EBOLA IN WEST AFRICA
FACING AN EMERGENCY HEAD ON
Dear Friends,

Even long-time MSF veterans will tell you: The volume and complexity of emergencies in 2014 was unparalleled. Bookended by a typhoon’s aftermath in the Philippines and the ongoing West Africa Ebola outbreak, it also included war in Syria, South Sudan, and Central African Republic, among other crises. While your support assured us the financial resources needed to respond, it was challenging, to say the least.

On Ebola—we were there when it began, in March, and repeatedly sounded the alarm about the need for a broader, faster response from the international community. That was slow to develop, and the consequences were severe, as we’ve seen. No one saw this more immediately than MSF field staff in Guinea, Liberia, and Sierra Leone. We are profoundly grateful to them, our colleagues who have answered the call, especially the national staff.

There is risk involved in this work—be it with Ebola, in conflict zones, or in other contexts where MSF operates—and while I think MSF does well to mitigate risk, we cannot eliminate it altogether. Staff members have indeed contracted the virus in the field. Several have died. We investigate every incident to learn how it occurred and make adjustments as needed, but we also knew there was a chance that one of the field workers sent from the US could develop symptoms after returning home.

That happened in October. Dr. Craig Spencer did everything he should have done once he felt the onset of a low-grade fever; the protocols we had in place proved successful. Public anxiety and a media frenzy ensued, however, and both were heightened when MSF nurse Kaci Hickox was forced into quarantine after landing in Newark, despite having no symptoms. Through it all, we tried to support Craig and Kaci as best we could, while also communicating transparently with the public, our supporters, and concerned field staff, and working with state and federal officials to understand the shifting, often opaque directives that were being issued.

That process continues, but Craig was treated, declared healthy, and discharged on November 11, and thus far no one else has developed symptoms upon their return. We have therefore been trying to redirect attention back to the field, to West Africa, where more than 3,000 MSF staff are doing their utmost to staunch the spread of the virus, just as teams in South Sudan and CAR and dozens of other countries are doing their utmost to deliver lifesaving medical care.

Our work continues to evolve on other fronts as well. MSF is breaking ground (for us) by taking part in clinical trials of potential Ebola treatments, as well as the first new tuberculosis drugs in 40 years. We continue to call for changes in the way research and development is carried out as well, while also challenging excessive pricing regimens for vaccines for children and advocating against policies and trade agreements that would impede access to medicines.

I’d say we were wishing for a calmer 2015, but that seems unlikely. So we will stand ready, with your support, to respond as we must, where we must, as we’ve done for more than 40 years.

Yours,

DEANE MARCHBEIN
President, MSF-USA Board of Directors
When Ebola came to West Africa, it came unannounced and unexpected. No cases had ever been reported in Guinea, and when patients began to fall ill in that country this past March, it was initially suspected that they’d contracted other diseases, such as Lassa fever. As the number of cases increased and the death toll rose, however, fears that it was something worse began to mount.

First identified in 1976, Ebola is considered one of the world’s deadliest viruses. Fruit bats are believed to be the natural hosts. Once transmitted to humans, Ebola is spread through close contact with bodily fluids of an infected person. The fatality rate can vary from 25 to 90 percent, depending on the strain.

The disease can be difficult to diagnose because its initial symptoms are often nonspecific. Ebola is characterized by the sudden onset of fever, weakness, muscle pain, headaches, and/or sore throat, followed by vomiting, diarrhea, rash, impaired kidney and liver function, and, in some cases, internal and external bleeding. Symptoms can appear from two to twenty-one days after a patient’s exposure.

Testing confirmed the presence of Ebola in Guinea, and on March 22, the Ministry of Health (MoH) reported cases in Guéckédou, Kissidougou, Macenta, and Nzérékoré districts. There were many reasons for concern, among them the fact that West Africa hadn’t experienced Ebola before, as well as the geography of the area: the affected region shared permeable borders and frequent traffic and trade with its neighbors, Sierra Leone and Liberia.

By March 23, Guinea’s MoH had registered 49 suspected cases of Ebola and 29 deaths. Two days later, the World Health Organization (WHO) put the death toll at 59. MSF launched its emergency response that same week, sending a team of experienced doctors, nurses, logisticians, and hygiene and sanitation experts to work with Guinea’s MoH to set up an isolation unit in Guéckédou. Another was quickly established in Macenta.

MSF was able to draw field staff from a pool of professionals who had fought viral hemorrhagic fevers before, but the work was grueling. Before entering the isolation wards of treatment centers, staff members must put on full-body personal protective equipment (PPE), cumbersome plastic gear that can be difficult to bear in temperatures that...
regularly reached the high 90s. Rounds inside the wards had strict time limits to reduce the risk of hyperthermia and dehydration among staff.

Perhaps even more challenging was the work’s emotional toll. There is no specific treatment or vaccine for Ebola. Standard treatment is limited to supportive therapy—hydration, maintenance of oxygen status and blood pressure, and treatment for any complicating infections—designed to keep the patient alive long enough for the body’s immune system to defeat the virus. A high mortality rate is almost guaranteed. “Many patients die, including children,” explained MSF doctor Hilde de Clerck. “Palliative care for this disease is tough, as patients are terrified. We comfort patients whenever possible. We are the last people to touch them, and many of them ask us to hold their hands. These moments are both difficult and emotionally intense.”

With the treatment centers in Guéckédou and Macenta up and running, mobile MSF teams began evaluating the situation in nearby Kissidougou and Nzérékoré, then turned their attention to neighboring Liberia, where suspected cases were being reported.

The teams focused on “contact tracing,” the process of identifying people who’ve had direct contact with Ebola patients and could have caught the disease. “Our Ebola-specialist doctors go from village to village in areas where there have been cases,” explained MSF emergency coordinator Marie-Christine Férir in March. “They trace people showing symptoms of the disease and bring them to the dedicated facilities for medical care.” Contact tracing was done in tandem with a widespread health promotion campaign. “Above all, we must avoid generating panic,” said Férir. “That is why it is so important to spread correct information, so people understand the disease and how to protect themselves.”

**APRIL-MAY: AN UNPRECEDENTED EPIDEMIC**

By the beginning of April, Ebola had reached Conakry, Guinea’s capital, a city of some two million people that was completely unprepared to manage the outbreak. MSF moved quickly to strengthen support for patient isolation at Donka referral hospital in collaboration with the WHO and initiated specialized training sessions to educate health care providers, both Guinean and international, on symptom recognition, hygiene protocols, and triage methods for possible patients.

There were cultural challenges as well. MSF outreach teams were facing a fearful public struggling to reconcile traditional cultural and religious beliefs with the strict medical protocols required to halt the spread of the disease. Rumors spread that the aid workers in their outlandish protective gear had actually brought the virus with them. In Macenta, mounting public anxiety culminated in violent protests that resulted in the brief closure of a treatment center.

An apparent lull in new cases inspired cautious hope, but MSF continued working through April and into May to contain the outbreak. “We remain vigilant and cannot say that the outbreak is over, as we continue to see new confirmed patients and are continuing to provide care for the patients who remain in treatment centers,” said MSF emergency coordinator Marc Poncin in early May.

**JUNE-JULY: OUT OF CONTROL**

In early June, new cases of Ebola were reported in Sierra Leone, where MSF worked with the country’s MoH to set up a treatment center in the Kailahun district, near the Guinean border. In Guinea, meanwhile, the number of confirmed cases began to climb again, particularly in the Kailahun district, near the Guinean border. In Guinea, meanwhile, the number of confirmed cases began to climb again, particularly in regions that hadn’t previously registered any. MSF had some 300 staff—both national and international—working in the region and had sent 44 tons of equipment and supplies to support the response. It quickly became clear that this was not enough.

By the end of June, Ebola patients had been identified in more than 60 different locations in Guinea, Sierra Leone, and Liberia, and the virus was responsible for 528 cases and 337 deaths across the region. On June 23, an MSF press release sounded the alarm: “The epidemic is out of control,” said Dr. Bart Janssens, MSF director of operations. “We have reached our limits. Despite the human resources and equipment deployed by MSF in the three affected countries, we are no longer able to send teams to the new outbreak sites.”

“The WHO, the affected countries, and neighboring countries must deploy the resources necessary for an epidemic of this scale,” Jans-
sens continued. “In particular, qualified medical staff need to be made available, training in how to treat Ebola needs to be organized, and awareness-raising activities among the population need to be stepped up. Ebola is no longer a public health issue limited to Guinea. It is affecting the whole of West Africa.”

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AUGUST: BREAKING POINT

By early August the death toll had risen to 932, and Ebola was ravaging the Liberian capital of Monrovia, a city of nearly one million still trying to right itself after a lengthy and brutal civil war. The outbreak crippled the city’s already fragile health system, leaving most hospitals closed and dead bodies lying in streets and houses. Treatment centers were filled to capacity, and exhausted health care workers were forced into the heartbreaking situation of turning away patients in need.

“The first person I had to turn away was a father who had brought his sick daughter in the trunk of his car,” remembered Pierre Trbovic, a Belgian anthropologist who worked with MSF in Monrovia in August. “He was an educated man, and he pleaded with me to take his teenage daughter, saying that while he knew we couldn’t save her life, at least we could save the rest of his family from her. At that point I had to go behind one of the tents to cry.”

Without functioning hospitals, deaths from common illnesses like malaria and diarrhea began to mount as well. MSF continued to struggle against the spread of the virus, but again cited a dire need for the WHO and other organizations to rapidly—and massively—scale up the response.

SURVIVING EBOLA, HELPING OTHERS

Ebola killed both of Salome Karwah’s parents, but she herself managed to survive with treatment at an MSF Ebola case management center in Monrovia. Then Salome [photo on back cover, bottom] began working as a mental health counselor there, helping others fight the virus:

After 18 days in the treatment center, the nurses came in one morning and took my blood and carried it to the laboratory for testing. Later that evening, they announced that I was ready to go home because I had tested negative. I felt that my life had begun again. I went home with joy, despite having lost my parents.

My neighbors were still afraid of me. There was a particular group that kept calling our house “Ebola home.” But, to my surprise, I saw one of the ladies in the group [and she asked] me to take her mother to the treatment center because she was sick with Ebola. I did it, and I felt happy that at least she knows it’s a disease that anyone—any family—can get.

Now, I am back at the treatment center, helping people suffering from the virus to recover. I am working as a mental health counselor. When I am on a shift, I counsel my patients; I talk to them and I encourage them. If a patient doesn’t want to eat, I urge them to eat. If they are weak and are unable to bathe on their own, I help to bathe them. I help them with all my might because I understand the experience—I’ve been through the very same thing.

I feel happy in my new role. I treat my patients as if they are my children. I tell them my story to inspire them and to let them know that they too can survive. My elder brother and my sister are happy for me to work here. Even though our parents didn’t survive the virus, we can help other people to recover.

CLINICAL TRIALS: WORKING TOGETHER TO FIGHT EBOLA

In the absence of specific treatments for Ebola, MSF is working with three research partners to host clinical trials of possible new treatments in three Ebola management centers in West Africa. Starting in December 2014, these trials are designed to find, quickly, an effective therapy for use against the disease.

“This is an unprecedented international partnership that represents hope for patients to finally get a real treatment against a disease that today kills between 50 and 80 percent of those infected,” said Dr. Annick Antierens, who coordinates investigational partnerships for MSF. “As one of the principal providers of medical care to Ebola patients in West Africa, MSF is taking part in these accelerated clinical trials to give people affected by the current outbreak a better chance of survival.”

While clinical trials are underway, MSF is urging the drugs’ developers to scale up production now, to ensure there is no gap between the end of the trials and the large-scale introduction of products found to be safe and effective. MSF is also urging drug manufacturers to ensure that end products are affordable and available in the quantities needed to tackle the outbreak. Distribution should be driven by needs, irrespective of where people live or the capacity of a country to purchase medicines.
PERSONAL PROTECTIVE EQUIPMENT (PPE)

PROTECTIVE GOGGLES
Goggles keep health workers from rubbing their eyes after touching infected patients or contaminated surfaces, and protect against infected bodily fluids.

FACE MASK
Ebola is not an airborne disease, but it is important for health care workers to cover their mouths, as infected bodily fluids can enter here. This makes breathing and speaking difficult but is essential for effective protection.

CHEMICAL-RESISTANT GLOVES
Ebola is transmitted through contact with bodily fluids. MSF health workers wear two sets of chemical-resistant gloves to minimize risk.

PLASTIC APRON
MSF protocol requires that when treating Ebola patients health workers must wear an extra protective layer to further limit the risk of infected bodily fluids entering through tears or rips in the main suit.

PROTECTIVE SUIT
Our health care workers’ entire bodies, from their necks to their ankles, are covered by this suit, the base of the PPE, ensuring that they do not come in contact with infected bodily fluids.

RUBBER BOOTS
These heavy duty boots offer protection from Ebola while also providing comfort. They are relatively easy to remove during the lengthy undressing process.

“As an international health emergency, states with the capacity to help have the responsibility to mobilize resources to the affected countries, rather than watching from the sidelines with a naïve hope that the situation will improve.”
In October, the Ebola crisis came home for MSF-USA, thrusting the organization and our aid workers into the American media spotlight in an unprecedented way. It began early on October 23, when Dr. Craig Spencer, just back from Guinea, informed the office that he was running a light fever, 100.3 degrees. MSF-USA immediately called the New York City Department of Public Health, which dispatched a specialized team to bring Dr. Spencer to Bellevue hospital, where he later tested positive for the Ebola virus.

His earlier movements were subsequently dissected, his adherence to MSF protocols questioned, and MSF’s own regard for public health cast in doubt (his initial fever was misreported as 103 degrees). While mobilizing staff to support him and his family through the trying times ahead, MSF-USA also explained how and why it managed and advised health workers home from working in West Africa, stressing how the protocols were based on solid, established medical evidence. That meant stressing, among other things, the fact that Ebola cannot be spread by an asymptomatic person, thus making mandatory quarantines of individuals showing no signs of the virus unnecessary and counterproductive. MSF instead favors rigorously monitoring potential symptoms (as Craig had done).

As the clamor rose, however, New York and New Jersey governors announced new quarantine requirements for health workers back from Ebola projects—just as MSF nurse Kaci Hickox was flying into Newark airport after a stint in Sierra Leone. She was essentially detained in a quarantine tent at a Newark hospital, without being given a chance to debrief with the MSF-USA office and without being told how the quarantine would play out (likely because state officials did not know yet). Kaci let it be known that she was going to challenge the order, and she did so in the days that followed and later when she was relocated to her home in Maine. Both she and MSF, which staunchly opposes quarantines for healthy aid workers but was not involved in Kaci’s legal challenges, came in for criticism. Once again, MSF-USA explained its protocols and the reasons behind them, while also taking public concerns very seriously. We initiated a review of those same protocols and worked with state and federal officials to find a balance between policy based on anxiety and the science around the virus.

In Kaci’s case, a Maine judge ruled against a mandatory quarantine and the 21-day time frame in which people with Ebola show symptoms passed. Better news came on November 11, when Dr. Spencer was discharged from Bellevue, fully recovered. While there were certainly numerous lessons learned for MSF-USA from this episode, and we will continue looking at what we might have done differently and better, Dr. Spencer spoke for us all when he said, “Please join me in turning our attention back to West Africa, and ensuring that medical volunteers and other aid workers do not face stigma and threats upon their return home. Volunteers need to be supported to help fight this outbreak at its source.”

**TOP TO BOTTOM**

- MSF staff carry the body of a deceased Ebola patient to the burial team in Kailahun, Sierra Leone. © Fabio Basone/MSF
- An MSF worker dons PPE in Monrovia, Liberia. © Morgana Wingard
- An MSF staff member is disinfected after taking off PPE in Foya, Liberia. © Martin Zinggl/MSF
- Waste from the high-risk area is incinerated at MSF’s Donka Ebola management center in Conakry, Guinea. © Julien Rey/MSF
On August 8, the WHO finally declared Ebola an international public health emergency. By August 14, the disease had claimed more than 1,000 lives. Several weeks later, though, the global effort to stem the outbreak was still dangerously inadequate, and MSF’s human resources were stretched to a breaking point.

At month’s end, the WHO issued a road map for management of the outbreak but had yet to take meaningful action. “We have learned an uncomfortable lesson over the past six months,” said MSF director of operations Brice de le Vingne on August 28. “None of the organizations in the most-affected countries—the UN, WHO, local governments, NGOs (including MSF)—currently have the proper set-up to respond at the scale necessary to make a serious impact on the spread of the outbreak. For some, the limits are due to capacity constraints—the simple inability to do more—and others may need to be encouraged to demonstrate more willingness to push the boundaries and scale up effective activities at a meaningful scale.

“We cannot escape the need to rapidly and effectively contain this epidemic and provide the necessary care to patients, their families, and...
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SEPTEMBER-OCTOBER: “TO PUT OUT THIS FIRE, WE MUST RUN INTO THE BURNING BUILDING”

In early September, as the fear surrounding the epidemic spread far beyond the affected countries, MSF international president Dr. Joanne Liu addressed a special UN briefing on the outbreak and once again called on the international community to mobilize all assets at their disposal to bring the virus under control. “UN member states cannot focus solely on measures to protect their own borders,” she asserted. “Only by battling the epidemic at its roots can we stem it. This is a transnational crisis, with social, economic, and security implications for the African continent. It is your historic responsibility to act. We cannot cut off the affected countries and hope this epidemic will simply burn out. To put out this fire, we must run into the burning building.”

On September 17, the UN General Assembly finally responded with a unanimously adopted resolution on measures to combat Ebola in West Africa. By that point, however, the virus had already claimed over 2,500 lives and decimated the health systems of all three affected countries.

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One week later, Dr. Liu again addressed the UN, this time at a high-level meeting on Ebola. “Generous pledges of aid and unprecedented UN resolutions are very welcome,” she said. “But they will mean little unless they are translated into immediate action. The reality on the ground today is this: the promised surge has not yet delivered.”

As October turned to November, the epidemic continued to rage in West Africa. There have been victories—more than 1,100 MSF patients have survived the virus, for instance, and the beginning of a more robust international response can be seen on the ground—but the future remains deeply uncertain. Ebola’s appearance in the United States [see box, p7] may have turned the spotlight away from West Africa, but it might ultimately help people understand the urgency of the situation and the need to fight the outbreak where it’s doing the most damage, in West Africa.

The US is building a host of treatment centers in Liberia. Others are stepping up elsewhere. Case numbers are dipping in Liberia. All could be indications of better days ahead. But MSF is not slowing its response. It has maintained its operations in the field and increased training programs for would-be field workers—people headed to the field for MSF and for other organizations—while also expanding efforts to counter malaria and other diseases that have largely gone unchecked in recent months.

And our teams on the ground continue to work day after exhausting day to care for the men, women, and children who have contracted the virus and are fighting for their lives. There can be no other way. We know that a strong, coordinated response can save lives and prevent the spread of the disease, after all. And we also know that in the months ahead, complacency could be a worse enemy than the virus.

IN OTHER NEWS

A far from exhaustive list of things that also happened in the week media attention was focused overwhelmingly on Ebola in the US and MSF’s field workers at the center of the storm:

- **Amman, Jordan**: Khatam, a four-year-old girl from Aleppo, Syria, whose face, hands, and neck were badly burned in a barrel bomb attack, was recovering from surgery, performed a week earlier, at MSF’s reconstructive surgery project in Amman.
- **Kunduz, Afghanistan**: Ramin, a 12-year-old boy badly wounded by an improvised explosive device last month, was discharged in good health after receiving extensive surgical, medical, and psychological care at MSF’s trauma center in the city.
- **Bentiu, South Sudan**: On October 30, after a particularly brutal stretch of violence in the Bentiu area, staff at the hospital MSF runs in a displacement camp provided emergency medical care to 12 people with gunshot wounds and related injuries, carrying out nine surgical interventions, including one that helped stabilize a pregnant woman who had been shot in the chest, and her baby.
- **Port-au-Prince, Haiti**: Staff at MSF’s cholera treatment center (CTC) in Delmas were treating 200 patients per week.
- **Kibera, Nairobi, Kenya**: Over a 48-hour period, staff at MSF’s project in East Africa’s largest slum helped deliver 20 babies—13 boys and 7 girls.
- **Monrovia, Liberia**: Hundreds of women who received antimalaria tablets for themselves and their families from MSF, which launched an emergency malaria campaign, walked through the streets singing, “Thank you, MSF.”
- **Bangui, Central Africa Republic**: Staff at one of two clinics MSF established in CAR’s capital for victims of sexual violence, a massive problem in a country convulsed by conflict, counseled and provided medical assistance for those in need.
- **Epworth, Zimbabwe**: Gibson Chijaka, a 16-year-old TB patient, finished his grueling, two-year-treatment regimen.
- **Al Zaatari refugee camp, Jordan**: Two patients transferred from Ramtha tried on their leg prostheses for the first time.
- **Chaman, Pakistan**: A pregnant woman facing complications delivered healthy twin daughters with the help of MSF staff at the hospital MSF supports near the Afghanistan border.
- **Borno State, Nigeria**: MSF opened a 150-bed CTC in response to an outbreak that has afflicted 4,500 and killed 70.
- **Northern Iraq**: MSF opened a new clinic in Kalar, near Sulaimaniya, for Iraqis displaced by recent fighting, performing 668 consultations in the first week.
- **Pozzallo and Augusta, Italy**: MSF teams provided medical assistance to nearly 200 migrants, refugees, and asylum seekers coming to Europe by boat from Africa.
- **Lankien, South Sudan**: Teams in Lankien continued responding to a Kala Azar outbreak, for which they’ve treated more than 4,000 patients since the beginning of the year.
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A LOOK AT SOME OTHER TOP STORIES FROM 2014

SOUTH SUDAN: FIGHTING DISRUPTS ACCESS TO HEALTH CARE

Conflict between several armed groups continues to rage in South Sudan, causing widespread casualties and complicating access to desperately needed health care for hundreds of thousands of people. Violence against civilians and health care workers has in fact reached shocking levels since the conflict began last year.

CAR: “DESPITE ALL THE RISKS, WE ARE STILL COMMITTED”

In October 2013, after a brief ebb, political tensions spiked again in conflict-riven Central African Republic. Widespread fighting soon broke out once more, with civilians—and aid workers—bearing the brunt of the violence.

“The increase in the number of acts of banditry and the strategy of the armed groups—that is, to strangle basic services—has threatened aid efforts, which are critical in CAR,” explained MSF head of mission Delphine Chedorge in an October interview. “The ongoing reduction in humanitarian space in Bangui and throughout the rest of the country deprives the population of emergency assistance, and endangers [aid workers].”

In April 2014, 19 civilians, including three Central African MSF staff members, were killed during an armed robbery on the grounds of an MSF hospital in Boguila. That project did eventually reopen, but as access to health care is stretched thinner and thinner, more and more people are suffering from treatable diseases such as malaria, respiratory tract infections, and diarrhea. As people can no longer work in the fields for fear of violence, widespread malnutrition is another problem.

MSF continues to operate despite the dangers, providing essential services in health centers across the country, training health workers in communities isolated by violence, and orchestrating vaccination campaigns. “Despite all the risks, we are still committed to working here,” says MSF project coordinator Roelant Zwaanswijk.
MSF’s work in South Sudan is now the organization’s largest deployment in the world—MSF currently maintains 25 projects in nine of South Sudan’s ten states—and among its most dangerous. In 2014, MSF medical facilities in Malakal, Leer, Bentiu, and Nasir were partly damaged—and in some cases completely destroyed—by armed groups.

In late September, MSF secretary general Jerome Oberreit addressed the UN General Assembly on the situation, calling for parties to the conflict to ensure that all people in South Sudan be allowed to seek medical care without fear of violence. Oberreit urged countries with influence on the belligerents to exert pressure to ensure respect for humanitarian assistance and the civilians caught up in the war.

Violence is not the only threat to civilians, however. South Sudan’s ongoing political crisis has also left its health system in shambles, leading to insufficient distribution of antimalarial drugs in many health facilities and a precipitous spike in the number of life-threatening cases of the disease. MSF is struggling to respond to this new crisis, while also addressing several disease outbreaks, spikes in malnutrition, and war injuries.

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SYRIA: THE WAR GOES ON

There was no let up in the Syrian conflict in 2014; in many ways, in fact, the situation continued to worsen. The death toll is nearing 200,000, and the number of displaced is nearing 10 million. Violence has made it all but impossible to provide medical care in numerous parts of the country, despite the overwhelming needs, and medical workers and medical facilities themselves continue to be targeted.

Insecurity has forced MSF to scale back its operations in the country, but the organization continues to run three hospitals in the north and to support some 100 other health posts with supplies, training, and guidance. One such facility treated nearly 1,000 trauma patients in a 10-day period in October, including 180 children younger than five. On just one day, it treated around 250 people wounded by a bombing in a Damascus suburb, a bombing that was “a clear example of the relentless violence in Syria’s besieged enclaves [which] illustrates why these hospitals need massive support,” said Bart Janssens, MSF director of operations. “The conditions and stress for the Syrian medics, who live under direct threat every day, have reached unbearable levels.”

As chronicled in MSF’s Reach of War project [reachofwar.msf.org], MSF continued to work with Syrians in the surrounding countries as well, primarily in Jordan, Lebanon, and Iraq. The Syrian war has put added pressure on all the neighboring nations, and the spillover of the Islamic State insurgents has displaced several hundred thousand more people inside Iraq, where MSF has opened new projects in an attempt to tend to some of their needs.

With no end in sight for this conflict, MSF is planning to continue to work extensively in Syria and with Syrians in the year ahead.

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A LOOK BACK... AND FORWARD

Among the highlights we can report from the past year are the wider use of new vaccines in emergency situations...

VACCINES: PROMOTING A GOOD START

Vaccines—delivering them and advocating for greater affordability and more appropriate products to enable wider distribution of them—were an area of focus for MSF in 2014 and will continue to be in 2015.

Among the highlights we can report from the past year are the wider use of new vaccines in emergency situations, such as the oral cholera vaccine that teams distributed in South Sudan, and the pneumococcal conjugate vaccine and pentavalent vaccine for South Sudanese refugees in Uganda. This was a significant accomplishment given that conflict so often interrupts the ability of parents to get children vaccinated.

MSF also conducted and published original research on vaccines that focused on, among other topics, our use of an oral cholera vaccine in several locations and a tetanus toxoid vaccine outside of the cold chain, both important steps in the effort to combat potentially devastating illnesses.

Greater thermostability of vaccines—i.e. making them more suitable for resource-limited settings where constant electricity is a challenge—is a priority for MSF field operations that must surmount challenging logistical obstacles to transport vaccines to isolated regions. The MSF Access Campaign called for pharmaceutical companies to label their vaccines for their true heat stability during advocacy around World Immunization Week.

The second edition of MSF’s “The Right Shot” will be released in early 2015. The report has come to be known as a definitive source of information on vaccine pricing and the challenges facing a vaccine industry where such data is extremely limited. The publication is the first time anyone had documented the costs charged by drug makers for essential vaccines for children—thus giving patient advocates the ability to call for and negotiate better prices.

TPP: TRADING AWAY HEALTH

Negotiations for the Trans-Pacific Partnership Agreement (TPP), a trade agreement affecting about 800 million people in 12 Pacific Rim countries, are being conducted in complete secrecy without the opportunity for public scrutiny.

However, leaked portions of the draft agreement indicate that the TPP could be the most harmful trade agreement ever for public health, particularly for developing countries that are part of the pact. Today, the TPP countries include Australia, Brunei Darussalam, Canada, Chile, Japan, Malaysia, Mexico, New Zealand, Peru, Singapore, the United States, and Vietnam, but the agreement is expected to set a standard for future trade agreements.

MSF relies on lower-cost quality generic medicines to treat millions of people every year for diseases such as tuberculosis, malaria, HIV/AIDS, and numerous other afflictions. The TPP threatens to restrict access to these lifesaving treatments by lengthening, strengthening, and broadening monopolies on medicines. For example, the TPP would grant secondary patents for modifications to existing medicines (a practice known as “evergreening”) and impose an unprecedented period of exclusivity for clinical data required to prove the safety and efficacy of drugs and vaccines that are “biologic” products. These provisions could further restrict or delay access to affordable medicines for millions.

MSF has spoken out against these proposals for three years because they threaten to impede access to affordable medicines and dismantle public health safeguards enshrined in existing international law. MSF will continue to call for increased transparency in the negotiation process and to urge all participating governments to reject provisions that will inhibit access to medicines.

ABOVE LEFT: MSF vaccinated 4,000 children under five against measles and polio in Bambari, Central African Republic. © MSF
As is, the TPP threatens to stop the flow of these lifesaving generic drugs by extending patent monopolies on medicines...

TB: CALLING FOR CHANGE IN THE FIGHT AGAINST DR-TB

Though curable, TB is still one of the most deadly infectious diseases in the world, killing some 1.5 million people last year. Though it’s often cast as a disease of the past, there has been an alarming surge in cases of drug-resistant (DR-TB) in recent years.

In October, MSF released “Out of Step: Deadly Implementation Gaps in the TB Response,” a report outlining the realities of the DR-TB crisis. The report surveyed eight high TB-burden countries and identified critical failures in the DR-TB response, most importantly outdated policies and practices and gaps in care for the disease. For example, the most recent data from WHO shows that less than one-third of estimated MDR-TB patients worldwide are even diagnosed, and only one in five receives proper treatment.

Gaps in care fuel the spread of drug-resistant TB from person to person; in some countries, MDR-TB is diagnosed in up to 35 percent of new TB patients. For decades, there have been no treatment options other than a lengthy, grueling regimen that cures only half those who take it; for the other half, the disease is fatal. The first new TB drugs in half a century—bedaquiline and delamanid—hold promise, but there is a lack of clinical research aimed at incorporating them into much-needed short, tolerable, and effective regimens to treat drug-resistant TB. In addition, companies and countries are dragging their feet with registering the new drugs in TB-endemic nations.

“It’s time for TB research and development efforts to be prioritized and funded in a way that ensures lifesaving diagnostics and treatments rapidly reach the people who so desperately need them.”

LEFT: A patient with suspected TB provides a sputum sample for testing at the Malolaua health center in Papua New Guinea. © Aris Messinis/Matternet

BELOW: A multidrug-resistant tuberculosis patient at MSF’s Kibera South Health Center in Nairobi, Kenya. © Phil Moore
During high-profile emergency response efforts—the Ebola outbreak, for instance, or the earthquake in Haiti—MSF customarily sees an uptick in giving. We are grateful that exposure to our work and to people in need inspires others to support our efforts to deliver medical care to those who need it most.

Understandably, many people want to make a restricted donation, which is to say, they want to direct their money to a specific relief effort, often one that has the spotlight in a given moment. Of the money raised to combat Ebola in West Africa, for instance, some $21.5 million has, to date, come in the form of restricted donations.

We have both an ethical and legal obligation to honor a donor’s intent in these instances. And we do just that. Still, if and when possible, we encourage donors to support us with unrestricted gifts, for two main reasons.

The first is that a given response may not in the end demand as much financial support as was initially thought. This happened after the 2004 Indian Ocean tsunami, when the majority of people were either killed or unharmed, or they lived in places with functioning medical systems. The outpouring of support outpaced what MSF could actually do on the ground, so we had to go back to donors who’d made restricted donations, offering to return their money or asking them to reclassify their donation as unrestricted. It was an onerous process, but most donors derestricted their gifts, which helped us respond to a nutritional crisis in Niger, an earthquake in Pakistan, and other emergencies.

This leads to the second reason: “Unrestricted gifts ensure us the flexibility needed to respond to our operational priorities, which always seek to determine where our lifesaving medical care is needed most,” says Sophie Delaunay, executive director of MSF.

We cannot predict where extraordinary humanitarian crises will develop. We just know we have to be ready. We rely on unrestricted funds to give us the ability to mobilize the instant it becomes apparent our work is needed. That’s how we were able to move resources and personnel swiftly into West Africa when we saw how dire the Ebola outbreak was, and how we’ve been able to expand operations amidst conflict in CAR and South Sudan, or how we’ve been able to launch extensive projects to combat neglected diseases in remote locations.

We understand the desire to make restricted donations and honor those that we are entrusted with. But we prioritize unrestricted giving in our fundraising efforts so that we can remain flexible, mobile, and ready to act first and foremost based on the medical needs on the ground.

**MSF PRINCIPLES OF FUNDRAISING: UNRESTRICTED VS. RESTRICTED DONATIONS**

**SUPPORT MSF**

**JOIN OUR LEGACY SOCIETY**

Naming MSF as a beneficiary on a retirement or other account is a simple way to leave a legacy to MSF without writing or re-writing your will or living trust. Please ask your IRA administrator or institution for the appropriate form.

If you have already named MSF as a beneficiary of your estate, please tell us so we can welcome you to our Legacy Society.

To learn more about beneficiary designations to MSF or other legacy giving opportunities, please contact Beth Golden, planned giving officer, at (212) 655-3771 or plannedgiving@newyork.msf.org.

**STRENGTHEN YOUR COMMITMENT**

MSF would like to thank all of our donors who have made commitments towards the Multiyear Initiative. With annual commitments of $5,000 or more, these generous supporters help provide MSF with a predictable revenue stream that better serves our ability to respond rapidly to emergencies and ensure the...
continued operation of our programs. To date, we have received commitments totaling more than $33 million towards the initiative. To find out how you can participate, please contact Mary Sexton, director of major gifts, at [212] 655-3781 or mary.sexton@newyork.msf.org. You can also learn more about the Initiative at doctorswithoutborders.org/support-us/other-ways-to-give/multiyear-initiative.

INCREASE YOUR IMPACT

Does your employer have a matching gift program? Many companies have matching gift programs that will double or even triple the impact of your gift. Companies will sometimes also match donations made by spouses, retirees, and board members. Because conditions and criteria for gift matching vary by employer, please check with your company’s human resources department for details. Doctors Without Borders is happy to confirm your gift or to satisfy any other requirements your company may have.

If you or your company is interested in learning more about MSF, or have any questions about our matching gift program, please email corporate.donations@newyork.msf.org or call [212] 763-5745.

STOCK DONATIONS

Did you know you can donate gifts of securities to MSF? Making a stock gift is simple and offers a number of valuable financial benefits. You can donate appreciated stocks, bonds or mutual funds, and the total value of the stock upon transfer is tax-deductible. Also, there is no obligation to pay any capital gains taxes on the appreciation. MSF currently maintains an account with Morgan Stanley Smith Barney to offer donors an easy way to transfer securities to MSF hassle-free.

For more information on how to make a security donation please visit our website www.doctorswithoutborders.org/support-us/other-ways-give. You can also call [212] 679-6800 and ask to speak to our Donor Services department.

PLAN AN EVENT FOR MSF

At MSF, your support makes our lifesaving work possible. By taking the initiative to fundraise on our behalf, you give our medical and logistical staff the ability to reach people in need around the world and provide them with critical medical care. Humanitarian action starts with you.

Organize your own fundraising event or campaign by creating a personal fundraising page to support our mission, whether it is by running in a marathon, hosting a bake sale, encouraging your friends to give in lieu of gifts for your birthday, organizing a community event, or hosting a house party.

Please visit events.doctorswithoutborders.org to read more about organizing fundraising events. We support you with your own online fundraising page, helpful guidelines, materials, and tips and ideas to help you reach your goal.

DONOR PROFILE

“THE OBLIGATION TO HELP WHEN ONE CAN IS UNIVERSAL”

Harlan B. Miller explains why he and his wife have been MSF Field Partners since 2004, part of a roster of donors whose scheduled monthly gifts allow MSF to respond immediately to emergencies and decrease fundraising costs, so more resources go to the field:

I think those of us who can have a general obligation to help those who are in the most desperate shape, especially since the nations of the world aren’t doing it. I think it’s a general obligation of sorts, to contribute when one can.

I give to MSF because I’m particularly impressed by the relative single-mindedness of MSF. MSF knows what it wants to do—which is providing medical care where and when needed, especially in emergency situations—without any other agenda. Many other organizations have other aspects to their agenda that I’m not necessarily interested in contributing to. I don’t doubt that they do good things, but MSF doesn’t carry that kind of baggage.

My wife and I have always been very interested in what’s going on in the world. We travel fairly widely. My first real experiences of countries in real need came many years ago when I was in active duty in the Navy. I sailed to parts of the western Pacific, and I remember being taken aback and shocked at what I saw when I stepped off the ship in many places.

We contribute because we can! We think it’s worth doing. It’s the obvious effectiveness and efficiency of MSF that appeals to us. The low overhead, but also that MSF dives in where it can, sometimes at great risk—that impresses me.

I think the obligation to help when one can is universal—not because anyone will know about it, or because you’ll be rewarded for it, but because it’s the right thing; because I can.
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.