Dear Friends,

This is a crucial year for Afghanistan. A presidential election is scheduled for April, and it seems certain that there will be a significant withdrawal of US troops sometime after that. A great many questions are floating around about the political situation, the security situation, human rights, and more.

As a medical humanitarian organization, Doctors Without Borders/Médecins Sans Frontières (MSF) is focused on the medical element of the equation. There have been significant improvements in the public health picture in Afghanistan over the past decade, but many of the gains are extremely fragile, and the country still ranks distressingly low in many categories of the United Nations Human Development Index.

We have four projects in the country and in recent months, our teams, in addition to treating patients in a host of different capacities, have been surveying people in different regions to understand their health needs. We wanted to use the resulting data and our experience in the country to urge all involved to keep access to medical care and the health of Afghans high on the agenda going forward. We share the results of this project in the pages that follow, along with some stunning images from MSF project sites.

Also in this issue, we bring you firsthand accounts of MSF’s work in Central African Republic and South Sudan, two countries that were plunged into violence towards the end of 2013. MSF has been working in both places for many years—each was featured in Alert cover stories over the past 18 months—and our staff on the ground has been working around the clock to stem some of the suffering that’s resulted from the wholesale breakdown of order.

We tried to do the same in the Philippines following Typhoon Haiyan, and here we bring you an account from one of our “first responders.” Additionally, Manica Balasegaram, executive director of MSF’s Access Campaign, weighs in on trends and developments in the ongoing fight to secure access to medicines for neglected and underserved populations the world over, and the need for new thinking when it comes to research and development of drugs.

All of these stories are part of our effort to bring reports from our projects back to you, to remain transparent and accountable while conveying the scope and nature of our work. We took what we think is another important step in this direction with the launch of our new website in February—doctorswithoutborders.org—which you may have already noticed. We’d love to know what you think about the new site, about Alert, and about our work, and invite you to send any thoughts to alert_editor@msf.org, so we can continue the conversation.

Sincerely,

SOPHIE DELAUNAY
Executive Director, MSF-USA

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Alert is a quarterly newsletter sent to friends and supporters of Doctors Without Borders/Médecins Sans Frontières (MSF). As a private, international, nonprofit organization, MSF delivers emergency medical relief to victims of war and disaster, regardless of politics, race, religion, or ethnicity.

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Over the past decade, Afghanistan has been pulled in many directions at once, not all of them good. It is still plagued by insecurity and poor governance, and it ranks distressingly low in many categories of the UN’s human development index, such as infant mortality. At the same time, however, access to both education and health care, particularly for girls and women, has increased exponentially, and opportunities exist now that past generations could not have imagined. In some areas, people are rushing into tomorrow at breakneck speed; in others, age-old cultural traditions dictate much of life. There are also some very big questions about what will happen after this April’s presidential elections, and after the US military completes a partial or full withdrawal of forces over the next year.

As a medical organization, MSF sees this through the prism of access to health care. Having returned to Afghanistan in 2009 after a five-year absence that followed the murder of five MSF staff members in the country’s interior, the organization now runs a hospital and other programs in Kabul, the capital; a trauma center in Kunduz, one of the largest cities in the north; a full service hospital in Lashkar Gah, in long-embattled Helmand province; and a maternity program in Khost, the capital of a province of the same name that borders Pakistan.

In recent months, our teams in the country carried out extensive surveys, asking people about their medical needs and their access to medical care. Herewith, along with a selection of striking images from Afghanistan, we present some of the findings, some information about MSF’s work, and some words from Afghans themselves.
**Above:** Haji Muhammad Gul at Boost Hospital in Lashkar Gah, with his son, who is receiving treatment for a kidney disease. © Mikhail Galustov

**Right:** Najibullah (far left), a father of 11, was shot during a firefight that broke out near the construction site where he worked and later lost his leg because he couldn’t reach a hospital until the fighting stopped. © Mikhail Galustov

**Facing Page:** Abdul Ghani from Garsmir holds his eight-year-old daughter at Boost Hospital. © Mikhail Galustov

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**World Health Organization Estimates for Afghanistan:**

<table>
<thead>
<tr>
<th>Metric</th>
<th>Figure</th>
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</thead>
<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>60 years</td>
</tr>
<tr>
<td>Maternal mortality ratio per live births</td>
<td>4.6/1000</td>
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<tr>
<td>Under-five mortality ratio per live births</td>
<td>10.1/1000</td>
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</table>

Figures from 2011

- **36%** of the population cannot meet their basic requirements such as access to food, clean water, clothing, and shelter. [National statistic](#)
- **500,000+** people in Afghanistan will need emergency shelter and non-food assistance in 2014. [OCHA](#)
- **2.6 Million** Afghans are currently refugees in neighboring countries. [UN](#)
- **600,000** people internally displaced as of Nov. 2013. [UN](#)
PATIENT TESTIMONY

Excerpts from testimony given to MSF researchers by a 50-year-old farmer from Kapisa Province

“There is no sleep in my village. We experience harassment from every side. Each night helicopters and planes circle overhead. There are constant roadblocks, checkpoints, and attacks. Sitting or resting, we live in fear, from everyone. We are all affected, with two or three people killed, injured, or traumatized in every home.

I am a farmer; we harvest pomegranates. But when my wife and I go to our crops in our fields, we are in danger. Always at risk, always afraid.

It is too insecure to go out at night. So we can’t bring someone to the doctor at night, even if their sickness or injury is serious. We can’t drive at night, as then all of us would be killed on the road. So, we prefer if they die quickly rather than suffer through the night only to die the next day on the way. This is the reality.

In our village there are no public doctors, and there is no big public hospital in our district either. There is a public hospital at the provincial level, but there are no female doctors. What good is that to our women when our culture means they have to be seen by a female doctor for certain problems?

It’s normal because we are used to this. All this violence. But it is no life, we are just existing. Surviving the insecurity—which is the mother of all our problems.”
**MSF ACTIVITIES IN AFGHANISTAN**

*Coordination office in Kabul, with 22 international and 134 national staff*

<table>
<thead>
<tr>
<th>Helmand</th>
<th>Kabul</th>
<th>Khost</th>
<th>Kunduz</th>
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<tbody>
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<td>District</td>
<td>Maternity</td>
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<tr>
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*per year **since September 2011

**OVERVIEW**

- 351 beds
- 232,500 outpatient consultations
- 84 international staff
- 23,600 babies delivered safely
- 400 national staff
- 30,990 patients admitted to hospital
- 1,219 Afghan staff
- 3,590 surgeries performed
- 49,500 patients treated in emergency rooms

**MSF SURVEY: IMPACT OF CONFLICT ON HEALTH CARE**

1 in 5 have been a victim of violence or know someone in their family or village who suffered violence.

This was even higher in Khost, where 27% of respondents also knew someone who had died as a result of violence, 83% as a result of armed conflict.

Reasons for lack of access to health care and subsequent death:

- Conflict: 18%
- Distance: 22%
- Cost: 32%
- Other: 6%

Reasons for not going to their closest public health facility:

- Preference: 10%
- Quality: 42%
- Availability: 26%
- Cost: 3%
- Other: 6%

Survey was conducted in the four provinces where MSF has activities; all results for the last 12 months.
TOP: Medics treat a patient at the Kunduz trauma center. © Mikhail Golustov

ABOVE LEFT: Newborns in the neonatal ward of MSF’s maternity hospital in Khost. © Andrea Bruce/Noor

ABOVE RIGHT: A woman at an MSF mobile clinic outside Kabul comforts her 12-year-old son, who is suffering from an aggressive form of sarcoma that will likely soon take his life. Several hospitals had refused to treat him before his mother brought him to MSF, but by that time, doctors said, the disease had progressed too far. © Andrea Bruce/Noor

BOTTOM LEFT: A relative leads an injured man towards the entrance of MSF’s trauma center in Kunduz. © Mikhail Golustov
MSF Q&A: CENTRAL AFRICAN REPUBLIC

MY MOST DIFFICULT MISSION

Jessie Gaffric recently completed an assignment as project coordinator of MSF’s program at Bangui’s Community Hospital in Central African Republic (CAR), where the organization performs emergency surgery for victims of the violence that has convulsed the city and much of the country’s northwest since a March 2013 coup d’état. Gaffric, who has worked with MSF in several conflict settings, says this was her “most difficult” assignment yet:

Who are MSF’s patients at the Bangui Community Hospital?

In Bangui, we treat primarily men between the ages of approximately 20 and 35. Most are combatants. Women and the elderly make up a minority of the patients. They happened to be in the wrong place at the wrong time. Children under the age of 15 were treated at another facility: the Bangui Pediatric Complex. However, many of the patients who came from outside the city—from villages in the provinces that have been burned and looted and who are transferred by the ICRC [International Committee of the Red Cross] or other MSF teams—were women and children.

Nearly all of our patients are victims of violence. The most common injuries are bullet and grenade wounds, followed by knife and machete wounds. Then there are victims of lynching, confinement, and torture, and, lastly, people who have been wounded while fleeing.

What were the obstacles and constraints that you faced in your work?

Insecurity is the main problem. That makes it hard for us to do our work. Our teams cannot stay in the hospital after the 6PM curfew. It’s too dangerous. So we have to do a full day’s work during the 11 hours that we are there. Sometimes, we had to lock ourselves in the operating room or evacuate on short notice.

MSF places all patients together and does not distinguish based on group or religion. We talked a lot with the patients and everyone living on the hospital grounds about that policy and explained it to the families. That took a lot of time, too. But I think it allowed us to avoid serious problems.

As project coordinator, how did you manage security for the team?

We often had to postpone surgeries, and some nights there were only a few or no staff members at the hospital. We had to leave patients alone, without medical monitoring. We didn’t know whether they’d be alive when we returned.

On some days when there was fighting, hospital employees couldn’t leave home to come to work. We had to manage as best we could with the MSF expatriates and Central African staff members who had slept at the hospital.

The issue of security outside the hospital is equally important. I was in constant contact with MSF’s head of mission. I kept him informed about what was happening.

Dorassio L. is 23. On January 18, he was shot in the arm in Bouar, in northwestern CAR, and his arm had to be amputated. MSF treated him in Bouar then transferred him by plane to the Bangui Community Hospital, where MSF surgical teams continue to monitor his condition.
“Nearly all of our patients are victims of violence. The most common injuries are bullet and grenade wounds, followed by knife and machete wounds. Then there are victims of lynching, confinement, and torture, and, lastly, people who have been wounded while fleeing.”

example, shooting or movements of armed groups) and he did the same for me. He provided tremendous support. He would come to the hospital in the event of a serious incident or a surge of patients to help manage the crowd. We made decisions jointly on issues like freezing team movements or evacuating the team when it was too dangerous in the hospital. It would have been much harder to deal with that alone.

Were you ever afraid?
Yes. Some of the armed men in the hospital frightened me. I had to step between them to prevent the lynching of a patient. The attackers looked at me with hate in their eyes.

I was also afraid when we traveled by car when there was shooting, when we would encounter combatants who looked really intimidating, and when we saw corpses on the roads. I was afraid at MSF living quarters, too, when there was shooting in the neighborhood. That happened almost every night, but some nights were worse than others. We even had stray bullets enter the house.

I was also afraid of making the wrong decision when we were evacuating a team. And of my responsibility for their safety.

How was this different from other MSF missions you’ve been on?
On my other missions, things were clear. This group was fighting that group. In CAR, the clashes have developed into inter-communal conflicts. Everyone is fighting everyone. The rise in violence, the levels it’s reached, the hatred that creates this fury to kill and mutilate, the wounds and the injuries, particularly knife wounds—it was horrible.

The workload was heavier. Even “normal” days were much worse than what I was used to. We had several mass casualty incidents with a lot of serious cases. That’s unusual. In Bangui, the percentage of serious cases was greater than that of minor injuries.

I think Bangui was the most difficult mission I’ve ever been on. Luckily, the team was great. We had a tremendous sense of cohesiveness.

Is there a specific patient who particularly affected you?
There were several. Idriss suffered a cranial trauma. His face was torn to shreds. He had to be strapped to the stretcher because we had to leave and he was very agitated. We showed the people who were there with him how to administer pain medication while we were gone. He died during the night.

Another man arrived, upright, walking, with his throat slit and his trachea open to the air. He also had machete wounds on the back of his neck and one ear had been cut off. He had been tortured for four days. He died the next day.

Then there was Michael, who had been stabbed in the throat and thorax. The entire team mobilized. He was stabilized and the surgical team did an amazing job. He’s doing well and can move his arm—which had been lifeless—again. That was a small victory!

All the patients in the orthopedic tent, too, who were there for weeks at a time, face to face, calm and in a pretty relaxed mood, despite their conflicts and differences. They had moved beyond what made them enemies outside.

MSF now manages seven regular projects and eight emergency projects in CAR. Overall, MSF provides free medical care to nearly 400,000 people in 12 hospitals, 16 health centers, and 40 health posts. The organization’s teams include approximately 200 expatriate staff and more than 1,800 national staff.

“I think Bangui was the most difficult mission I’ve ever been on. Luckily, the team was great. We had a tremendous sense of cohesiveness.”

to be amputated. MSF treated him in Bouar then transferred him by plane to the Bangui Community
The following is excerpted from a press release MSF issued on February 18, 2014.

The extreme levels of violence against civilians and targeted killing of minority groups in CAR illustrates the utter failure of international efforts to protect the population. MSF calls on member states of the UN Security Council, as well as donor countries, to mobilize to immediately halt the atrocities against the population; establish the level of safety needed for people to move freely without fear for their lives; and organize a massive deployment of aid to meet the basic needs of the population. Local and national leaders must do their utmost to stop the violence and enhance protection.

“We are caught in a sense of helplessness faced with extreme violence, treating thousands of wounded, and seeing hundreds of thousands of people fleeing their homes as it is their only option to avoid being slaughtered,” said Dr. Joanne Liu, MSF international president, who recently returned from CAR. “There is a shocking lack of engagement and mobilization of political leaders in the UN Security Council, and a too-limited one from African countries and the African Union to address the violence that is literally tearing apart the Central African Republic.”

Central African civilians of both of the main religious communities are being held hostage to violence instigated by armed groups who bear primary responsibility for the atrocities. Since December 5, MSF teams have treated over 3,600 wounded in the capital and around the country. This includes gunshot, grenade, machete, knife, and other violent trauma.

“When I was in Bozoum, we found 17 injured people with wounds from gunshots, machetes, and a grenade, hiding in a small courtyard,” said Dr. Liu. “They were too scared to go to the hospital in case they were targeted again.”

MSF teams are constantly dealing with violent attacks taking place in close proximity to or inside hospitals. For instance on February 12 in Berberati town, men armed with machetes and guns entered the hospital where MSF is working, firing shots and threatening patients. On countless other occasions in various locations, local leaders, religious clerics, and MSF medical staff have had to physically intervene in situations in which armed men were attacking or threatening to kill individuals, including sick and wounded patients.

In eight places where MSF works, some 15,000 civilians are gathered and trapped in hospitals, churches, or mosques, living in fear of being killed by armed groups. MSF has opened health posts in many of these enclaves, including in Bangui, as people are too fearful to go to the hospital even if it is only a few hundred meters away.

Over the past two weeks, MSF teams have seen tens of thousands of people from the Muslim community in Bangui, Baoro, Berberati, Bocaranga, Bossangoa, Bouca, Bozoum, and Carnot fleeing or being trucked away to neighboring countries by international armed forces that were, otherwise, incapable of protecting them. Others have been evacuated from the northwest of the country to Bangui and are now trapped in enclaves and camps where they continue to live in terror. Fear of persecution has pushed tens of thousands of civilians from all communities to flee to the bush, without access to any form of protection or humanitarian assistance.

The devastating toll has been further compounded by the lack of a meaningful scale-up of humanitarian assistance to meet even the most basic needs of the people. Assistance has been appalling in Bangui and practically nonexistent outside the capital.

Even though security incidents hamper MSF’s operations on a daily basis, the extensive deployment of MSF staff—more than 2,240 international and national staff—and activities in 16 towns around the country shows it is feasible to provide humanitarian assistance.

“It is a massive catastrophe unfolding in full view of international leaders,” said Dr. Liu. “To not respond is a conscious and deliberate choice to abandon the people of the Central African Republic.”
EMERGENCY SURGERY IN SOUTH SUDAN

MSF surgeon Paul McMaster has worked with MSF in Haiti, Syria, Sri Lanka, and several other emergencies. He recently returned from South Sudan, where conflict erupted last December, after which MSF quickly expanded its already far-reaching efforts in the country. In five weeks, teams responding to this crisis carried out 71,973 consultations, hospitalized 2,710 patients (including 1,600 children under 5), treated 1,252 war-wounded patients, and assisted in 1,610 deliveries. In an article originally published in the Guardian (UK), he described his experience:

I was phoned by MSF’s emergency desk on the weekend before Christmas. The fighting in South Sudan had broken out a few days before, and I was asked if I’d take in an emergency team to get some extra surgical capacity into the areas where the fighting was really intense. We left the next day.

We went first to Bentiu, the capital of Unity State. There had been fighting in the town the day before; the markets had been trashed and looted, and the doctors had left the local hospital. We found a ward full of about 45 quite severely wounded people, so we set about trying to help them medically. I started operating that evening. But the situation was deteriorating, and there were rumors of a major attack on the town. The next morning we were evacuated.

The town was extremely tense as we left. Lots of men with guns were walking around. Small columns of people with bundles were heading out across the main bridge.

Not long after, government forces went in and took over Bentiu. By then the population had disappeared to small villages and to the bush. Another MSF team went in five days later but again was pulled out because of disturbances. Our compound was trashed and looted and broken up, so it remained a very tense situation.

From Bentiu, we flew to Nasir. There had been fighting in the area all week and MSF’s hospital was full of casualties. We worked for 36 hours with the local MSF team, with the surgeon and I doing some complex cases. Then we left for Lankien, where more casualties were coming in.

Lankien is a small, remote town of mud huts. When we got there the town was crowded; the population of 7,000 had more than doubled with people fleeing the fighting, and the hospital was full of casualties and distressed people. We treated 130 to 140 people with gunshot wounds over the next three or four weeks.

The majority were young men of 16 or 17, some younger, who had been injured in the fighting to the north of us in Malakal, or to the south of us in Bor. They were brought to us two or three days after being injured, with major gunshot wounds and fractures, all of which were contaminated with dust and becoming infected. It took a lot of work to prevent these wounds developing blood poisoning and sepsis.

There were also a significant number of civilians, including children, who had been wounded in the fighting. One young boy of 11 had been shot in the spine and was paralyzed from the waist down. I operated twice, and although I was able to remove the bullets and repair the area, I very much doubt he will be able to walk again.

Late one evening I was asked to see a girl of about 12 who had been convulsing and had other medical problems. We worked hard, and I was thrilled to see her in the morning looking very much better and with a good prospect of a full recovery. But I was anguish to see that her caretaker was her nine-year-old brother.

Immediately after, the hospital itself was under great pressure. A lot of our admissions were ordinary people who had made the three-day trek from either Bor or Malakal, walking through the heat of the day. They had no food and very little water and some of them were simply collapsing from exhaustion. The number of outpatient consultations tripled in our clinics, which were overwhelmed.

It’s imperative that we keep up our work to provide essential medical care and emergency surgical care across the country—that we manage to keep our teams safe enough to carry on working with the wounded and the people who have been displaced from their homes. I don’t know of any other organization that could do what MSF is doing there right now.
Two days after Typhoon Haiyan hit the Philippines, Ib Younis, an Arizona-based member of MSF’s emergency team, got a call from headquarters; 24 hours later, he was in the country as part of the first wave of MSF’s response. Here he recounts arriving in the affected areas and figuring out where and how to get to work.

I arrived in the Philippines three days after the typhoon hit, met with MSF colleagues in Cebu, and then took a ferry to Ormoc, a town in the northwest of Leyte Island. I traveled with a Filipino nurse who had been working with MSF in Papua New Guinea. My role was to assess the situation and to give feedback to headquarters so we could deploy the resources needed. Then, I would manage the medical and logistical teams, the relationship with the government, and the strategic direction of the emergency response, including primary and secondary health care, mental health care, water, and sanitation.

I did not expect Ormoc to be damaged because it was not in the projected path of the typhoon. But as soon as we arrived, we saw heavy wind damage, with roofs gone and a lot of wear and tear on the buildings. There was no electricity and the city was in complete darkness. The level of destruction reminded me of Aceh, Indonesia, where I worked with MSF after the 2004 tsunami.

The port and all the hotels were full of people waiting to leave the island by boat. It was hard to find a place to sleep. We went to Ormoc District Hospital, which was badly damaged—the roof was gone. They had to discharge most of their patients and put the rest in the reception area, along with the staff, because it was the only structurally sound part of the building.

ADDRESSING NEEDS

Their generators were running out of fuel, so I paid for two or three drums of diesel. They needed to get their surgery and delivery rooms repaired as soon as possible. I looked at the structure with a flashlight and said we could fix it for them.

They helped us find space in a nearby hotel: two beds, no mattresses, just pieces of wood. As people left the island in the days that followed, other rooms became available. I paid in advance for each one, because we had more people on their way in to help.

Soon afterward, I drove across the island with the director of the hospital to see the provincial administrator in Tacloban. On the way, I assessed the areas along the road and stopped at health centers to make inquiries. Most houses were severely damaged. Many health centers were intact but most of the staff were missing or were looking for relatives.

I asked whether they had wounded people or evacuees from other communities, and if they had cases of infectious diseases such as diarrhea or tetanus. I also asked whether children had received routine vaccinations, such as for measles. I sent this information back to our headquarters so we could deploy more resources.

RUNNING MOBILE CLINICS

Back in Ormoc, more MSF personnel were arriving. Congestion at the airport delayed arrival of most of our supplies, but we had kits with basic medical items, so we formed mobile teams to do primary health care and assessments, especially for tetanus.

Our water- and sanitation team looked at all the evacuation centers in Ormoc district as well. We were concerned about waterborne diseases, and water- and-sanitation systems were malfunctioning because there was no electricity. We positioned generators where they were needed to power water pumps, boosted chlorine levels in the water supply, and closely monitored cases of diarrhea everywhere.

By the second week, our mobile teams were providing primary care and mental health care in about 20 locations in and around Ormoc and Santa Fe, which is close to Tacloban. Our teams saw quite a few neglected wounds, and we provided tetanus vaccinations. We treated common colds, upper respiratory tract infections, and light fevers among children under five. We also conducted a measles vaccination campaign.

USING BOATS & HELICOPTERS

Aid was not reaching remote communities, where roads and bridges had washed away, so we used helicopters and boats to access them. Local medical facilities were still in emergency mode, and chronic diseases were going untreated, so we pushed to supply medications for conditions such as diabetes and hypertension.

Shelter remained a problem for many families. In Santa Fe, we gave every household basic items to improve their living conditions, including blankets, mosquito nets, jerry cans, kitchen sets, plastic sheets, hammers, and nails.

Sometimes we found people with broken bones or chronic diseases, and we immediately
evacuated them. In the east of the island, we referred patients to MSF’s field hospital in Tacloban. In the west, we referred them to the Ormoc District Hospital. It was damaged, though, so I contacted the Canadian Red Cross, which worked with the Norwegian Red Cross to build a tent hospital inside. Meanwhile, over the next three weeks, we fixed the roof over the emergency ward and emergency room.

We handed over our programs in northwestern Leyte to the government and other aid agencies in late December. In general, I would say that the Philippine government is prepared for disasters, since they experience typhoons fairly frequently. But they were not prepared for the scale of this disaster. Our role was to make sure that the medical infrastructure was still running. We filled the gap as much as possible.

MSF ACTIVITIES IN THE PHILIPPINES, NOV 2013–JAN 2014

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<td>Families received food relief</td>
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<td>Children vaccinated for measles</td>
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Source: MSF
DRUGS FOR THE POOR, DRUGS FOR THE RICH

Why the current research and development model doesn’t deliver

By Manica Balasegaram, executive-director of MSF’s Access Campaign.

This originally appeared on the website of the British Medical Journal.

The past month has seen the reputation of “Big Pharma” dented more than usual. The CEO of German pharmaceutical company Bayer, Marijn Dekkers, was reported as saying that the company didn’t develop a cancer drug for the Indian market, but rather “for Western patients who can afford it.” The comment summed up the attitude of the pharmaceutical companies towards the poor and succinctly described what is wrong with today’s research and development (R&D) system.

In a similar vein, last month British/Swedish pharma company AstraZeneca announced it was pulling out of all early stage R&D for malaria, tuberculosis (TB), and neglected tropical diseases. Instead, the company stated it will focus efforts on drugs for cancer, diabetes, and high blood pressure, all diseases that affect rich countries, with potentially plenty of people to pay the high prices on new drugs.

This system of R&D—which increasingly relies on patents, market monopolies, and high prices of drugs to recoup costs—is broken. We are seeing a complete lack of R&D into areas of real need, especially in diseases that affect the poor. The effects of this system on patients in developing countries is something that I—as someone who has worked as a doctor in some of the most remote areas in the world with MSF—have witnessed for years.

The pharmaceutical industry touts the need for strong intellectual property (IP) protections and patents as a means to secure funding for R&D needs. They say that without this system of R&D into areas of real need, especially in diseases that affect the poor. The effects of this system on patients in developing countries is something that I—as someone who has worked as a doctor in some of the most remote areas in the world with MSF—have witnessed for years.

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Barbara W. Alerding and her husband William Alerding were loyal donors to MSF for more than 15 years. When Barbara passed away last year, MSF received a generous gift from the Alerdings’ estate.

Barbara grew up in Evanston, Illinois, and Bill in Boston. They met in Chicago in the mid-60s and married a few years later, dedicating their lives to helping others. For most of the next three decades, they lived and worked for the Institute of Cultural Affairs (ICA) in countries such as Guatemala, Nigeria, Zambia, Indonesia, Egypt, and Mexico, putting into practice their shared commitment to education, community organization, leadership training, and human development.

Bill and Barbara left their mark on the world and improved the lives of countless individuals. MSF is most grateful for their generosity.

In 1993, they moved to Indianapolis and became instructors for Technical Training Services, Inc., a program that provided training and assistance to the urban unemployed and underemployed, before later working with other organizations that promoted social and economic justice. At age 77, Barbara earned a master’s degree in adult and community education from Ball State University. She was a proud member of Sigma Alpha Iota, an international honorary music fraternity for which she served as president of its Indianapolis Alumnae Chapter. Bill, in addition to being a passionate storyteller, loved to read and golf and was a politics and sports enthusiast.

Through their work and travel, the Alerdings learned of MSF and came to greatly admire the organization’s work providing medical care to people like the people with whom they had themselves worked. Bill passed away in July 2011, and Barbara in June 2013. During their lives together, left their mark on the world and improved the lives of countless individuals. MSF is most grateful for their generosity.
Doctors Without Borders/Médecins Sans Frontières (MSF) works in nearly 70 countries providing medical aid to those most in need regardless of their race, religion, or political affiliation.