept the country. In Sudan and the Democratic Republic of Congo, we adapted to the shifts in conflicts and prepared for contingencies that could occur in the year ahead. And in Haiti, when cholera hit a country already battered by an earthquake, MSF staff treated more than 51,000 people for cholera-like symptoms in the first eight weeks of the outbreak.

Simultaneously, we continue to argue that improved medicines, diagnostics, and vaccines must be made available to the people who need them most, and that countries that have the means must continue to support global health initiatives.

We can do this work thanks to the dedication and perseverance of our national and international staff, and thanks to your support. Your commitment allows us to launch, sustain, and improve our programs, and to build on our successes in order to become a more effective organization for the years to come.

Sincerely,

Sophie Delaunay

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**HUMANITARIAN SPACE**

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In September, however, word came from the Artibonite region in central Haiti, north of the capital, that patients were presenting with cholera-like symptoms. Cholera had not been seen in Haiti in many decades, but the signs—rapid and severe dehydration caused by excessive vomiting and diarrhea—were all too apparent.

Knowing that the post-earthquake conditions in the country were ideal for cholera to work its way through significant portions of the population, a four-person MSF team quickly responded, traveling to the town of St. Marc on October 21, the day after initial reports were received, to confirm the diagnosis as best they could. They didn’t have access to lab testing, but the symptoms and progression fit, and they could see that many patients needed assistance right away.

MSF immediately opened a cholera treatment center (CTC) in the town of St. Marc. "The most important thing is to isolate the cholera patients there from the rest of the patients, in order to best treat those people who are infected and to prevent further spread of the disease," Federica Nogarotto, MSF’s emergency coordinator in St. Marc, said at the time.

As it got to work, the organization had to keep one eye on the treatment of the sick in Artibonite and the other on the immediate area and other parts of the country, scanning the terrain for any new cases. Preparations were made in the capital: 10 beds were set aside for cholera treatment at St. Louis Hospital and 25 beds at MSF’s facility in Tabarre.

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supplies were sent into the country as well, along with a nine-
person emergency team that could respond as needed.
As it happened, more cases presented in St. Marc, as well as
nearby Petit Pétrie, and then in Gonâve, forcing teams to rapidly scale up their capacity in the region. Next
to experience the outbreak were the northern cities of Cap
Haïtien, Port de Paix, and Gros Morne, beginning on October
29. Three members of the emergency team went to the north,
and at one point, sending the entire emergency team up
there was considered. They stayed put in the capital, however,
in what would later prove to have been a prudent move.
At this point, it was clear that the cholera outbreak was going
to require a large-scale response across several sectors.
And then, on October 31, large numbers of patients began
coming to the CTC at Tabarre in Port-au-Prince with the
symptoms of cholera.
The transmission dynamics were nearly impossible to
predict because there were no models for cholera in Haiti, noted
Dr. Greg Elder, MSF’s Deputy Operations Director.
Aside from saying that it was likely to spread widely in a
country where most people lacked access to clean drinking
water or sanitation, where the population was unfamiliar
with the necessary prevention measures, and where national
health staff had no past experience with the disease, there
was little to go on. Further complicating the issue was the
fact that it was extremely difficult to determine whether or
not the numbers being reported by the health ministry were
comprehensive. MSF could really only count the people
showing up at its own facilities and work from there.
There was no question that the case load was growing.
In the capital, the number of people seeking treatment at
MSF-run and supported medical structures jumped from
350 for the week ending November 7 to 2,250 the week
ending November 14. And in the north, MSF teams logged
280 cases during the week ending November 7, but that
number jumped to 1,200 for the week ending November 14.
And they continued to grow after that.
What’s more, people were becoming increasingly frightened
and angry. Treatment for cholera is straightforward, but
often, patients can go home after two or three days. But responding to an
outbreak is extremely labor intensive. One staff member is
needed for every five patients. Patients must be tended to
day and night. Huge amounts of fluids must be brought into
facilities and administered on a regular basis, and a great
deal of waste must be disposed of. And if patients die, the
bodies must be removed and a host of other procedures
followed, all of which require medical and paramedical staff
to carry out the work.
MSF hired and trained hundreds of new national staff
members, but the organization nonetheless struggled to keep
up with the growing caseload. Increasingly, it seemed as
if other actors were not doing as much as they could, that
there were too many meetings occurring without enough
action. An MSF press release on November 19 stated that
“despite the huge presence of international organizations in
Haiti, the cholera response has to date been inadequate in
meeting the needs of the population.”
Whatever the reasons, it was affecting both treatment
and prevention efforts and delaying urgent sanitation and
hygiene activities, provision of clean water, and other crucial
measures (According to one calculation, more than 9,000
beds would be needed if the worst-case scenario
came to pass, something beyond MSF’s ability or
resources to provide). Soon after the press release
was issued, a high-level MSF delegation that
included Dr. Umke Karunakara, president of MSF’s
International Council, traveled to Haiti to lobby the
Haitian government, UN agencies, and others to
increase their activities related to cholera.
MSF, meanwhile, continued to scale up activities,
focusing on case management and making more
beds available—while also making sure that non-
cholera activities continued as normally as can
be. As of early December, the cases in the north
seemed to be stabilizing, with around 80 new
cases emerging per day. In some opinions, that
meant another six to eight weeks or so before
projects in the north can be closed. Others think
it will still be several months. And that could be
affected by what happens in Artibonite, if the
cholera spreads into the west and south (as it
seems likely to do), and by what occurs in Port-
au-Prince, where dynamics could be different
from neighborhood to neighborhood (the slums,
for instance, have thus far been harder hit than
the displacement camps because the camps
have received more and better services from aid
groups). There seems to be a consensus that the
cholera response in the capital will have to last
several more months at the very least.
In a smaller outbreak, MSF would be as focused on
trying to break transmission as it is on treatment,
carrying out community awareness and education
efforts, distributing water, and so forth.

In this situation, though, it has been necessary to decide how
the organization can be most effective given the resources it has. MSF is
doing prevention work, and it continues to engage in a wide range
of information campaigns, but, in the main, it has focused on serving
the most severe cases, on saving lives, while hoping other actors will
fill in the gaps elsewhere. “If that doesn’t happen,” said MSF Operations
Manager Duncan MacLean, “the cases will perpetuate themselves.”
Early supply issues appear to have been solved. Staffing is in much
better shape than it was. Some of the education efforts are proving
effective as well. But challenges remain. More than 2,000 people had
died as of early December. Tens of thousands had been affected, and
on November 24, the Pan American Health Organization, which was
taking a prominent (if not necessarily a leading) role in coordinating
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would ultimately be affected from 200,000 to 400,000. Given what
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At this point, it was clear that the cholera outbreak was going to require a large-scale response across several sectors. And then, on October 31, large numbers of patients began coming to the CTC at Tabarre in Port-au-Prince with the symptoms of cholera.

The transmission dynamics were nearly impossible to predict because there were no models for cholera in Haiti, noted Dr. Greg Elder, MSF’s Deputy Operations Director. Aside from saying that it was likely to spread widely in a country where most people lacked access to clean drinking water or sanitation, where the population was unfamiliar with the necessary prevention measures, and where national health staff had no past experience with the disease, there was little to go on. Further complicating the issue was the fact that it was extremely difficult to determine whether or not the numbers being reported by the health ministry were comprehensive. MSF could really only count the people showing up at its own facilities and work from there.

There was no question that the caseload was growing. In the capital, the number of people seeking treatment at MSF-run and supported medical structures jumped from 350 for the week ending November 7 to 2,250 the week ending November 14. And in the north, MSF teams logged 280 cases during the week ending November 7, but that number jumped to 1,200 for the week ending November 14. And in the north, MSF teams logged 280 cases during the week ending November 7, but that number jumped to 1,200 for the week ending November 14. And in the north, MSF teams logged 280 cases during the week ending November 7, but that number jumped to 1,200 for the week ending November 14. And in the north, MSF teams logged 280 cases during the week ending November 7, but that number jumped to 1,200 for the week ending November 14. And in the north, MSF teams logged 280 cases during the week ending November 7, but that number jumped to 1,200 for the week ending November 14.

Nevertheless, MSF set up 20 CTCs in the country not long after the middle of November and 40 by early December. Oral rehydration points were set up in all the affected areas as well. Some 3,300 beds were set aside for cholera treatment, and as of mid-December, MSF had provided care for more than 62,000 people.

Finding the people to provide that care—and to carry out information campaigns about the disease—was no easy task. Cholera treatment is relatively simple for the patients, involving rehydration and antibiotics. Often, patients can go home after two or three days. But responding to an outbreak is extremely labor intensive. One staff member is needed for every five patients. Patients must be tended to day and night. Huge amounts of fluids must be brought into facilities and administered on a regular basis, and a great deal of waste must be disposed of. And if patients die, the bodies must be removed and a host of other procedures followed, all of which require medical and paramedical staff to carry out the work.

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FINANCIAL UPDATE:
By the end of 2010, MSF estimates it will spend all of the $138 million donated by private supporters for the earthquake relief effort and the cholera outbreak response in Haiti. As of October 31, MSF had spent $104 million of these funds. MSF estimates it will spend a total of $124 million in 2010. The remaining funds raised for Haiti will be used to mobilize MSF’s cholera response. MSF estimates it will spend approximately $14.2 million on cholera emergency programs in 2010. Another $9.9 million is projected to be required for cholera treatment in 2011.
EMERGENCY RESPONSE: PAKISTAN’S FLOODS

At first, the flooding that began this past July in Pakistan was said to have affected tens of thousands of people in the northeast. Then the water began to spread south and west and the numbers grew. Hundreds of thousands were impacted, it was reported, then one million, then five million, then ten. Eventually, the number of people whose lives were uprooted reached an astonishing 20 million in all four of Pakistan’s provinces—Khyber Pakhtunkhwa (KPK), Balochistan, Punjab, and Sindh—as well as the Federally Administered Tribal Areas (FATA) and Kashmir.

As the monsoons rains fell, rivers rose precipitously, destroying bridges and roads and stranding people on newly created islands. “The devastation caused by the floods is enormous, and some towns have been completely washed away,” said Josep Prior Tio, MSF’s field coordinator in Swat.

Shelter from the elements—hard rain, stifling heat, fierce winds—was scarce. Schools and public buildings became ad hoc displacement camps for those with nowhere else to go. “In the first few days of the flooding, there was a mass movement of people, which was terrible to witness,” said Dr. James Kambski, MSF’s project coordinator in Balochistan. “People were on tractors, on ox carts, on donkey carts, on motorbikes, on tuk-tuks, and on foot, picking up anything to cover themselves. It was quickly becoming difficult for many to find food to eat or safe water to drink.”

VALUABLE PAST EXPERIENCE

MSF has been providing health care in Pakistan since 1988 and was running several projects in the north before the floods arrived. In Balochistan, MSF was active in Dera Murad Jamali, at the border town of Chaman, and among the Afghan refugees living in Kulchak; in the districts of Peshawar, Malakand, Mansehra, Hangu, and Dir in KPK; and in FATA’s Kurram agency. The organization provided primary and secondary health care to people who had scant access to either, along with obstetric and maternal care, nutrition programs, surgical and post-operative services, pediatrics, and treatment for chronic diseases. It responded to cholera and leishmaniasis outbreaks and natural disasters such as the 2005 earthquake in Kashmir and previous flooding in Balochistan. And it assisted the more than two million people displaced by fighting between the Pakistani military and insurgent groups.

Staff had grown accustomed to the challenges of working in the country, particularly the large-scale population movements, the lack of services, and the security concerns that affected the mobility of both patients and MSF personnel. Nevertheless, MSF was able to tend to hundreds of thousands of people in some of the poorest regions of the country last year, and was well situated to respond again.

MSF, in essence, followed the floodwaters, tending to those in their wake. The effort began with exploratory missions to assess needs in the districts of Swat, Lower Dir, Malakand, Peshawar, Nowshera, andCharsadda in KPK, along with the Nasirabad and Jaffarabad districts in Balochistan, and proceeded later into Punjab and Sindh. In some instances, the impact was immediately evident. In others, especially where roadways and bridges had been destroyed, it took longer to identify the needs.

At the height of its flood response, MSF had 160 international staff and more than 1,500 Pakistani staff supporting hospitals, treating injuries and illnesses—particularly malnutrition and acute diarrhoea—running mobile clinics, and distributing hygiene kits, cooking sets, plastic sheeting, and tents. They also trucked in safe drinking water in order to prevent the spread of water-borne diseases, such as cholera.

MSF provided general care along with specialty care, adapting its work to the circumstances. Take maternal care, long a staple aspect of MSF’s operations in Pakistan: “In June, we dealt with 13 complicated deliveries and performed 4 complicated C-sections” said MSF obstetrician, Dr. Linnea Ekdahl. “Now after the floods, in the month of September, we have seen 79 women facing complicated deliveries and performed 10 complicated C-sections.”

RAIN LETS UP, CONFLICT DOES NOT

By October, the rain had abated, and the waters had, for the most part, receded. In the north, people began returning to their villages to salvage what was left of their homes. In KPK, said MSF Country Representative in Pakistan Thomas Conan, the nutrition situation was stable and disease outbreaks had been controlled. Water distribution was handed over to other actors, Diarrhea Treatment Centers were closed, and the number of projects in the province returned to pre-flood numbers. But even into December, teams were providing flood-related medical care, water and sanitation services, and distributions in Sindh, where the water was slower to recede. And MSF opened a new base to serve flood-affected communities seeking refuge in Karachi.

All told, through the end of November, MSF had conducted 80,150 consultations as part of its emergency flood response, treated more than 4,500 malnourished children, distributed a total of 64,836 relief item kits and 16,300 tents, and built 843 latrines. Expenditures for the emergency (also through the end of November) stood at $12.33 million. (MSF’s 2010 budget for regular activities in Pakistan is approximately $11.28 million.)

The task of rebuilding and recovering is an immense one. Thomas Conan said nutrition would have to be watched long-term because the fall harvest was ruined for many farmers and the next one was jeopardized by damage to their fields. Additionally, he added, as winter arrives, “the population still will not have shelter,” particularly in the north, “or proper access to quality primary health care.” MSF is therefore still distributing materials to build transitional shelters and running mobile clinics and nutrition centers for affected populations in southern Sindh.

Furthermore, the end of the rains has not meant the end of other serious issues. “The conflict existed before the floods and the conflict is still present after the floods,” Conan said, and there is still “a deficit of capacity in terms of primary and secondary health care for the population.” In KPK and FATA, where fighting has been a constant for the last five years, “we are the only organization with surgical capacity for some one million people.” There is still a yawning divide between the needs on the ground and services offered by governmental and non-governmental organizations. “It’s part of MSF’s responsibility, if not to speak out, then to point out that these populations are still in need,” he said.

POLITICIZATION OF AID

An additional concern was the politicization of the flood response discussion, one that officials from several countries, including the United States, linked to national and security interests. Christopher Stokes, MSF’s General Director in Belgium, addressed this in an op-ed on Foreign Policy magazine’s website. “Rarely hidden beneath the surface of Pakistan’s worst flooding in living memory were the geopolitical stakes shaping both the justifications for official Western assistance and how aid was delivered to victims of the disaster,” he wrote. “The perverse result may be a further restricting of the ability of humanitarian aid workers to assist the Pakistani population in the most volatile areas of the country.”

He continued: “Winning the trust of all parties in a conflict and gaining access to the affected population depends on being understood as purely humanitarian—that is, not taking sides but delivering aid based on need alone regardless of political or other influences.”

The worry on the medical front is that the impact of the floods lingers, and that the conflict continues to injure, kill, or drive from home civilians who cannot escape the theater of war. The concern on the political front is that the ability to independently and impartially deliver crucial medical aid will be undermined by decisions taken in faraway capitals. “This,” Stokes concluded, “may ultimately jeopardize our ability to provide assistance to populations trapped in one of the most volatile and neglected regions in the world.”
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All told, through the end of November, MSF had conducted 80,150 consultations as part of its emergency flood response, treated more than 4,500 malnourished children, distributed a total of 64,836 relief item kits and 16,300 tents, and built 843 latrines. Expenditures for the emergency (also through the end of November) stood at $12.33 million. (MSF’s 2010 budget for regular activities in Pakistan is approximately $11.28 million.)

The task of rebuilding and recovering is an immense one. Thomas Conan said nutrition would have to be watched long-term because the fall harvest was ruined for many farmers and the next one was jeopardized by damage to their fields. Additionally, he added, as winter arrives, “the population still will not have shelter,” particularly in the north, “or proper access to quality primary health care.” MSF is therefore still distributing materials to build transitional shelters and running mobile clinics and nutrition centers for affected populations in southern Sindh.

Furthermore, the end of the rains has not meant the end of other serious issues. “The conflict existed before the floods and the conflict is still present after the floods,” Conan said, and there is still “a deficit of capacity in terms of primary and secondary health care for the population.” In KPK and FATA, where fighting has been a constant for the last five years, “we are the only organization with surgery capacity for some one million people.”

There is still a yawning divide between the needs on the ground and services offered by governmental and non-governmental organizations. “It’s a part of MSF’s responsibility, if not to speak out, then to point out that these populations are still in need,” he said.

POLITICIZATION OF AID

An additional concern was the politicized nature of the flood response discussion, one that officials from several countries, including the United States, linked to national and security interests. Christopher Stokes, MSF’s General Director in Belgium, addressed this in an op-ed on Foreign Policy magazine’s website. “Barely hidden behind the surface of Pakistan’s worst flooding in living memory were the geopolitical stakes shaping both the justifications for official Western assistance and how aid was delivered to victims of the disaster,” he wrote.

“The perverse result may be a further restricting of the ability of humanitarian aid workers to assist the Pakistani population in the most volatile areas of the country.”

He continued: “Winning the trust of all parties in a conflict and gaining access to the affected population depends on being understood as purely humanitarian—that is, not taking sides but delivering aid based on need alone regardless of political or other influences.”

The worry on the medical front is that the impact of the floods lingers, and that the conflict continues to injure, kill, or drive from home civilians who cannot escape the theater of war. The concern on the political front is that the ability to independently and impartially deliver crucial medical aid will be undermined by decisions taken in faraway capitals. “This,” Stokes concluded, “may ultimately jeopardize our ability to provide assistance to populations trapped in one of the most volatile and neglected regions in the world.”
There were 42 people treated for injuries in one day at the beginning of this past July, and 45 in one day at the end of the same month. Weeks later, 127 people were treated for injuries over three days, and another 81 were treated in a 12-hour period in late September. What’s more, three MSF staff members were killed in January 2008 and a fourth in June 2009. Two others were abducted and later released in April 2009. Operations were suspended temporarily in three facilities at various points over the past two years, while some health posts had to be closed entirely due to security concerns. And one site, in Belet Weyne, was hit by two mortar shells this past January.

“Then another day we had 52. And on the maximum,” says Thierry Goffeau, “the team in Daynile Hospital is experienced in mass casualties and knows how to cope.”

Given the circumstances, it’s crucial for MSF to constantly reaffirm its neutrality and its desire to provide lifesaving medical care for all people who need it, regardless of their clan, political alliance, or religious beliefs. The organization also must prepare for contingencies that might occur, especially for disease outbreaks or clashes that cause, as in September, a flood of wounded people to arrive en masse at MSF facilities. At Daynile, for example, “Four tents have been set up already in the hospital courtyard and we have today a total of 120 beds in this hospital which normally has a capacity of 95,” Goffeau says.

In December, Doctors Without Borders/Médecins Sans Frontières (MSF) will support the national Ministries of Health of Niger and Mali to carry out meningitis vaccination campaigns using a new, low-cost, longer-lasting vaccine. This vaccine, which was recently endorsed by the World Health Organization (WHO), is a major improvement over older meningitis vaccines and has the potential to save thousands of lives each year.

Meningococcal meningitis is a serious, highly contagious bacterial infection of the brain and spinal cord. Around 10 percent of cases are fatal, and even with treatment up to 25 percent of patients suffer permanent damage, including hearing loss, mental retardation, and epilepsy. Epidemics of the disease routinely occur in the “meningitis belt” of sub-Saharan Africa—a massive expanse of more than 20 countries, from Senegal in the west to Ethiopia in the east—during the annual dry season between January and May. Each year, more than 400,000 people are at risk of contracting the disease. During the 2009 epidemic season, more than 78,000 suspected cases were reported in Africa, and more than 4,000 people died from the disease, the largest number of fatalities in a single year since 1996.

In June, a new meningococcal conjugate A vaccine called MenAfriVac that had been developed by the Serum Institute of India was prequalified for use by the WHO. Developed specifically for Africa, the new vaccine protects against serogroup A meningitis. Meningitis is caused by different serogroups (A, C, Y, and W135), and the effectiveness of a given vaccine depends on which serogroups it targets and which serogroups are present in the affected region.

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Compared with the existing meningitis A vaccine, the new vaccine provides four times greater protection, and this protection lasts for 10 years, compared with 3 years with the older vaccine. Another major benefit of the new vaccine is that it can help stop meningitis transmission by eliminating healthy carriers—people who are infected but do not manifest the disease, yet can still pass it on to others—thus conferring “herd immunity,” where immunization of part of the population provides protection for the whole.

MSF ordered 3 million doses of the new meningitis A vaccine as part of larger vaccination campaigns led by the Ministries of Health in Niger, Mali, and Burkina Faso, and the WHO. MSF will support the vaccination of 800,000 people in Mali and 600,000 people in Niger. These vaccination campaigns will target all those from 12 months to 29 years old. Future campaigns will target each year’s cohort of one-year-olds.

Previously, MSF teams carried out reactive vaccination campaigns against meningitis outbreaks, but because the existing vaccine is not highly effective, vaccination teams had to return every year in anticipation of new epidemics. Stocks of the older vaccine were also often limited. Now, with the advent and availability of the new vaccine, campaigns can be planned ahead of time in an attempt to prevent meningitis outbreaks before they occur.

With this more effective and longer-lasting vaccine, MSF and other health actors now have the opportunity to stop “chasing” meningitis A epidemics and can instead prevent them from occurring in the first place. However, the rollout of the new vaccine will take several years. In the meantime, existing vaccines will still need to be used.

Full coverage with the new vaccine in Niger, Mali, and Burkina Faso is expected by the end of 2011. For other countries in the meningitis belt, rollout of the new vaccine will depend on each country’s epidemiological situation in terms of meningitis infection, the readiness and willingness of national health authorities to conduct large-scale vaccination campaigns, and sufficient funding and support from the international health community.

An MSF staff member in Niger readsies a meningitis shot during a mass vaccination campaign in 2009. Niger 2009 © Guillaume Ratel

A NEW MENINGITIS VACCINE BRINGS HOPE

BY OLIVER YUN, MSF USA MEDICAL EDITOR
Earthquake in Haiti

(Clockwise from left)
Port-au-Prince soon after the quake.
© Kadir van Lohuizen / NOOR

Surgery at a makeshift operating room.
© Frederic Sautereau

MSF physiotherapy program for amputees.
© Nicola Vigilanti

Wounded mother, wounded child. © Julie Remy
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Cholera Strikes

(This page, clockwise from top)
A young patient is brought into MSF’s Sarthe CTC. © Aurelie Baumel / MSF

An MSF aid worker measures the safety of water in Cite Soleil during the cholera outbreak. © Ron Haviv/VII

A man rushes his sick child to a clinic in Saint Denis. © Jake Price

Female patient is treated at Sarthe. © Orlando Barria/EPA

(Opposite, top to bottom)
MSF’s cholera treatment center in Petite Riviere. © Spencer Platt /Getty Images

Cholera victim receiving treatment. © Moises Saman/Magnum

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Distribution near Peshawar. © Ton Koene

Staff tending to female patients near Charsadda. © Ton Koene

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The rules of MSF’s hospital in Lashkargah. © Ton Koene

Seeing female patients in Kabul. © Kate Ribet /MSF

Kyrgyzstan and Ingushetia

People who were driven from their homes by ongoing strife in the republic of Ingushetia, in Russia’s volatile North Caucasus region. © Lana Abramova

The aftermath of ethnic violence in Osh, Kyrgyzstan. © Alexander Glyadyelov
MSF Back in Afghanistan

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A malnourished child is treated in Djibouti. © Marcus Bleasdale/VII

(Opposite, clockwise from top)
The parched landscape of Djibouti. © Marcus Bleasdale/VII
Congolese mothers getting nutritional aid for their children. © Franco Pagetti/VII
Infants looked after by their mothers in Dhaka, Bangladesh. © Ron Haviv/VII

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Trauma in Kashmir

(Above)
Consultations at MSF’s primary and mental health care program in Kupwara. MSF has offered psychosocial counseling in Jammu and Kashmir since 2001, serving a population traumatized by decades of violence.
© Giulio Di Sturco/VII Mentor

Advocacy and Action

(Opposite, top to bottom)
Soccer match between players living with HIV and AIDS, held during the World Cup. © Lisa Skinner
Demonstrating in Delhi against potential restrictions on the production of generic medicines. © Suraj Mishra

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2010: THE YEAR IN PICTURES
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2010: THE YEAR IN PICTURES
The World Health Organization estimates that 8,700 people in Uzbekistan are stricken with multi-drug resistant tuberculosis—or MDR-TB—each year. Patients with MDR-TB must endure an even longer, even more painful treatment regimen than the already tedious process patients with drug-responsive TB go through. Due to high costs and the complexity of diagnostics and treatment, most countries with a high TB burden struggle to treat those who need it.

In Karakalpakstan, an autonomous republic within Uzbekistan, MSF is working with the Ministry of Health to treat MDR-TB patients in the towns of Nukus and Chimbay. Some 1,300 patients have been treated since the program started in 2003. This year, despite an overall decline in funding for TB treatment worldwide, MSF’s program in Uzbekistan was expanded to include more districts and to provide more patients with care and psychosocial counseling. But as the following pictures show, MDR-TB patients have a long and often isolated road to travel before they get better.

(Above)
A 19-year-old MDR-TB patient who must be connected to an oxygen machine at all times.

[Clockwise from top left]
An MSF psychosocial counselor visits a teenaged MDR-TB patient at his home.
An 18-year-old MDR-TB patient in the intensive ward of a TB hospital; she has to take 22 pills everyday.
An MSF counselor takes a patient in the advanced stages of TB on a walk outside hospital grounds.
Five male MDR-TB patients sharing a room at the TB hospital in Nukus.

all pictures: © Misha Friedman
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**PHOTO ESSAY: ISOLATION**

(Above) A 19-year-old MDR-TB patient who must be connected to an oxygen machine at all times.

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all pictures: © Misha Friedman
Dallas-based nurse Kaci Hickox began working with MSF in 2007. Last March, she was sent to Nigeria to be the Doctors Without Borders/Médecins Sans Frontières (MSF) emergency medical team leader following outbreaks of measles and meningitis. Two months later, however, she found herself in the middle of the organization’s first-ever response to lead poisoning and an international effort to assist the Nigerian authorities that came to include the World Health Organization and the U.S. Centers for Disease Control.

I arrived in Nigeria at the height of the measles epidemic, at a time when our teams were seeing 2,000 new cases in children every week. MSF was working in four states in the north—Zamfara, Kebbi, Sokoto, and Niger—and it was my job to oversee case management and surveillance.

Case management means, basically, treating patients. I had to make sure the staff running our mobile and fixed clinics understood the medical protocols and had the right drugs, as well as the right assessment techniques to determine when children needed inpatient care. Surveillance means sending teams to remote villages to look for and treat thousands of children every week. MSF was working in four states in the north—Zamfara, Kebbi, Sokoto, and Niger—and it was my job to oversee case management and surveillance.

When we see a child with these symptoms, we first think of infection. Malaria is always present in this part of the world. There is a type of malaria that causes swelling in the brain and seizures. Meningitis also affects the brain and can cause fevers and seizures.

The toll the sickness had already taken was made clear when the team visited the local cemetery. “I was standing in front of 39 fresh child graves,” Anja told me. I immediately notified my supervisor, Hamza, the emergency coordinator for Nigeria, who notified our team in Amsterdam to find out if MSF was responding and if I could help in any way. I was informed that the rainy season had come, rendering the village inaccessible for the time being. MSF will send a team as soon as it is possible.

I had started studying at Johns Hopkins University to earn a dual masters degree in public health and global nursing. I am more than 5,000 miles away, but a part of me remains in Zamfara. It was one of the most difficult projects I have been a part of with MSF, but I hope I can be a part of something like it again. It was a great health mystery and MSF responded with strong teamwork that made lifesaving treatment available in a place it was desperately needed.

In Yargalma, we started treating the children in the village dispensary. The building had no electricity, no running water, no advanced medical equipment, but we managed to transform it into a kind of intensive care unit.

For the first few days, the children were on the floor. Then people from the village brought mats for us to use as makeshift beds. We used candles and oil-burning lamps for light. I focused on medical care while Frank, a bone-setting doctor, set up tents and put up makeshift beds. We used candles and oil-burning lamps for light. I focused on medical care while Frank, a bone-setting doctor, set up tents and put up makeshift beds. We used candles and oil-burning lamps for light. I focused on medical care while Frank, a bone-setting doctor, set up tents and put up makeshift beds.

Unraveling a Mystery

After two days, we decided to give blanket treatment: Every child with high fever and seizures automatically got drugs for severe malaria and meningitis. We knew it would not harm the children, and it was the quickest way for us to treat the children who were very weak from the high fever and seizures. But they weren’t getting better.

We knew that gold mining took place in the village, but Frank was the one who started asking questions. He saw women breaking stones, their babies on their backs. He realized that a heavy metal such as lead, arsenic, or mercury was probably getting released as well.

We needed lab confirmation before we could treat because medical protocols for lead, mercury, and arsenic poisoning are very different. HQ in Amsterdam decided that the best option was a testing facility in Germany. The Nigerian Ministry of Health helped us gain permission to export human lab samples to Europe. And these samples confirmed that the children were suffering from severe lead poisoning.

AN INTERNATIONAL RESPONSE

As soon as the diagnosis was confirmed, we contacted the Centers for Disease Control and the World Health Organization for medical protocols, because this is something MSF had never treated before. The CDC called it the worst case of acute lead poisoning they have on record. As of today, more than 400 children have died in five villages, most of them under three years of age. (Young children are so vulnerable because they have a different metabolism, the concentration of lead in their bodies is higher, and they have more fat, which absorbs the lead.) The Blacksmith Institute, a nonprofit that leads international cleanup efforts in polluted sites in the developing world, is now at work in the affected villages.

We had to move the clinic, because, we learned, if you treat patients for lead poisoning while they are still being exposed to it, you can actually do more harm than good. A hospital in nearby Anka offered us one of its wings, which our logisticians prepared with water, electricity, and beds. By August, MSF was treating 130 patients from three of the affected villages in the hospital—children as well as pregnant and nursing women—with chelation therapy, using a drug that binds to the lead and takes it out of the body.

Watching from afar

I had to leave the project soon after we started treatment. My colleague, Emergency Desk Manager Lauren Cooney, later wrote me that they were seeing improvements, that a girl whose muscles had been so weakened that she couldn’t walk was back on her feet, for instance, and that a boy who was enduring repeated convulsions was no longer experiencing them. “But it’s only a small start,” Lauren wrote.

And, in fact, in late August, BBC reported that 13 more children died in a single village in one week. News like this is tough to take. I immediately contacted HQ in Amsterdam to find out if MSF was responding and if I could help in any way. I was informed that the rainy season had come, rendering the village inaccessible for the time being. MSF will send a team as soon as it is possible.

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Surveillance means sending teams to remote villages to look for and treat new cases. It was primarily measles that we were finding because the outbreak was so massive, though we did treat more than 1,000 people for meningitis.

The teams were covering pretty large areas, often driving for three or four hours a day and then spending a few hours in clinics and hospitals treating infected children. They traveled by land cruiser or jeep. This area is primarily desert. In Niger state, though, there were lakes and rivers, so our team was going out on boats to reach villages where they found and treated thousands of children.

We had 8 to 10 mobile teams in each state—a doctor and a nurse who would travel from village to village, clinic to clinic. I worked with Frank Peters, a logistician from Colorado, and several nurses and doctors. We took a small supply of malaria medicines, IV catheters and fluids, anti-fever medicines, and some anti-seizure medicines.

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UNRAVELING A MYSTERY

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We knew that gold mining took place in the village, but Frank was the one who started asking questions. He saw women breaking stones, their babies on their backs. He was shown machines used to grind down rocks, sending fine dust far and wide. He realized that a heavy metal such as lead, arsenic, or mercury was probably getting released as well.

We needed lab confirmation before we could treat because medical protocols for lead, mercury, and arsenic poisoning are very different. HG in Amsterdam decided that the best option was a testing facility in Germany. The Nigerian Ministry of Health helped us gain permission to export human lab samples to Europe. And these samples confirmed that the children were suffering from severe lead poisoning.

AN INTERNATIONAL RESPONSE

As soon as the diagnosis was confirmed, we contacted the Centers for Disease Control (CDC) and the World Health Organization for medical protocols, because this is something MSF had never treated before. The CDC called it the worst case of acute lead poisoning they have on record. As of today, more than 400 children have died in five villages, most of them under three years of age. (Young children are so vulnerable because they have a different metabolism, the concentration of lead in their bodies is higher, and they have more fat, which absorbs the lead.) The Blacksmith Institute, a nonprofit that leads international cleanup efforts in polluted sites in the developing world, is now at work in the affected villages.

We had to move the clinic, because, we learned, if you treat patients for lead poisoning while they are still being exposed to it, you can actually do more harm than good. A hospital in nearby Anka offered us one of its wings, which our logisticsian prepared with water, electricity, and beds. By August, MSF was treating 130 patients from three of the affected villages in the hospital—children as well as pregnant and nursing women—with chelation therapy, using a drug that binds to the lead and takes it out of the body.

WAVING FROM AFAR

I had to leave the project soon after we started treatment. My colleague, Emergency Desk Manager Lauren Cooney, later wrote me that they were seeing improvements, that a girl whose muscles had been so weakened that she couldn’t walk was back on her feet, for instance, and that a boy who was enduring repeated convulsions was no longer experiencing them. “But it’s only a small start,” Lauren wrote.

And, in fact, in late August, BBC reported that 13 more children died in a single village in one week. News like this is too much to take. I immediately contacted HG in Amsterdam to find out if MSF was responding and if I could help in any way. I was informed that the rainy season had come, rendering the village inaccessible for the time being. MSF will send a team as soon as it is possible.

I had started studying at Johns Hopkins University to earn a dual masters degree in public health and global nursing. I am more than 5,000 miles away, but a part of me remains in Zamfara. It was one of the most difficult projects I have been a part of with MSF, but I hope I can be a part of something like it again. It was a great health mystery and MSF responded with strong teamwork that made lifesaving treatment available in a place it was desperately needed.
A boy holds his younger brother as he stands in a field in Gogrial, in southern Sudan. The people of southern Sudan will face a huge choice on January 9, when they vote in a referendum that could result in the birth of a new country.

The boy looks to be peering into the future, wondering what it holds. MSF must be ready to do the same wherever it works, including in southern Sudan, where it has operated through years of conflict, drought, and, at present, a massive outbreak of kala azar.

It is because people like this boy cannot know what lies ahead that MSF must be ready for whatever might be. MSF can do this in large part because it is generously supported by donors and because it is able to find exceptional candidates for its field missions. In 2010, a year that required MSF to respond to a host of predictable and unpredictable contexts, the organization is on pace to send out more than 340 US-based aid workers on more than 435 departures to 45 countries. Along with the national staff in the mission countries, these are the people who are ready to help those who need medical humanitarian assistance through whatever may come their way.

For more information about MSF recruiting, please visit doctorswithoutborders.org/work