Partners In Health

Partners In Health Media Highlights
2010

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2010 Media Highlights

The New York Times

"The hospital is a project of Partners in Health, an exemplary nongovernmental organization whose founder, Paul Farmer, has spoken forcefully about the need to break bad old habits of international aid, which in half a century has never reached the goal of creating a functioning country run by Haitians for Haitians."
-NYT Editorial, *August 29, 2010*

The Boston Globe

"When the quake hit, Partners in Health became the go-to international group for coordinating the emergency medical response."
-February 12, 2010

THE WALL STREET JOURNAL.

"This oasis-like hospital, made famous by the 2003 bestseller "Mountains Beyond Mountains," sits on a dirt road in Haiti's central plateau, one of the poorest regions of the poorest countries in the Western Hemisphere. Yet it attracts top-notch doctors from around the world. Its innovative AIDS-treatment program is copied internationally. It's is one of the best medical facilities in Haiti."
-January 20, 2010

The New York Times

"Here in Haiti's central plateau, I visited a cholera treatment center run by an excellent aid group, Partners in Health, in collaboration with the Ministry of Health."
-Nicholas Kristof, *December 1, 2010*

CBS

"I couldn't help marveling over the small miracle PIH has created in the midst of a nightmare."
-Dr. Jonathan LaPook, *April 15, 2010*

St. Petersburg Times

"And I can tell you, you will never find a foreign (aid organization) more successful and more sensitive than Partners in Health,'' said Beverly Bell, an associate fellow for the Institute for Policy Studies, a Washington think tank. "They have a beautiful respect for the Haitian culture and treat every Haitian individual with respect.''

-October 10, 2010

"The investment PIH has put into Malawi has been enormous. They have built two brand new district hospitals equipped with wards and operating theatres. But the best and the most visible return on their investment is Edna's shy smile."
-March 11, 2010

"When Ophelia Dahl is sitting in front of you, you want to hear her talk about so many things, from life as the daughter of a famed and beloved writer to the beautiful Kazakh tapestries in her Commonwealth Avenue offices, and, especially, her work as a cofounder of Partners in Health. The longtime healthcare and antipoverty nonprofit has become synonymous with Haiti, especially since January's earthquake, and also serves those in need right here at home, in a city with the nation's third-largest community of Haitian immigrants."
-July 22, 2010

THE LANCET

"Substantial inequalities exist in cancer survival rates across countries. In addition to prevention of new cancers by reduction of risk factors, strategies are needed to close the gap between developed and developing countries in cancer survival and the effects of the disease on human suffering. We challenge the public health community's assumption that cancers will remain untreated in poor countries, and note the analogy to similarly unfounded arguments from more than a decade ago against provision of HIV treatment."
-Dr. Paul Farmer *et al.*, *August 16, 2010*

"In a crowded hospital ward in Cange, Haiti, Ophelia Dahl chats with 25-year-old Shelove, who lost her entire family, her home, and a leg in the earthquake that devastated Port-au-Prince. It is Dahl's third visit since January, and though the trauma injuries have been largely treated, she understands that the real human cost of the disaster is just emerging. Their broken bones now healed, victims will need rehabilitation, housing, mental health services, prosthetics, jobs, and protection from infectious diseases."
-September 2010

The New York Times

Another terrific Haiti-focused organization is Partners in Health, (pih.org), founded by Dr. Paul Farmer, the Harvard Medical School professor.
-December 18, 2010

"Not all of the news out of Haiti is bad right now. Partners in Health just broke ground on a state-of-the-art teaching hospital about 90 minutes outside the capital."
-*October 13, 2010*

"Some charities ensure that they work with the Haitian authorities, rather than undermine them. One is the US charity Partners In Health (PIH), which has 10 clinics and hospitals in Haiti. They are run jointly by the health ministry and are staffed with Haitian doctors and nurses."
-*March 31, 2010*

The Miami Herald

"When a new teaching hospital opens in this central Haiti town a little over a year from now, it will be far more than a 320-bed, six operating room facility. Local and international doctors say it will represent a towering example of post-earthquake recovery."
-*September 13, 2010*

"Like hundreds of other earthquake victims, they were brought here by worried family members because of the reputation of its founder, Dr. Paul Farmer, a Boston infection control specialist whose organization Partners in Health champions health care in Haiti and much of the developing world."
-*March 23, 2010*

The New York Times

Partners in Health also took Salem on a couple of home visits. At a one-room shack in Cange, a mother presented her 3-year-old daughter, saying she had gained 11 pounds on a regimen of Nourimanba. But the mother complained that there was no help for other serious problems she faced, like the fact that she had no job and the tin roof of her shack leaked.
-*September 2, 2010*

"Two organizations currently implementing successful systems in Haiti are: Hôpital Albert Schweitzer and Partners in Health. Philanthropic capital can strengthen and replicate these models throughout the country."
-*February 24, 2010*

Los Angeles Times

"There's no reason to anticipate that this [cholera] wouldn't spread widely," said Joia Mukherjee, chief medical officer for Partners In Health, a Boston-based relief organization that runs three hospitals in the area.
-*October 23, 2010*

"The situation has deteriorated. We really need a massive push of political will," says Joia Mukherjee, medical director of Partners in Health, which is helping the Haitian government halt the outbreak that has killed more than 1,100 people. "This can't just be about handing out water purification tablets."
-*November 19, 2010*

The Philadelphia Inquirer

Naomi Rosenberg was washing dishes in her Center City apartment when she got a text message from a friend at Partners in Health, the international medical-aid organization she worked for in Haiti…
"When things happen," Rosenberg explains, "you show up."
-March 11, 2010

The New York Times

"Conditions at Mars and Kline are particularly bad, although this kind of place is not unique to Haiti," said Dr. Giuseppe Raviola, director of mental health and psychosocial services for the Boston-based Partners in Health, which runs 10 hospitals in Haiti. "Still, now that we've seen the hospital in the capital city, it is clear that that we have to treat people in their communities."
-March 19, 2010

"Almost four months after the earthquake we are seeing people having various kinds of emotional distress responses. These include difficulty sleeping, heart palpitations, somatic complaints, and significant sadness, worry and anxiety. Some of these can be seen as normal reactions to a highly abnormal situation. However, the level of distress for many is severe. We also see people who have developed psychotic reactions, and other more acute mental health problems, since the earthquake," said Eddy Eustache, a priest and director of mental health and psychosocial services for Partners in Health in Haiti.
-*May 3, 2010*

The Philadelphia Inquirer

"The hospital, Zanmi Lasante, began 25 years ago as a church clinic and has expanded through its affiliation with the well-known Boston medical relief group Partners in Health."
-May 16, 2010

THE WALL STREET JOURNAL.

As the WSJ reports, what public-health experts say is the first big post-quake disease outbreak has now been confirmed: a cholera epidemic in the Artibonite region of the country. The area has become home to a lot of earthquake refugees, and even before the quake obtaining clean water was a problem, the paper says, citing a spokesman for public-health group Partners in Health, which has a longtime presence in Haiti.

-*October 22, 2010*

The New York Times

"Andrew Marx, a spokesman for Partners in Health, a nongovernmental organization that works closely with the Ministry of Health in rural areas, said that it had been warning of such a calamity away from the capital but that authorities had focused disease prevention mostly on Port-au-Prince."

-*October 23, 2010*

"Dr Koji Nakashima from Partners in Health, a group working with the Haitian health authorities throughout the country, has spent all day administering intravenous drips to patients. "The terrifying thing about this disease is how quickly it can kill," he says. "Patients come in and they're unresponsive. They don't have the resources to get here quickly - they come by donkey, on foot. It is a very challenging environment."

-*October 24, 2010*

Dr. Joia Mukherjee on Talk of the Nation said, "The facilities throughout Haiti are really under-funded, understaffed. We're very fortunate that we have been working for so long that the 10 facilities where we work in Haiti, we have staff, we have supplies. I'm very proud to report that we've not had a single stock-out since the beginning of this epidemic, and yet it's our warehouse, jointly operated between Partners in Health and the ministry, that's supplying all of the affected areas in Haiti."

-*October 28, 2010*

The New York Times

Plans and Benchmarks for Haiti

August 29, 2010
Editorial

The Interim Haiti Recovery Commission was set up after the Jan. 12 earthquake as a joint Haitian-international effort to effectively channel billions of dollars of donated reconstruction aid.

Like everything else about the recovery effort, the commission, led by Prime Minister Jean-Max Bellerive and former President Bill Clinton, has been too slow off the mark. But we were encouraged by its second meeting in Port-au-Prince this month, where it announced dozens of new projects with clear benchmarks and the commitment of more than $1 billion to complete them.

The commission finally has its executive director, a Haitian, Gabriel Verret, a former economic adviser to President René Préval. About 30 crucial staff positions are still unfilled, a troubling sign. Without a full, permanent staff, the commission will surely have a harder time showing results and pressing donors to meet pledges.

The goals outlined at the meeting include clearing a million cubic meters of rubble in Port-au-Prince and building enough short-term hurricane shelters for 400,000 to 500,000 people — both by November. The longer-term plans include a two-year, $4.3 billion reinvention of Haiti's public school system, a $200 million program for agricultural development, and a $15 million, 320-bed teaching hospital in Mirebalais, in central Haiti.

The hospital is a project of Partners in Health, an exemplary nongovernmental organization whose founder, Paul Farmer, has spoken forcefully about the need to break bad old habits of international aid, which in half a century has never reached the goal of creating a functioning country run by Haitians for Haitians. At a Capitol Hill hearing in July, he noted that only 3 percent of earthquake aid had gone to the Haitian government.

The low figure is understandable, since the government was weak to begin with and devastated by the quake. Dr. Farmer's larger point is valid. Rebuilding Haiti requires building a functioning, responsive Haitian state. A hospital that teaches a new generation of Haitian doctors and nurses, meeting an aching need for medical care while spurring the home-grown economy, is a fine example of how to do that.

Commission members and supporters insist that by the standards of international bureaucracies, they are moving quickly and efficiently. Perhaps. But Haiti's urgent and unmet needs are staggering.

The International Federation of Red Cross and Red Crescent Societies recently announced that it was distributing new plastic tarps to 80,000 families. They are replacing old tarps that have frayed in the last seven months while people have waited, fruitlessly, for homes.

The Boston Globe

Haiti expert shares a vision at Harvard

February 12, 2010
By James F. Smith

Drawing on 27 years of helping patients in Haiti, Dr. Paul Farmer suggested a treatment plan for post-earthquake Haiti yesterday that could turn the devastation into an opportunity.

In his first public forum since the Jan. 12 quake, Farmer challenged an overflow audience at Harvard Medical School to work with Haitians to attack the impoverishment that made the suffering from the disaster far worse than it needed to be.

"Might addressing the acute needs of the displaced and injured afford us a chance to address the underlying chronic condition?'' he asked.

Invoking medical metaphors, Farmer described Haiti as an "acute-on-chronic affliction - evident, at last, to the entire world.'' He said postquake Haiti was "an already bad problem rendered immeasurably worse by the gravest natural disaster to befall this part of the world in centuries.''

Farmer, cofounder of the Boston-based nonprofit Partners in Health and also a United Nations deputy envoy to Haiti, stopped short of offering a specific treatment plan. He said that is the job of the Haitian people. "How often in medicine have we learned that plans for patients must be, if they are to succeed, made with patients?''

But he said institutions in Boston and beyond now have a rare opportunity to not only help Haiti treat its immediate wounds, but also to help generate the longer-term development that Haiti desperately needs.

Farmer cited several specific challenges for research institutions and the hordes of nongovernmental organizations working in Haiti before and since the quake.

For example, he said doctors are now seeing cases of tetanus that are "a reminder of the chronic failure to inoculate with an effective, safe vaccine that costs pennies.'' He said that Dr. Natasha Archer, a Haitian-American physician from Brigham and Women's Hospital, was part of a team that confronted an emergency surgery case probably caused by typhoid.

"Natasha warned, correctly, that a lack of proper sanitation in the coming days and weeks and months would lead to more such cases,'' Farmer said, "and I was thinking, with some shame, that a decade before, I had reviewed the scant literature on typhoid in Haiti, which revealed the same high burden of the disease, and came to the same conclusion.''

Farmer also pointed to the crisis of clean water in a country that, one year before the quake, was declared the most "water-insecure'' nation in this hemisphere.

The biggest challenge is to get people working, he said, and some aid groups have begun implementing "cash-for-work'' programs. These have generated about 35,000 jobs, he said - far short of the 500,000 paying jobs that are needed. "This is the only way to move resources from the self-described donor nations to the survivors who are able-bodied and anxious to work.''

Apart from testifying before Congress soon after the quake, Farmer has had few opportunities to speak publicly on what happened in Haiti and what needs to be done.

Farmer first worked in Haiti when he was a Harvard medical student in 1983, and he cofounded Partners in Health in 1987. The nonprofit employs about 4,000 people in Haiti, more than half of them community health workers who have built a network of services reaching villages across the Central Plateau. **When the quake hit, Partners in Health became the go-to international group for coordinating the emergency medical response.**

In part because of Farmer's personal prominence as a crusader for better health care in Haiti and 10 other countries, Partners in Health has attracted worldwide attention and has raised more than $52 million for earthquake relief and longer-term rebuilding.

Harvard's president, Drew G. Faust, opened the meeting by acknowledging the contributions from across Harvard to the relief effort. She asked those who had done volunteer work in Haiti since the quake to stand up, and more than a dozen people in the hall rose to their feet to applause.

She also recognized Farmer's critical role, as cofounder of Partners in Health as well as chairman of the medical school's Department of Global Health and Social Medicine and chief of the global health equity unit at Brigham and Women's Hospital.

Faust told Farmer: "You were there with an understanding of the context, the culture, and the history that would enable you to be focused and effective amid the chaos all around you, and to bring order out of that chaos.''

But in his address, Farmer acknowledged the risks of overstating any doctor's role. Although he saluted the heroism in Haiti of doctors, nurses, and citizens, he said, "What we need are teams, and above all, systems to deliver services effectively.''

Farmer said he was reluctant to offer a prognosis on Haiti's future. Instead, he cited the opinion of two young Haitians he met who answered an old man's plaint that "Haiti is finished.'' The two young people answered, "No, Haiti will never be finished,'' Farmer said. "Haiti's is not a terminal illness.''

THE WALL STREET JOURNAL.

Refugees From the Capital Swamp a Model Rural Hospital

January 20, 2010

By Ianthe Jeanne Dugan

CANGE, Haiti—Joanel Joasil, the medical director of the Zanmi Lasante Sociomedical Complex here on a steep mountain road in rural Haiti, rushes down a walkway, past volunteers bearing stretchers.

He pauses to study the X-ray of a wounded child. The air is hot and smells of gangrene. "All these people could not find care in Port-au-Prince," he says. "So I have mobilized my staff."

Much about modern Haiti is explained by the rough 35-mile journey from Port-au-Prince to Zanmi Lasante, Creole for "Partners in Health." This oasis-like hospital, made famous by the 2003 bestseller "Mountains Beyond Mountains," sits on a dirt road in Haiti's central plateau, one of the poorest regions of the poorest countries in the Western Hemisphere.

Yet it attracts top-notch doctors from around the world. Its innovative AIDS-treatment program is copied internationally. It's is one of the best medical facilities in Haiti.

It also has only 104 beds and an emergency room built for two. The staff here, many of whom lost friends and relatives themselves, has been working around the clock as refugees stream in from the city. They're seeing the leading edge of a wave of reverse urban migration that holds major implications for Haiti as a whole.

"This reversal of decades of migration into Port-au-Prince will reshape the country for years," says Ophelia Dahl, executive director of Partners in Health, a Boston-based organization affiliated with Boston's Brigham and Women's Hospital and Harvard Medical Center, which runs the hospital here and also uses it as a hub for a network of dozens of hospitals and clinics it runs here and in Africa, Peru and Russia.

In recent decades, Haiti aggressively promoted urbanization at the expense of the countryside, putting much of its scarce tax dollars and aid money into the swelling capital. The services that define modern society, from electricity to universities to hospitals, existed almost entirely in the capital. The bias for urban development was so strong that people who live in the countryside are still called moun andeyo, or "people outside."

The quake could change that as the city's jobless and homeless, at least for the moment, look to return to the villages they came from. As waves of wounded from the capital arrive in trucks and on the backs of donkeys, the outflow is transforming Zanmi Lasante.

Bichard Gerson Pierre of Port-au-Prince pulls up in a bus with 12 relatives, including a mother-in-law on the edge of death. The vehicle is driven by his uncle, who until last week used it to

shuttle paying customers around Haiti. Now the bus is packed with ripped clothing and shreds of photos clawed from the rubble of their homes.

"Our houses were crushed and our businesses destroyed," says Mr. Pierre. "So we came to Cange. Maybe we will sleep on our bus."

At a time when the world is struggling to understand why it took so long for foreign aid to arrive, the Cange clinic is a reminder that some successful foreign collaborations have been here all along. Ms. Dahl co-founded the facility in the mid-1980s, along with an Episcopal priest named Fritz Lafontant and Paul Farmer, a doctor who is now the U.S. deputy special envoy to Haiti.

The compound sits behind a tall cement and stone fence. Inside, trees rustle in the breeze over walkways joining a maze of buildings. In addition to the hospital, Zanmi Lasante has pediatric and inpatient wards, a school, an orphanage and a drug warehouse.

Now it looks like a war hospital. The school is a recovery room. Its church is a triage center. The morgue is full.

Rob Sheridan, a trauma and burn surgeon who was visiting from Massachusetts General Hospital when the quake hit, is carving off part of a woman's leg with a hack saw, the best tool available in a facility that doesn't normally do amputations. In the next room, another surgeon drops an arm in a waste basket.

"We need ten operating rooms, not two," Dr. Sheridan says.

Medical supplies are thinning. In the church, Koji Nakashima, an internist and pediatrician, rushes around triaging patients. He sniffs the mangled hand of Joseph Shello, a construction worker. Dr. Nakashima tells him he will likely lose it.

A three-year-old boy screams while doctors splint his leg. One of the people attending him is a second-year Harvard Medical student, Thierry Pauyo, who is here for the year. The boy is his cousin. The boy's parents, Mr. Pauyo says, are dead.

"We are all asking ourselves, 'Why Haiti?" says Marie Flore Chipps, a project manager and daughter of co-founder Father Lafontant.

She, like many here, represents the extraordinary measures taken by Haitians in the quake's aftermath. Ms. Chipps drives to Port-au-Prince daily and returns with the wounded. On Friday, she collected eight nuns who were living in a field.

Ms. Chipps had begun to believe that the country—cursed with a history of poverty, sickness and environmental despair—was finally marching toward prosperity. Roads were getting built. Health was improving. Businesses and agricultural projects were sprouting.

Now, Ms. Chipps says, "We are just living. But we don't know why we are living."

Among the volunteers is Serena Koenig, a Brigham and Women's Hospital infectious-disease doctor who splits her time between the U.S. and Haiti working for Partners in Health and another institution.

On Friday, Dr. Koenig brings morphine and malaria drugs to a clinic about 10 miles from Cange. A woman there awakes to find that her foot has been amputated. Because the hospital was without morphine, she sits upright and sings, trying to forget the pain.
Dr. Koenig rushes seven patients back to Cange. One, a man paralyzed from the waist down, dies of kidney failure four days later as he awaits dialysis. On Dr. Koenig's return to the clinic, another patient dies while she is in the room.

At Zanmi Lasante, the crowds continue to build.

"We've been here before, but this time we aren't leaving," says Jean Laurent Oliscar, who's getting out of a van with boxes and suitcases tied to the top. He eases his wife to the curb and explains that she was trapped under the rubble for two days.

Cange began as a squatter settlement in 1956, after the Artibonite river was dammed as part of an international development project. The rising waters stripped farmers of their land, forcing them to move up the mountain. Zanme Lasante's founders picked this spot to prove that good healthcare could be delivered to impoverished communities.

The hospital slowed the spread of AIDS by giving free tests and counseling and ensuring that people were taking medicine by sending workers to their homes. The hospital built a hydraulic system to bring clean water to Cange, helping to eliminate child deaths caused by diarrhea.

"Sometimes people complain that HIV investment sucks money away from treating other diseases," says Dr. Koenig. "Now, this network built in part with money for AIDs is being used for disaster relief."

After the earthquake struck, Gina Etienne dug her six-year-old son out of the rubble and hitched a ride on a motorcycle. Ten miles out of town, she switched to a packed open-air passenger truck called a tap-tap. She connected to another tap-tap.

Finally, a stranger on a donkey took Ms. Etienne and her son, Anderson, up a hill and dropped them at Zanmi Lasante's green iron gates. Ms. Etienne's business, selling T-shirts on the roadside, is destroyed.

Asked how long she would stay in Cange, she starts crying. "I have nowhere to go," she says. Her son begins crying, too.

The New York Times

Haiti, Nearly a Year Later

December 1, 2010
By Nicholas Kristof

MIREBALAIS, Haiti- An emergency cholera hospital is the grimmest kind of medical center, and it's a symbol of the succession of horrors that have battered Haiti over the last year.

Here in Haiti's central plateau, I visited a cholera treatment center run by an excellent aid group, Partners in Health, in collaboration with the Ministry of Health. Nobody goes in or out without being thoroughly disinfected; to try to control the epidemic, bodies are buried rather than released to families.

In one tent, 40 seriously ill patients were lying next to each other on cholera beds — boards with holes in the middle and waste buckets underneath to catch the constant diarrhea. Staff members put a sheet over Tiphay Merilus, 66, just as I arrived. Patients a few feet away in other beds averted their eyes as a sanitation crew carried out Mr. Merilus's corpse and disinfected his cot.

Already, more than 1,700 people have died of cholera in less than a month, and the Pan American Health Organization estimates that 400,000 Haitians may get cholera over the next year.

The earthquake in January caused some 250,000 deaths. The death toll was a result not only of seismic activity but also of poverty: shoddy construction and slow rescue efforts meant many more deaths than if the same quake had occurred in, say, California. Then came cholera, which is a disease of poverty — abysmal sanitation and lack of potable water can create an epidemic.

One cholera patient, Dieulimere Renatu, 21, told me that she gets drinking water from a river. If she were to seek water from a safer source, she would have to spend three or four hours a day fetching water for her family — and then would have less time to work and earn money. Those are the trade-offs that Haitians face.

After the earthquake, Bill O'Reilly suggested that humanitarians were romanticizing aid as a solution for Haiti: "One year from today, Haiti will be just as bad as it is right now." I criticized him at the time, but he wasn't far off. Haiti has certainly improved since the immediate aftermath of the quake, and aid kept alive many who would otherwise have died. But reconstruction has barely started. Most of the rubble is still waiting to be cleared off, and more than one million people are still living in tents.

Part of the problem is that the government, crippled by the quake, has done little. Another is that aid groups created a parallel state that further diminishes the government — and a country needs a central authority to make decisions. The limitations of aid are very much on display in Haiti.

After the quake, aid groups rushed in porta-potties to provide sanitation, but they cost $13 a day to clean and empty the wastes. So many thousands of dollars each day go to companies with the specialized trucks that clean porta-potties and then dump the wastes untreated at the city dump.

There are solutions. One sanitation aid group, SOIL, has provided 300 dry composting toilets that turn human waste into fertilizer. The composting kills the cholera bacteria and other pathogens within a few days, according to Sasha Kramer, the executive director of SOIL. The compost then provides desperately needed topsoil and fertilizer to boost agricultural production.

Ultimately what Haiti most needs isn't so much aid, but trade. Aid accounts for half of Haiti's economy, and remittances for another quarter — and that's a path to nowhere.

The United States has approved trade preferences that have already created 6,000 jobs in the garment sector in Haiti, and several big South Korean companies are now planning to open their own factories, creating perhaps another 130,000 jobs.

"Sweatshops," Americans may be thinking. "Jobs," Haitians are thinking, and nothing would be more transformative for the country.

Let's send in doctors to save people from cholera. Let's send in aid workers to build sustainable sanitation and water systems to help people help themselves. Let's help educate Haitian children and improve the port so that it can become an exporter. But, above all, let's send in business investors to create jobs.

Otherwise, there will always be more needs, more crises, more tragedies, more victims. Back in the cholera treatment center here in Mirebalais, health workers were still disinfecting the bed on which Mr. Merilus had died when, in the tent next door for milder cases, a middle-aged woman suddenly collapsed.

Nurses splashed water on her face but could not revive her. So they rushed her to the main cholera hospital tent to take the newly vacant bed there.

And that is the brutal cycle of poverty in Haiti that only jobs and trade can break.

Small Miracles In Haiti

April 15, 2010
By Jonathan LaPook, M.D.

Seven days ago, at a mission in the north of Haiti, I watched a nurse remove oxygen from a premature baby boy in order to give it to a woman in labor. The heartbeat of the baby who was about to be delivered had dropped dangerously low and there was only one working oxygen machine. Perhaps the cord was wrapped around the baby's neck or there was some other problem. A Caesarian section - which can quickly and safely deliver a baby who is in trouble - was not an option. The public hospital was at least an hour's drive away over bumpy roads.

These kinds of cruel triage decisions are commonplace in Haiti and existed long before the earthquake struck on January 12th. The poorest country in the Western Hemisphere has never had an effective public health system. Thousands of non-governmental organizations (ngos) - by some counts more than 10,000 - are trying to plug holes in the ship.

What's really needed is a new ship.

So far there's been no significant spending on rebuilding because there's nobody to spend it. The best hope is effective action by the Interim Haiti Recovery Commission co-chaired by President Bill Clinton and Haitian Prime Minister Jean-Max Bellerive. The Haitian parliament is still in the process of approving this commission, which will help allocate donor funds and oversee reconstruction.

Meanwhile, the clock is ticking in a major way. The rainy season has already arrived. With it will come an increase in problems such as malaria, dysentery, and lung infections. Malnutrition, disease, and stress - all exacerbated by the earthquake - are a particular threat to pregnant women and their offspring. And, of course, the generally miserable conditions present on January 11th not only persist but are significantly worse.

Where do ngos fit in? The Haitian people are desperate for relief today. They need the basics: food, clean water, housing, and medical care. In the absence of an effective government response, ngos have been stepping up. One Haitian man living in a tent told me that "the foreigners are helping us more than the government." There is no question that the activities of ngos need to be coordinated; too many people are doing their own thing. But until a strong, effective central authority arises, the ngos will continue to fulfill a crucial role.

A powerful example is Partners in Health (PIH), an ngo that has been helping Haitians for over twenty years. On April 5th, I visited the largest tent camp in Haiti: Parc Jean Marie Vincent. It houses almost 50,000 people displaced by the earthquake. PIH has set up a small clinic right inside the camp. Every worker I met was Haitian. Ten doctors see a total of 400-500 patients a day. Physicians, nurses, and other health professionals arrive first thing in the morning and don't leave until the last patient is seen. A rudimentary lab tests patients for pregnancy and illnesses like malaria, HIV, syphilis, and urinary infections. There's a small pharmacy. Family planning, psychological counseling, and social services are all provided. There are definite logistical challenges, such as maintaining enough supplies given the limited storage space. And the doctors and nurses told me they could use more of pretty much everything (space, health professionals, medications, lab equipment, supplies). **But I couldn't help marveling over the small miracle PIH has created in the midst of a nightmare.**

Back to the mission in the north of Haiti. After some very tense moments, a healthy baby girl was delivered and the premature baby boy survived the temporary lack of supplemental oxygen. And I left Haiti wondering whether the country will ever reach the point where the fate of its children doesn't rely on the roll of the dice.

In Haiti, former Hernando resident helps provide model aid

October 10, 2010
By Dan Dewitt

MIREBALAIS, Haiti- A new 320-bed teaching hospital in a town of 100,000 would be a big deal anywhere in the world, worthy of the display of pride — the brass band and the speeches — at a cornerstone-laying ceremony here last month.

But this was boosterism against a backdrop of deforested mountains. It was a rare sign that Haiti can be built back better, as former President Bill Clinton vowed after January's catastrophic earthquake.

Port-au-Prince remains choked with rubble. More than a million survivors still live under tarps or in tents. Wealthy nations have sent only a small fraction of the billions of dollars they pledged in March for building roads, schools and water systems.

The hospital in Mirebalais, 38 miles northeast of Port-au-Prince, is still just a graded site and a blueprint. But it's a blueprint for a modern building with solar panels and landscaped courtyards that will be turned over to the Haitian government after it opens in early 2012. It will have as much floor space as a Walmart Supercenter, enough for operating theaters and the country's first intensive care unit.

And it will train future doctors and nurses with the long-term goal of breaking the country's historical dependency on foreigners — one humbling symbol of which was the U.S. Navy's medical vessel, the Comfort:

"On the seventh day after the earthquake,'' said Paul Farmer, one of the speakers at the ceremony, "the best hospital in the country was floating in the bay of Port-au-Prince.''

• • •

Farmer is a Harvard-trained doctor and anthropologist who spent his teens in Hernando County. In 1987, he helped found Partners in Health, or PIH, the medical organization for the poor that is building the hospital.

Clinton, the United Nations special envoy for Haiti, named Farmer as his deputy and cited the group's work as a model for rebuilding. A New York Times editorial in August called PIH "exemplary.'' Haiti's minister of health, Dr. Alex Larsen, said it is "our best partner in Haiti.''

Farmer would say PIH doesn't have much competition. A lack of private partnerships with the government, he says, is a major reason the aid delivered so far has accomplished so little.

Private charities raised more than $1.4 billion from individuals and corporations in the United States in the first six months after the quake, according to Indiana University's Center on Philanthropy. These groups also received much of the $1.8 billion in emergency aid from public

sources, including the U.S. government, that was tracked by the United Nations. Just 0.3 percent of that went directly to the Haitian state.

Bypassing the government in Haiti has long been justified by its corruption and volatile politics. This was U.S. policy during the final term of former President Jean-Bertrand Aristide, who was ousted in 2004. Even now, the largest aid group in Haiti, the International Federation of the Red Cross, makes it a practice not to contribute directly to foreign nations.

But most of the estimated 10,000 aid groups working here are more accountable to overseas donors than to Haitians, Farmer said. Over the years, these organizations have taken on the job of providing public services — usually poorly — rather than building a government that can do this work itself.

"The rules of the road for development assistance need to be rewritten," Farmer testified in July to the Congressional Black Caucus, "not to favor contractors and middlemen and trauma vultures, but to favor the victims of the quake.''

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The Red Cross, which raised more than $800 million for earthquake relief, says it's doing all it can for these victims.

It fed more than 1 million Haitians for a month after the earthquake and still trucks water to 40 percent of the population of Port-au-Prince, the capital.

But the weakness of the government —- its inability to clear or secure land —- has frustrated one of the main long-term efforts listed on the Red Cross website: "semipermanent shelters to house 165,000 people.''

L'Annexe de la Mairie, a camp of 850 tarp-covered hovels at the base of the towers for the national radio station, is one of the few public parcels of land that can be used for building. And as of early September, it was the site of the Red Cross' biggest housing project in Port-au-Prince — 51 partially completed plywood houses with metal roofs.

Even here there's a problem: If the Red Cross is to finish its plan to build shelters for 350 families, it will have to displace 500 others.

Pascal Panosetti, an international Red Cross housing coordinator, said the organization is working with both groups of residents. It has handed out kits of timber, tarps and tools to help those who must move. It is screening candidates for new houses to select the most deserving, including elderly and disabled residents.

But a group of about a dozen parents who stood outside the settlement's temporary school last month remained skeptical of the Red Cross program.

They worried the corrupt camp committee that had earlier hijacked the distribution of food and other aid would do the same with housing, favoring friends and family. And though none of them said they were satisfied with life at the settlement — the wandering pigs, the mud, the trampled piles of garbage and the leaky tarps — it's all they have.

"This is public land,'' Mona Altanor, 38, said through a translator. "I'm not going anywhere.''

• • •

In one way, the formula for providing aid is simple, said Beverly Bell, an associate fellow for the Institute for Policy Studies, a Washington think tank, who has worked in Haiti on and off for three decades: The better an organization knows a country, the more it can help.

"And I can tell you, you will never find a foreign (aid organization) more successful and more sensitive than Partners in Health,'' she said. "They have a beautiful respect for the Haitian culture and treat every Haitian individual with respect.''

The Red Cross didn't arrive in force until after the earthquake. Farmer first came to Mirebalais in 1983. Two years later, while still a medical student, he helped open a clinic in the nearby town of Cange. That clinic laid the foundation for Zanmi Lasante, the Haitian affiliate of Partners in Health.

As for the new hospital, there's no question it has the support of the people of Mirebalais (pronounced MEER-ba-lay).

Many of them were outraged in 2007 when the Haitian company that ran the old hospital in town allowed a pregnant woman who couldn't afford treatment to die outside its doors. The following January, the mayor of Mirebalais led a mob that pulled all the patients out of the old hospital, chained it shut, and drove them to a new PIH hospital in a nearby city.

That was when PIH started planning a regional health care center in Mirebalais. The earthquake's devastation made expansion of the plans a necessity. Several buildings at the national teaching hospital in Port-au-Prince had been damaged. The nursing school had been leveled, entombing more than 100 students and faculty members.

"It smelled like a carrion house,'' Farmer said in September. "Ten days after the quake I was sure it would take years before medical teaching infrastructure could be rebuilt in Port-au-Prince.''

PIH, which has raised about $85 million for earthquake recovery, will pay the $15 million to build the hospital (a small fraction of the amount it would cost in the United States) as well as $8 million annually to run it.

Besides donating the land, the government will set medical policy. Most important, the Haitian state will own this hospital as it does 11 other clinics and hospitals PIH has established in central Haiti. Eventually, the Ministry of Health can staff that network with its own doctors, nurses and administrators.

Said Corrado Cancedda, a PIH doctor who flew in from Rwanda for the ceremony: "Your ultimate goal is to make yourself unnecessary.''

• • •

The immediate goal is to enlist Haitians as directly as possible in helping their own cause.

"Our model is on-the-ground, shoulder-to-shoulder accompaniment,'' said Ted Constan, PIH chief program officer.

Take the case of 1-year-old Bosquette Jude, who was brought to the PIH hospital in Cange in late August with symptoms of severe malnutrition — lethargy, rust-colored hair and a bloated abdomen. She quickly began to recover, her swelling going down, her weight climbing, under the care of a medical staff that is almost entirely Haitian. Only a handful of the PIH's 212 doctors and 5,600 total employees in Haiti are from foreign countries.

Her therapy consisted mainly of eating PIH's brand of fortified peanut butter, Nourimanba, made at a Haitian-staffed factory in Cange. It uses peanuts raised by local farmers, who receive seeds from PIH's agricultural development group, Zanmi Agrikol, and a guarantee the group will buy their entire harvest.

Bosquette's family would be referred to an Agrikol program that supports 1,400 struggling farmers — giving them tools, seeds, advice on planting, a fruit tree to boost the output of their land, and another tree to help build and hold topsoil in the denuded countryside.

The American Red Cross and World Vision, a Christian aid group that raised $192 million for earthquake recovery, have smaller staffs than PIH. But both employ thousands of Haitians through a system of temporary labor called cash-for-work. World Vision also runs a food-for-work initiative that pays workers directly with beans or rice.

These programs have a place in post-earthquake Haiti, where the unemployment rate is an estimated 70 percent, said Elizabeth Ferris, a senior fellow with the Brookings Institution, a public policy organization in Washington.

But in the hierarchy of aid-based employment, food-for-work is at the bottom because it denies recipients the right to choose how to spend their earnings. Cash-for-work is next, Ferris said, and PIH's approach is at the top.

"Giving people steady employment and directly involving them in the process has greater long-term benefits, is more sustainable, and there is more dignity."

• • •

Ali Lutz, PIH's Haiti program coordinator, pulled off a chaotic highway outside of Port-au-Prince and drove through steel gates toward a large house with a swimming pool in the middle of a fruit orchard.

"Welcome to the oasis,'' Lutz said.

She had arrived at Zanmi Beni, a home for developmentally disabled children that PIH opened after the earthquake with the help of the Christian charity Operation Blessing. The 54 children here are cared for round-the-clock by twice as many staffers, who provide physical therapy, education, meals, hugs and playtime. On this afternoon in early September, teenagers in wheelchairs watched a large-screen television in the shade of the fruit trees. Younger children ran in and out of the house and across its paved patios.

Zanmi Beni contrasts starkly with the tent schools World Vision operates at settlement camps throughout Port-au-Prince, where teachers work without books and children receive snacks of cheese and crackers instead of hot meals.

The contrast is even sharper when compared with the plight of thousands of disabled children sleeping on the ground at places such as L'Annexe de la Mairie, the camp of 850 tarp-covered hovels.

To some, showering so few with so much might not seem fair. But these children, most of whom had been abandoned at the teaching hospital in Port-au-Prince before the quake and neglected after it, are the beneficiaries of PIH's core philosophy, called a preferential option for the poor.

"The most resources go to those who need it most,'' Lutz said.

Put another way, people in poor countries have the same right to decent lives as those in rich ones. This explains the fish ponds in the courtyards of PIH hospitals, the rousing soccer match on a field next to the hospital in Cange, and the decision to fly cervical cancer patients from Haiti to the Dominican Republic for treatment.

In 1998, when Farmer started treating HIV patients in Haiti with expensive antiretroviral drugs — now a standard protocol that helped dramatically reduce the country's HIV infection rate — he was seeking a preferential option for the poor.

He is again in Mirebalais, where PIH is building not a bare-bones facility but one "providing the highest standard of care,'' he said at the ceremony. "So the best hospital in this country would not be floating in the harbor off Port-au-Prince, but would actually be on land.''

Social enterprise helps Malawi's poor

March 11, 2010
By Cassie Farrell

A health care worker is questioning one of them about their social and economic background. He writes down an increasingly grim litany. Education - none, job - none, children - many, rooms in mud hut - too few.

It is clear that these are people in need. In Malawi, one in eight adults are infected with HIV. But drugs alone may not be the answer to this deadly scourge.

Care in the community

In Neno, a remote area in southern Malawi, poverty and HIV are both rampant. There are clutches of straw roofed huts, neglected villages and abandoned crops.

People here are obviously very poor. It is the recipe for a major health crisis, one that is far beyond the resources of the government to cope with.

But in the last three years, they have joined forces with Partners In Health (PIH), a social enterprise dedicated to providing quality health care to the world's poorest people.

PIH believes that social factors are as important as medical ones.

They do not just offer medical care, but practical help as well. They argue that the poor need food, homes, work and education in order to stay healthy, not just tablets and surgery.

This means that a lot of their work does not take place in hospitals, but out in the community.

New life

Edna Joseph was taken in by PIH after she was diagnosed with HIV. Tiny and hunched, she is wasted by the disease and moves with difficulty.

I am so happy not to have to sleep in a house with a leaking roof any more
Edna Joseph

Seventeen-year-old Edna was married at the age of 13 and has two small children.

Her husband was adult when she met him.

After being diagnosed with HIV and suffering abuse from both husband and in-laws, she was turned out of the marital home.

She returned to her mother's home, but her parents were in no position to support her.

PIH was prescribed anti-retroviral drugs to control the illness, as well as given the food she needed to make the medicines effective.

PIH also built her a tin-roofed house with two bedrooms so she could start to re-build a life for herself and her children.

"When I moved into my new house," said Edna, "I sang a song to say I am so happy not to have to sleep in a house with a leaking roof any more."

Food enterprise

PIH also helps patients get jobs.

But with little formal employment, they have to do this by giving them grants to set up their own businesses.

In a nearby town, a group of 15 women recently set up their own restaurant with the support of PIH.

They are former prostitutes, and all are HIV positive.

The women, all on anti-retroviral medication, wanted a business, not only to provide money to live on, but to give them a sense of pride in themselves.

Good food is essential for HIV positive patients, but the local diet is generally poor.

The staple food is "sima", a maize flour mixed with water.

Its nutritional value is negligible and PIH has started programmes to encourage people to both grow and eat a wide variety of vegetables.

But growing vegetables takes a lot of water, a scarce commodity. One of the projects here failed simply because it lacked a proper well.

Successful business

The restaurant, named Peace, has been a tremendous success.

The rota is in place, Florence has a new right-hand woman named Ivy and, most importantly of all, the cooking is delicious.

The women are already turning a profit but their goal is even more ambitious. They want to be self-sustaining by the end of the month.

Soon after that, they hope to see their turnover top $200 a day - a staggering amount in Malawi.

Pride and hope

The investment PIH has put into Malawi has been enormous. They have built two brand new district hospitals equipped with wards and operating theatres.

The money comes from a partnership between Partners in Health and the Malawian government, and the running of the hospital will become the sole responsibility of the government within the next five years.

But the best and the most visible return on their investment is Edna's shy smile.

The medication has saved her life, but her new house, decent food and the prospect that soon she may have a job have given her back her pride and hope.

Top of Mind: Ophelia Dahl

July 22, 2010
By Paige Williams

When Ophelia Dahl is sitting in front of you, you want to hear her talk about so many things, from life as the daughter of a famed and beloved writer to the beautiful Kazakh tapestries in her Commonwealth Avenue offices, and, especially, her work as a cofounder of Partners in Health. The longtime healthcare and antipoverty nonprofit has become synonymous with Haiti, especially since January's earthquake, and also serves those in need right here at home, in a city with the nation's third-largest community of Haitian immigrants.

WHEN I WAS A TEENAGER, I still didn't really know what I wanted to do with my life. I knew I wanted to do volunteer work, but I had no concept of where that would be.

...

When I first saw Haiti, I was 18 years old and I was rightly knocked for six, as they say in England: I was blown away by everything. It was a real assault on your senses and the way you think the world works, even if you have a good imagination.

...

I met [future PIH cofounder] Paul Farmer out in the countryside - he was trying to get a job before he went to medical school. As an anthropologist, he had a good idea of what to expect and already knew a bit about Haitian culture and history.

...

All I knew was from Graham Greene novels and tourist books.

...

We address barriers to healthcare. When a patient says, "My children are sleeping in the rain; I have no roof on my house," you have to understand that housing is part of healthcare.

...

PACT (Prevention and Access to Care and Treatment) started when we asked why Bostonians who lived within spitting distance of an incredible hospital system were dying of HIV. Why were people falling through the cracks? Language barriers, domestic violence, all kinds of things.

...

It's suddenly not all first-generation immigrants who are poor in Boston. Certainly the financial crisis of the past couple of years has exacerbated the issue. People who were living on the edge are now falling off the edge.

...

I can leave my house in Cambridge early in the morning and be in Haiti by noon. You get on a plane in Miami and you're there in an hour and a half - it's like going from Boston to DC. Relief workers and supplies went in planes donated by Bostonians - who knew there were so many privately owned planes around?

...

What everybody saw and went through in the days after the earthquake was truly unimaginable. Even hardened medical professionals are still reeling from things you hope never to see in your life.

...

It's hard to be anywhere now and not think about an exit. How would you get out of any building?

...

We get young people today who want careers in global health and are absolutely ignited in their belief that they can build movements and change the world.

...

The young people of 20 years ago were more focused on making money quickly.

...

Things in Haiti are still really bad. Hundreds of thousands of people still aren't housed. The rainy season started early, so it's mud up to here; there'll be mudslides and other terrible things. After a disaster people think, "Okay, now it's finished and we can rebuild." But the work is only just beginning.

...

Even five bucks is helpful. Five bucks begins the partnership.

...

Our core philosophy involves the concept of accompaniment. When we're in Haiti, we're accompanied by Haitians. And we accompany the Haitians. And our supporters accompany us.

...

It's like anything in life: You don't expect to go through it alone.

THE LANCET

Expansion of cancer care and control in countries of low and middle income: a call to action

August 16, 2010

By Dr. Paul Farmer *et al.*

Summary:

Substantial inequalities exist in cancer survival rates across countries. In addition to prevention of new cancers by reduction of risk factors, strategies are needed to close the gap between developed and developing countries in cancer survival and the effects of the disease on human suffering. We challenge the public health community's assumption that cancers will remain untreated in poor countries, and note the analogy to similarly unfounded arguments from more than a decade ago against provision of HIV treatment. In resource-constrained countries without specialised services, experience has shown that much can be done to prevent and treat cancer by deployment of primary and secondary caregivers, use of off-patent drugs, and application of regional and global mechanisms for financing and procurement. Furthermore, several middle-income countries have included cancer treatment in national health insurance coverage with a focus on people living in poverty. These strategies can reduce costs, increase access to health services, and strengthen health systems to meet the challenge of cancer and other diseases. In 2009, we formed the Global Task Force on Expanded Access to Cancer Care and Control in Developing Countries, which is composed of leaders from the global health and cancer care communities, and is dedicated to proposal, implementation, and evaluation of strategies to advance this agenda.

Introduction

Once thought to be a problem almost exclusive to the developed world, cancer is now a leading cause of death and disability, and thus a health priority, in poor countries. Low-income and middle-income countries now bear a majority share of the burden of cancer, but their health systems are particularly ill prepared to meet this challenge.1-6 The rising proportion of cases in these countries is caused by population growth and ageing, combined with reduced mortality from infectious disease. In 1970, 15% of newly reported cancers were in developing countries, compared with 56% in 2008.4 By 2030, the proportion is expected to be 70%.2,4,6 Almost two-thirds of the 7·6 million deaths every year from cancer worldwide occur in low-income and middle-income countries, making cancer a leading cause of mortality in these settings.2,6 Furthermore, increases in age-adjusted mortality rates have been recorded in certain developing regions and for specific cancers, such as breast cancer.7

Low survival rates in poor countries and improved survival in developed countries contribute to the disparity in the burden of cancer deaths. Overall, case fatality from cancer (calculated as an approximation from the ratio of incidence to mortality in a specific year) is estimated to be 75% in countries of low income, 72% in countries of low-middle income, 64% in countries of high-middle income, and 46% in countries of high income.2 Survival is closely and positively related to country income for certain cancers-such as cervical, breast, and testicular cancer, and acute lymphoblastic leukaemia in children-and hence the scope for action on these diseases is particularly large (figure).

Wealthy countries have made major strides in the fight against certain cancers, particularly in the past three decades. In the USA, both cancer incidence and mortality have declined since peaks in the early 1990s because of heightened awareness, prevention, earlier detection, and the availability of new and more effective treatment regimes.8,9 Although little progress has been made in the treatment of some cancers, such as pancreatic and lung cancer, low-cost and effective treatment options are available for several malignancies, including cervical, breast, and testicular cancer, and childhood leukaemia. Unfortunately, these interventions for early detection and treatment remain inaccessible for many people in developing countries.

For many cancers, future changes in incidence, survival, and mortality rates will greatly depend on whether key risk factors can be controlled in low-income and middle-income countries. In these countries, major risk factors such as smoking continue to rise, awareness of the importance of screening and early detection is low, and stigma associated with cancer and the financial barriers of poverty prevent many people from seeking preventive services or care at early stages. Without substantially increased prevention, through strong antitobacco campaigns and vaccination against human papillomavirus (HPV) and hepatitis B virus, and a focus on early detection, growth of the cancer burden in these countries could make treatment virtually unaffordable in the long term.

Thus, the world faces a huge and largely unperceived cost of inaction around cancer in developing regions, which merits an immediate and large-scale global response. Yet, only a small proportion of global resources for cancer are

spent in countries of low and middle income: several studies have reported an estimate of 5% (see webappendix for further details).2,10,11 By contrast, these countries together account for almost 80% of the disability-adjusted life-years lost worldwide to cancer.1 Cancer is an underfunded health problem and an important cause of premature death in resource-poor settings, resulting in this staggering "5/80 cancer disequilibrium".12

International attention and financial resources to resource-poor settings have increased especially in the past 10 years, resulting in an impressive expansion in the availability of treatment for patients with certain infectious diseases, most notably AIDS. However, cancer remains sorely neglected. Public, private, and multilateral donors spend relatively little on efforts to expand cancer prevention, diagnosis, and treatment in these countries compared with other diseases. Furthermore, cancer is notably absent from the global health agenda,13 including key global health targets such as the Millennium Development Goals (MDGs).

A global call to action for cancer in low-income and middle-income countries is beginning to emerge, led by international agencies, academic institutions, and non-governmental organisations and associations.14-17 However, concerted action is needed from the global health community, together with the participation of local governments and extensive primary health-care networks to achieve an effective response. The agenda for action should catalyse expansion of cancer care, control, and prevention with strategies that are appropriate to the health systems of low-income and middle-income countries, accessible to patients with low incomes, and integrated into national health insurance systems. This agenda must include increasing access to drugs for treatment and palliation, expansion of coverage for preventive and diagnostic services, including vaccines, and development and implementation of innovative health-care delivery options to support rapid scale-up.

The Global Task Force on Expanded Access to Cancer Care and Control in Developing Countries

To push forward this agenda, the Dana-Farber Cancer Institute, Harvard Global Equity Initiative, Harvard Medical School, and Harvard School of Public Health convened the Global Task Force on Expanded Access to Cancer Care and Control in Developing Countries (GTF.CCC). Announced in November, 2009, the mandate of GTF.CCC is to design and implement global and regional initiatives for the financing and procurement of affordable cancer drugs, vaccines, and services, and, through local partners, to develop and apply innovative service delivery models that can be monitored and evaluated to provide key evidence for expansion of cancer care and control in countries of low and middle income.12

GTF.CCC's strategy is to collaborate with and support existing initiatives. GTF.CCC will base much of its work on the lessons learned from previous initiatives, including those designed to address AIDS, tuberculosis (including multidrug-resistant [MDR] tuberculosis), maternal and child health, maternal mortality, sexual and reproductive health, and mental health. Furthermore, the strategy calls for identification and exploitation of opportunities for synergy between these initiatives and cancer care and control, particularly in the context of health-system strengthening, and the wide network of services devoted to the health of women and children.

GTF.CCC also seeks to build on, work with, and support international calls, initiatives, and recommendations, including the UN 2011 General Assembly summit on non-communicable diseases,18 the World Cancer Declaration of the International Union Against Cancer;14 the 2005 World Health Assembly resolution on cancer prevention and control,15 the 2007 report on cancer in low-income and middle-income countries produced by the Institute of Medicine of the National Academies,1 the findings of the World Cancer Report 2008 by the International Agency on Cancer Control and WHO,4 and other work by academic institutions and grassroots associations and alliances in developed and developing countries.

Through collaborations with these initiatives and institutions, GTF.CCC will support existing efforts, particularly those on tobacco control, such as the WHO Framework Convention on Tobacco Control. GTF.CCC will also support continuing global and national efforts to improve diet and nutrition, reduce environmental risks, promote healthy lifestyles, increase screening and vaccination against cancer-causing infections (HPV and hepatitis B virus),19 and educate the public to combat existing misconceptions and stigma associated with cancer.

To contribute effectively to the global movement, GTF.CCC will focus on health-system strengthening, implementation of regional and global mechanisms for financing and procurement, and strengthening of primary and secondary care to allow innovative delivery at the local level. Thus, in addition to strong support for efforts to prevent future cancers by reduction of risk factors, especially tobacco, GTF.CCC calls for immediate action in the face of existing needs. Specifically, GTF.CCC focuses on development and implementation of pathways and public policies to expand coverage of existing vaccines, early detection and treatment of cancers for which cure or major improvements in life expectancy can be achieved, and palliation to reduce suffering and pain. The work of GTF.CCC is predicated on the conviction that barriers to access can be removed, and that the reasons for rapid scale-up of cancer treatment merit an invigorated global response (panel 1).

Scepticism about scale-up of access to an integrated system of early detection, diagnosis, treatment, and palliation in poor countries is concentrated on the scarcity of funds and perceived obstacles to treatment. Some contend that restricted international resources for global health should not be spent on expensive treatments for malignancies or costly vaccines. Furthermore, the prevailing belief is that safe and effective cancer treatment is rendered impossible in many poor countries by the shortage or absence of oncology specialists and facilities, treatment guidelines, and regulatory mechanisms.

Policy barriers are equally limiting and often among the most difficult to surmount. Restrictions on importation of drugs, especially for palliation, non-existent cancer treatment budgets, and failure to recognise cancer as a health priority will have to be overcome to effectively address prevention, detection, and treatment. The evidence presented in panel 2 challenges the assumption that cancer control and care is not feasible or effective in countries of low and middle income, and supports global and national policy change. In several middle-income countries, pioneering national programmes have been implemented throughout health systems,25-27 including health insurance coverage for people living in poverty and application of protocols to guide delivery of cancer treatment.

Lowering of costs and generation of effective financing and delivery mechanisms

Increased access to primary care combined with well designed and affordable disease-control programmes can greatly improve cancer care and control in low-income and middle-income countries.10 Primary health-as the first locus of care-must increasingly embrace a chronic care model, especially because diseases such as AIDS become chronic and require long-term management.28,29 Opportunities exist for cancers that are amenable to prevention, and education and strengthening of networks in primary and community care can be important for early detection of other cancers, which then offers substantial opportunities for cure when treatment options are made available (panel 3). Although surgical needs will continue to challenge treatment of cancers, important examples of initiatives show that low-cost techniques that are generally applicable can improve surgical services and help to strengthen health systems.30

Many of the cancers that pose the greatest burden in developing countries are amenable to treatment with drugs of proven effectiveness that are off-patent and can be manufactured generically at affordable prices. These drugs should be a focus of cancer treatment programmes, rather than expensive on-patent drugs. In the case of breast cancer for example, the USA achieved important improvements in outcomes before 1975 with surgery and early detection through awareness building, before the widespread use of mammography, adjuvant chemotherapy, and hormonal therapy.31,32 Additionally, in the past decade, tamoxifen-a low-cost drug for hormone-receptor-positive breast cancer-has substantially improved survival (Shulman LN, Willett WC, Knaul FM, unpublished data). Some forms of cancer are curable with systemic treatment even when diagnosed at a late stage, although surgery might sometimes also be needed (panel 3). For example, Hesseling and colleagues33 report that in Malawi, Cameroon, and Ghana, the total cost of a generic first-line chemotherapy drug with a 50% cure rate for Burkitt's lymphoma is less than US$50 per patient.

For several cancers, life can be substantially extended with fairly low-cost systemic drug treatment (panel 3). In settings, cases, and cancers (pancreatic, lung, and advanced cancer) where treatment is not an option, palliation to

relieve pain and reduce human suffering is a human right. Pain control is typically low cost and easily delivered, and the barriers to delivery are mostly caused by substance controls, which block health-care providers from supporting urgent needs in oncology and many other specialties.34,35

Delivery of education, diagnostics, surgery, drugs, and services to poor people is challenging, but innovation in developing regions has improved the design, implementation, and financing of effective delivery models. Many of these initiatives, adapted to the constraints of resource-poor environments, seek to upgrade the role of the community, non-specialised health professionals (eg, health promoters), nurses and primary care physicians, and clinics and non-specialty hospitals. Although special training is required, this approach can be effective for provision of high-quality care in many settings and should be considered as an option even for developed countries.23 Partners In Health-an institution that addresses seemingly untreatable health problems in especially challenging circumstances-is an example of innovation in and implementation of such models.2,24 Another is Mexico's conditional cash transfer programme, Oportunidades, which covers more than 95% of the poorest families, and provides cash transfer incentives to promote health education and use of health-care resources.36,37

The cost of drugs is often a specific and substantial barrier to prevention and treatment of cancer in poor countries, and opportunities to reduce price and expand absorptive capacity should be identified and implemented. Many chemotherapeutic interventions remain cost-prohibitive for national ministries of health in poor countries. One of the most promising recent innovations for prevention, vaccination against HPV, continues to be too costly for widespread use in these countries.38 Global and regional negotiation strategies for pricing and procurement can provide opportunities to reduce prices. Nevertheless, the costs of care and control are prohibitive for the vast majority of families in developing countries. Prevention and early detection of cancer should be incorporated into basic health-care packages and financed as entitlements. Cancer care must be free of charge to prevent further impoverishment.

Approaches to overcome challenges

Many challenges to widespread and comprehensive cancer control resemble those cited a decade ago, during debates about the feasibility of treatment for HIV infection and tuberculosis, especially MDR disease.10 Critics asserted that complex care could not be scaled up within weak health systems, particularly in sub-Saharan Africa.39 They thought that antiretroviral treatment and, especially, second-line tuberculosis therapy were not sufficiently cost effective to merit international funding, and were too impractical to effectively administer in countries of low and middle income. Some argued that prevention, palliation, and gradual implementation of the least expensive treatment interventions were the only possible steps.24,40-43

However, for HIV infection, MDR tuberculosis, and tuberculosis in general, effective therapy has quickly become a successful and integral component of control. Complex and (at least initially) expensive treatment became possible when accompanied by innovative treatment models and new investments. Coordination of financing and procurement strategies helped to lower prices and streamline supply chains for therapeutics and diagnostics.44 Through concerted global action and new sources of funding, the number of people receiving antiretroviral treatment for HIV infection in developing countries has increased by more than ten times since 2003, and is now close to 4 million.45 This achievement is impressive since the poorest countries have very few physicians and virtually no infectious disease specialists. As part of this revolution in treatment, AIDS is fast becoming a chronic illness requiring survivorship care.

One of the strategies that made the scale-up of HIV treatment successful was the inclusion of actors both within and outside of international institutions such as WHO, allowing many players to come to the table with innovative ideas. The early work of the Clinton Health Access Initiative substantially increased access to generic HIV drugs. The Global Fund to Fight AIDS, Tuberculosis and Malaria relied on normative and technical support from organisations like WHO, but channelled its funds directly to governments and non-governmental organisations. The US President's Emergency Plan for AIDS Relief, announced in 2003, greatly increased the funding available worldwide to combat HIV infection. UNITAID, launched in 2006, established a novel financing mechanism for the purchase of

commodities to treat HIV infection, malaria, and tuberculosis, and is now working to establish a patent pool for HIV drugs. Thus, a lesson for scale-up of cancer care is not to centralise or generate innovation-stifling central nodes of control.46

Advocates should not assume that global health resources for cancer care and control are limited to present levels. Efforts to control HIV infection, tuberculosis, and malaria have shown that substantial, life-saving investments can feasibly be raised from public and private sources for research in and implementation of global health interventions, saving millions of lives. The world has witnessed an unprecedented success in mobilisation of resources to increase awareness and access to vaccines and drugs in poor countries. UNITAID, the Pan American Health Organization Revolving Fund for Vaccine Procurement, the Global Alliance for Vaccines and Immunisation, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and non-profit organisations, such as the Bill & Melinda Gates Foundation and the Clinton Health Access Initiative, have pioneered financing and procurement schemes to guarantee access to much needed vaccines, drugs, and laboratory tests.

The experience with HIV provides an important lesson: neither care nor prevention can be neglected. In fact, some evidence suggests that global efforts to prevent HIV infections have waned, increasing the risk of a major increase in the need for antiretrovirals that cannot be met.47,48 In the case of both cancer and AIDS, neglect of care leads to unnecessary death and suffering, and neglect of prevention leads to unaffordable treatment.

Successful treatment of cancer in extremely resource-poor settings: Malawi, Rwanda, and Haiti

A frequently cited barrier to cancer treatment in resource-poor settings is the absence of specialists and specialty centres. An international partnership of Partners In Health and the Dana-Farber Cancer Institute, Harvard Medical School, and Brigham and Women's Hospital, working in rural Malawi, Rwanda, and Haiti, is proving that this barrier can be surmounted even in the poorest settings. In partnership with national ministries of health, Partners In Health helps to operate health centres and hospitals in rural districts, serving catchment areas of 1 200 000 in Haiti, 800 000 in Rwanda, and 175 000 in Malawi. Because no oncologists are available, care is provided by local physicians and nurse teams. With support and training from the Harvard-based facilities, these centres and hospitals have begun to deliver chemotherapy to patients with a variety of treatable malignancies including breast, cervical, rectal, and squamous head and neck cancers, Hodgkin's and non-Hodgkin lymphoma, and Kaposi's sarcoma.

Despite important success with the programme-patients have received treatments safely and with good outcomes-the reach of these pilot initiatives is dwarfed by the burden of disease. Treatment needs to be delivered free of charge, but scale-up is severely constrained by lack of funding, especially for the cost of drugs. Furthermore, late detection lowers the effectiveness of most treatments. Still, these pilot programmes in Malawi, Rwanda, and Haiti show that the absence of oncological specialists need not delay the implementation of mutually reinforcing efforts to prevent, screen, treat, and palliate cancer. Much can be accomplished in the short term, even in extremely resource-poor settings, by use of local clinicians and community health workers, supported by remote consultations with specialists, to deliver safe and effective cancer treatment.

Inclusion of cancer treatment in national health insurance programmes: Mexico and Colombia

A key aspect of scale-up of cancer treatment that will help to strengthen health systems is development of explicit entitlements to health care and financial protection. Cancer is a catastrophic illness in both financial and personal terms. Mexico and Colombia are examples of a handful of countries in which cancer care and control is an entitlement and is incorporated into health insurance programmes targeted to poor people.

In Mexico, recognition of the growing burden of cancer and the opportunity for treatment has been transformed into action as part of continuing efforts to strengthen the health system. Through Popular Health Insurance, Seguro Popular de Salud-which was introduced in 2004 and now covers almost 37 million individuals, with a focus on low-income populations-the range of entitlements to cancer treatment has been steadily expanded. Comprehensive

treatment regimes for cervical and breast cancer, and a range of childhood and adolescent malignancies are covered for all Mexicans.25,26,49-51 Although Mexico is a country of high-middle income, almost 20% of the population lives below the national food poverty line,52 and these are the families targeted by Popular Health Insurance. Furthermore, in view of the legal basis of the reform, the population and package of services continue to be covered despite the present economic crisis. The delivery of cancer services, though, is suboptimum and creative initiatives to reach more patients and detect disease earlier are needed.

In Colombia, universal social health insurance has been in place since 1993, with a subsidised scheme providing specific entitlements for the poor. The mandatory health plan has included treatment for cancers since 1994.27 The package is being updated to account for developments in medical technology, and to ensure equal access for subsidised populations. In the meantime, patients have been able to sue for the right to treatment that is not included in the package. Yet, and as in Mexico, delivery is suboptimum and financial sustainability is a challenge.

These examples show that entitlements for cancer treatment can be increased in middle-income countries by use of local funding. However, in most low-income and middle-income countries, national insurance is far from universal or entitlements are much more restricted than in Mexico or Colombia. Often, only the small proportion of people who can afford the most expensive, local private hospitals are able to access cancer diagnostics and treatments. These examples also show that insurance for treatment should be combined with additional investment in early detection and prevention. Delivery options need to be improved to guarantee effective access to both prevention and treatment.

Expansion of access to treatment through a national centre of excellence: Jordan

Jordan provides a replicable example of a country of low-middle income that, despite few resources, has been able to establish a specialised centre of excellence. The King Hussein Cancer Center-the only cancer centre in a developing region that has been accredited by the Joint Commission-is legally governed by the King Hussein Cancer Foundation, and operates the Foundation's medical arm. Founded in 1997, the Foundation is an independent, non-governmental, and non-profit organisation. The Center offers high-quality cancer treatment, professional training, and awareness building, and focuses on reaching internationally recognised standards of care. Both the Foundation and Center provide care to patients who have no means to cover the costs of their treatment, while simultaneously providing services under contract with the government and private sectors, and operating as a regional hub.53 In the case of breast cancer, the Foundation and Center treat about 60% of new cases in Jordan, and also lead the Jordan Breast Cancer Program focusing on awareness building, early detection, and establishment of national guidelines for screening and diagnosis.54

National shortages of human resources and infrastructure are evident in the face of the projected increase in the cancer burden and the increasing demand for services. In response, the King Hussein Cancer Center is undertaking training and upgrading of other centres in Jordan and surrounding regions, but financing mechanisms for these projects will need to be identified. In addition to service provision, key national and regional functions of the Center are to: provide proof of concept to drive policy around the provision of high-quality care to all population groups; serve as a model and catalyst to scale up delivery; promote dialogue between sectors and steer the course for policy change; and support the expansion of key instruments such as the national cancer registry and guidelines for increased access in a resource-poor setting.

Conclusions

The time has come to challenge and disprove the widespread assumption that cancer will remain untreated in poor countries. We, as participants in GTF.CCC, believe that compelling evidence of the feasibility and effectiveness of comprehensive cancer control merits a renewed global effort to expand cancer prevention, diagnosis, treatment, and palliation in countries of low and middle income, including provision of affordable and reliable drug supplies and vaccines. Achievement of this aim will require additional resources that can be derived from innovative global, regional, and national financing and procurement mechanisms.55

We propose that cancer care and control become rapidly and broadly available as quickly as possible, with the focus on cancers that can be prevented or cured, or, for cases in which neither is possible, palliated. More immediately, we propose three changes. First, simultaneous implementation of large-scale demonstration programmes in the next few years to define and build new infrastructure, train health professionals and paraprofessionals, and harness the opportunities of technology and especially telecommunications to overcome many on-site limitations in resources. Carefully designed evaluation and monitoring will enable identification of the most effective measures to alleviate the burden of cancer and expand the volume of health services in developing countries, and will provide lessons for all health systems, including those in the developed world. Second, design and implementation of regional and global pricing and procurement mechanisms to offer individual countries the opportunity to participate in collective, multicountry negotiation to secure reduced prices for essential services, drugs, and vaccines. Third, identification and implementation of innovative financing mechanisms, which should decisively expand the financial resources available for prevention, treatment, and palliation of cancer in the developing world.

A recalibrated global response could transform cancer care and control, but will need coordinated efforts and synergy among international organisations, such as WHO, the World Bank and regional development banks, bilateral donors, national research funding bodies, non-governmental agencies, governments, and local, regional, and global civil society organisations. New funding from private, bilateral, and multilateral donors should be used to strengthen entire health systems. Both advocates and experts should use evidence to convert zero-sum debates about which life-saving interventions to deny poor patients into alternatives to mobilise resources, identify synergies between disease-specific interventions, and recognise that saving a patient from one disease does not eliminate the risk that they can develop another.

We can no longer differentiate between diseases of the poor and the rich. Furthermore, restriction of health systems in poor countries to treatment of infectious diseases is a response to a false dichotomy. Even in the most severe of crises, exemplified by Haiti after the earthquake in January, 2010, suffering from chronic illness, especially cancer, intensifies alongside most other health needs. Poor people endure a double burden of communicable and non-communicable chronic illness, requiring a response that is well integrated into the health systems of low-income and middle-income countries. Extension of cancer prevention, diagnosis, and treatment to millions of people with or at risk of cancer is an urgent health and ethical priority. A bold research, financing, and implementation agenda is essential for the international community to fill the gaping voids in cancer care and control worldwide.

VOGUE

A PLACE CALLED HOPE

September 2010

By Marcia Desanctis

Activist Ophelia Dahl remains committed to helping Haiti, the country that inspired her life's work.

In a crowded hospital ward in Cange, Haiti, Ophelia Dahl chats with 25-year-old Shelove, who lost her entire family, her home, and a leg in the earthquake that devastated Port-au-Prince. It is Dahl's third visit since January, and though the trauma injuries have been largely treated, she understands that the real human cost of the disaster is just emerging. Their broken bones now healed, victims

will need rehabilitation, housing, mental health services, prosthetics, jobs, and protection from infectious diseases. “Everyone here has a similar story,” says Dahl. “But it's hard to get sadder than hers.”

For Dahl, 46, it's simple: No one should have to endure the inhumanity she has witnessed, especially because her work has proved time and again that change is eminently possible. “What drives me,” she explains, “is the knowledge that such inequality exists in this day and age, in spite of all we have and all we can do. Often, we feel inured to it or flummoxed by it. I'm lucky enough to be part of a group that doesn't feel that way and, in spite of the immense complexities, can do something about it.”

That group is Partners in Health (PIH), which Dahl cofounded in 1987 with Paul Farmer, M.D., Ph.D., and Jim Kim, M.D., Ph.D., businessman Tom White, and friend Todd McCormack, who banded together to redress disparities in health care throughout the world. PIH didn't just parachute into the disaster zone; they have spent years planting roots and building hospitals in destitute rural communities and nurturing relationships with the Haitian state, hiring 5,000 locals along the way. They were well situated to help handle the broken limbs, organ failures, and spiraling public-health crisis that followed, both in the provinces, where their facilities stood intact, and in the capital. They set up mobile clinics in the resettlement camps and the General Hospital, and dispatched planeloads of supplies, doctors, and nurses who volunteered to bolster their Haitian colleagues. Within six months, Dahl helped PIH raise $85 million for the recovery effort.

As executive director since 2001, Dahl is widely lauded for maintaining the organization's soul as it grew to employ 11,000 people in twelve countries. She lives near PIH headquarters in Boston with her partner of eleven years, Lisa Frantzis, a consultant in renewable energy, and their toddler, Luke. Dahl travels about one week per month, most frequently to Haiti, the country that inspired her life's work.

The soft-spoken but wickedly funny Englishwoman is a daughter of author Roald Dahl and his first wife, Oscar-winning actress Patricia Neal. She first visited Haiti in 1983, when her father helped her secure a position at a rural eye clinic there. “I think I knew I was, in some lovely way, being humored,” Dahl recalls. “But I came to realize my job was to witness things I had not seen before. Of course I didn't know then how it would change my life or, as Tracy Kidder puts it, ‘rearrange the cosmos.’ But that's really what happened.” Kidder's book Mountains Beyond Mountains follows the work of Farmer as well as the story of how Farmer, then 23, found a soul mate in this daughter of literary and Hollywood royalty. By the time the couple parted ways romantically, PIH was fast becoming a force in global health. The two remain collaborators and close friends.

In Haiti, Dahl is viewed as both a selfless ally and a world-class activist with the ability to allocate financial resources to make things happen. At the crumbling remains of the General Hospital in Port-au-Prince, she moves past the now-vacant lot where the national nursing school collapsed, killing 150 students. She tours the semi-outdoor operating rooms where flies zoom around oxygen tanks. She converses with the sick and the people who care for them, shifting effortlessly between Creole and the queen's English. She meets with the clearly beleaguered hospital director, Alix Lassegue, M.D., and Evan Lyon, M.D., an American physician and PIH volunteer. Haitian health officials asked PIH to help bring the hospital back to life. Dahl and Lyon are eager to explain how the medical services the organization provides are buttressed with training via relationships with Harvard Medical School and Boston's Brigham and Women's Hospital to raise Haiti's level of medical education and ultimately, patient care.

“I CAME TO REALIZE MY JOB WAS TO WITNESS THINGS I HAD NOT SEEN BEFORE. I DIDN'T KNOW THEN HOW IT WOULD CHANGE MY LIFE”

Three hours into the country's Central Plateau is Cange, the point of origin for PIH and its local counterpart, Zamni Lasante. It is a vast complex, encompassing a modern hospital, schools, feeding programs, churches, a women's-health clinic, and job and agricultural initiatives. Dahl discusses the bottomless caseload with medical professionals, commiserates with mothers in the pediatrics wing, and accompanies a community health worker on her rounds to nearby AIDS patients. In the quarantined tuberculosis ward, she notes they could use a radio. She writes nothing down but later will follow up on every detail.

Dahl doesn't question her commitment to the Haitian people and the poor, wherever they are. She is motivated in part by the resilience of the people she has grown to love. “The Haitians have been dealt blow after blow. And the absolute saddest thing for me is that they're still getting knocked down,” she says. “It's too much of a luxury to give up hope. The Haitians don't. They never have.” Given that, she asks, how could she?

The New York Times

The Gifts of Hope

December 18, 2010

By Nicholas D. Kristof

So what would your aunt prefer as a holiday gift — another Mariah Carey CD, or the knowledge that she’s sending a little girl in Haiti to school for a year?

Unless you’re cursed with the oddest aunt ever, the answer is probably the latter. In that spirit, this column will serve as a sort of Humanitarian Gift Guide: I’ll lay out some of the loftiest gifts of all, those that touch human lives and connect us. As I did last year, I’m going to skip over the big organizations that most people have heard of. So by all means, buy your kids a $30 beehive (or an $850 camel) for a needy family through Heifer International, or write a check to the International

Rescue Committee for its terrific work in Congo — but my focus today is groups that never make the spotlight:

¶Arzu (ArzuStudioHope.org) employs women in Afghanistan to make carpets for export. The women get decent wages, but their families must commit to sending children to school and to allowing women to attend literacy and health classes and receive medical help in childbirth. Rugs start at $250 and bracelets at $10, or a $20 donation pays for a water filter for a worker's family.

¶First Book (firstbook.org) addresses a basic problem facing poor kids in America: They don't have books. One study found that in low-income neighborhoods, there is only one age-appropriate book for every 300 children. So First Book supports antipoverty organizations with children's books — and above all, gets kids reading. A $100 gift will supply 50 books for a mentor to tutor a child in reading for a year. And $20 will get 10 books in the hands of kids to help discover the joys of reading.

¶Fonkoze (fonkoze.org) is a terrific poverty-fighting organization if Haiti is on your mind, nearly a year after the earthquake. A $20 gift will send a rural Haitian child to elementary school for a year, while $50 will buy a family a pregnant goat. Or $100 supports a family for 13 weeks while it starts a business.

¶**Another terrific Haiti-focused organization is Partners in Health, (pih.org), founded by Dr. Paul Farmer, the Harvard Medical School professor**. A $100 donation pays for enough therapeutic food (a bit like peanut butter) to treat a severely malnourished child for one month. Or $50 provides seeds, agricultural implements and training for a family to grow more food for itself.

¶Panzi Hospital (panzifoundation.org) treats victims of sexual violence in eastern Congo, rape capital of the world. It's run by Dr. Denis Mukwege, who should be a candidate for the Nobel Peace Prize. A $10 donation pays for transport to the hospital for a rape survivor; $100 pays for counseling and literacy and skill training for a survivor for a month.

¶Camfed (camfed.org), short for the Campaign for Female Education, sends girls to school in Africa and provides a broad support system for them. A $300 donation pays for a girl to attend middle school for a year in rural Zambia, and $25 sends a girl to elementary school.

¶The Nurse-Family Partnership program (nursefamilypartnership.org) is a stellar organization in the United States that works with first-time mothers to try to break the cycle of poverty. It sends nurses to at-risk women who are pregnant for the first time, continuing the visits until the child turns 2. The result seems to be less alcohol and drug abuse during pregnancy, and better child-rearing afterward, so that the children are less likely to tangle with the law even years later. A $150 gift provides periodic coaching and support for a young nurse by a senior nurse for a month.

¶Edna Hospital (ednahospital.org) is a dazzling maternity hospital in Somaliland, an area with one of the highest maternal mortality rates in the world. Edna Adan Ismail, a Somali nurse- midwife who rose in the ranks of the World Health Organization and also served as Somaliland's foreign minister, founded the hospital with her life's savings and supports it with her United Nations pension. A $50 gift pays for a woman to get four prenatal visits, a hospital delivery, and one postnatal visit. Or $150 pays for a lifesaving C-section for a woman in obstructed labor.

¶The Somaly Mam Foundation fights sex slavery in Cambodia and around the world (somaly.org). It is run by Somaly Mam, who was sold into Cambodian brothels as a young girl before escaping years

later. For $50, you can buy a lovely silk scarf made by a trafficking survivor; $25 buys a necklace made by a survivor.

One of the paradoxes of living in a wealthy country is that we accumulate tremendous purchasing power, yet it's harder and harder for us to give friends and family presents that are meaningful. In this holiday season, sometimes a scarf from a prostituted Cambodian girl, or a scholarship for a Zambian child, is the most heartwarming gift of all.

Haitians Forge Ahead As Quake Recovery Drags On

October 13, 2010
By Jason Beaubien

In Haiti, nine months have passed since a devastating earthquake killed more than 200,000 people, left 1.5 million homeless and destroyed much of the capital, Port-au-Prince.

The Caribbean nation has made some progress in recovering from the quake, but much more remains to be done. Hundreds of thousands of people still live in camps. Rubble fills many neighborhoods. Demolition remains a top priority, but by some estimates the cleanup process alone could take years.

Even the presidential palace in Port-au-Prince is still waiting to be torn down. Behind a wrought-iron fence and a long green lawn, the compound's white domes are collapsing in on themselves.

Fab Gladys lives in the sprawling tent camp located in Champs de Mars, across the street from the collapsed Presidential Palace.

Across the street, tens of thousands of earthquake victims are living in makeshift huts, many of which are also falling in on themselves.

Fab Gladys says she's been there since Jan. 12, the day the quake hit.

"The water runs right under us. We could be sleeping here and not knowing that it rains. You wake up and you see the water is running right under you," she says.

Gladys' shack, where she lives with her seven children, is a patchwork of tarps and plastic sheeting stretched over a rough timber frame. She says that when it rains she puts a plastic washbasin over her baby to keep the child dry.

The area used to be a park.

On a recent day, Leonard Joseph, the coordinator of a local environmental group, points to the piles of garbage and the stagnant green puddles in what used to be a fountain.

"Look at this," Joseph says. "The kids bathe here. They play here. They play soccer here."

Leonard Joseph is a camp coordinator at Champs de Mars.

He says the conditions in this camp are inhumane.

"We've heard that the government has received millions of dollars, and aid groups have received millions of dollars for Haiti," Joseph says. "But when we compare it to the conditions we are living in here, it doesn't make sense. We haven't benefited at all."

While the living conditions in the camp are difficult, they are better than in the weeks immediately after the quake. Now, at least, there are portable toilets and communal taps with running water. Small shops have sprung up selling pasta, bleach and cigarettes.

A vendor winds his way down the narrow alleyways between the huts. He's hawking mirrors, combs, hair gel and other beauty products. Young boys sell small plastic pouches of drinking water. Kids kick a ball. Teenagers flirt.

Next month, the school year restarts nationwide.

Much Work Still To Be Done

Amid the chaos, people are moving forward with their daily lives. But the challenges ahead for Haiti remain huge.

Nine months after the quake, aid groups have built only 13,000 transitional shelters for the roughly 1.5 million people left homeless.

Workers in Port-au-Prince, Haiti, clear rubble from a collapsed building using buckets in August in Port-au-Prince, Haiti. Demolition and rubble removal remain top priorities, but by some estimates the cleanup process alone could take years.

Rubble removal remains a major task. Across the city, men scamper over collapsed buildings, breaking them apart with sledgehammers. And throughout the capital, people dump wheelbarrow loads of debris along the main roads where it's eventually picked up in trucks.

Basic infrastructure is functioning. Although severely damaged, the airport operates. There's no reliable electricity, but the cell phones work. At the port, cargo is unloaded on temporary floating barges.

A giant industrial crane lies half-submerged in the harbor. Before the quake, the port used to be able to unload seven ships at a time. But now, with the piers destroyed, the floating docks can only accommodate four vessels.

Hugues Desgranges is an adviser to the port director.

"Right now, they're using the ship's crane to unload. It takes a longer time when you're using the ship's crane," he says.

In addition to this logistical bottleneck at the port, many aid agencies say the relief supplies and building materials they're trying to move into the country get tied up in Haitian customs — sometimes for months.

National Plan Needed

Desgranges says Haiti is at a crucial moment in its history.

"I think Haiti needs to make choices. For example, I think the Dominican Republic made them. They chose to do tourism. If you go to Punta Cana, they exploit it and it works," he says.

Desgranges says you can't build a successful country on humanitarian aid. Haiti, he says, has to figure out what it wants to be.

"We need to have a national plan," he says.

Haiti didn't just wake up one day and decide it wanted to be the poorest country in the hemisphere, Desgranges says. But without a plan for what exactly it's going to be, he says the rebuilding of the country lacks focus and direction.

Not all of the news out of Haiti is bad right now. Partners in Health just broke ground on a state-of-the-art teaching hospital about 90 minutes outside the capital. Most of the major streets in Port-au-Prince have been cleared of rubble, making the city more accessible. Many government agencies, whose offices were destroyed have relocated, and are operating again. And so far this season, the hurricanes have stayed away from the battered nation.

How can donors aid quake-hit Haiti?

March 31, 2010

By Henri Astier

Wednesday's UN conference in New York on co-ordinating assistance to earthquake-hit Haiti raises an awkward question - what has foreign aid ever done for Haitians?

The country has received an estimated $5bn (£3.3bn) over the past decade.

Thousands of charities have been operating there - yet even before the quake devastated the capital, Haiti was a wretched place.

It is the poorest country in the Americas. About 80% of the population lives on less than $2 a day and nearly half is illiterate. Jobs are scarce, public services woeful and corruption rife.

Haiti, says US political scientist Terry Buss, is largely run by "an army of NGOs and some international development organisations" whose programmes "cost a lot of money and don't make any difference".

Mr Buss - author of the book Haiti in the Balance, Why Foreign Has Failed And What We Can Do About It - cites as an example Haiti's judicial system, which he calls a "shambles".

The US government, he says, has tried to promote reform by running seminars for judges.

But few Haitian judges have extensive legal training, and teaching them US jurisprudence has not led to a noticeable reduction in the number of prisoners languishing without due process in Haiti's overcrowded jails.

Band-Aid approach

One of the reasons donors get little bang for their aid buck is the scattered nature of their efforts.

"One of the problems is a lack of co-ordination to make the most of the generosity of groups and people," says Ruth Levine, from the Center for Global Development, a Washington think tank.

NGOs and church groups, she adds, tend to get involved in short-term, local projects and move on.

"It's a Band-Aid approach," Ms Levine says. "It's not a sustained effort, so it's hard to build up the kind of trust with the community that would provide ongoing services."

Governments too can be fickle. The US, for instance, stopped funding family planning programmes - particularly crucial in Haiti - because of concerns over abortion.

Another factor affecting the efficacy of aid is the tendency of donors and charities to bypass local authorities.

Such mistrust can be understandable, as Haiti has a long history of oppression and misrule.

But by providing services directly, the aid community in effect takes on government functions, reinforcing the divide between officials and the people.

"It's the worst (form of) government you can possibly imagine," says US writer Tracy Kidder, author of Mountains Beyond Mountains, a book about Haiti.

"It is a government whose activities are not co-ordinated and that is not in any way accountable to the people it's supposed to be governing."

Meanwhile, Terry Buss says, Haiti's nominal government never feels pressure from people they do not serve. "They don't expect to deliver public services because it never does," he says.

Tyranny of emergency

Some charities ensure that they work with the Haitian authorities, rather than undermine them.

One is the US charity Partners In Health (PIH), which has 10 clinics and hospitals in Haiti. They are run jointly by the health ministry and are staffed with Haitian doctors and nurses.

"What we do is really make it a priority to strengthen the institutions in which we're working," says PIH's Donna Barry.

However PIH's efforts to involve Haitians are not the rule.

According to Pastor Michel Morisset, who heads Eben-Ezer Mission, a local charity in Gonaives, most aid workers regard Haitians as wards rather than partners.

"Instead of coming and doing everything for us, they should ask us where the problems are, where we suffer, and help us. Coming with ready-made programmes and dumping things has never worked," he says.

"We have been treated as helpless victims and that has stayed with us."

The earthquake, according to Pastor Michel Morisset, has reinforced a feeling of helplessness and dependency among Haitians.

"We have become a perpetual emergency," he says. "We are ruled by the tyranny of emergency."

On the bright side

Is Haiti doomed to remain in the grips of well-meaning but ineffectual benefactors? Not necessarily.

Jean-Louis Warnholz, a former economic adviser to the Haitian prime minister, speaking to the BBC in January, said that under the current government the country has enjoyed stability and good relationship with the international community.

Reforms have been undertaken, and a quarter of the foreign debt was cancelled last June.

Last year Haiti's economy grew by about 3% - not a stellar performance, but an encouraging one in the aftermath of a devastating hurricane in 2008 and amid a global financial crisis.

Before the earthquake the garment sector was the country's fastest-growing industry, with factories near Port-au-Prince supplying such major brands as Gap and New Balance. Thanks to a new trade deal, Haiti exported $512m worth of apparel to the US in 2009.

Tourism is another promising sector in a country with plenty of sunshine and pristine beaches.

Royal Caribbean Cruises recently spent $55m upgrading the northern port of Labadee, and sent the world's largest cruise liner there on its maiden voyage last year.

Mr Warnholz believes that even after the earthquake, the potential for growth remains.

"The pockets of opportunities that still exist need to be expanded," he said. "I don't think that Haiti is forever cursed."

Few deny that outsiders have a key role to play in Haiti. An impoverished country that has suffered as many deaths in a single region as the 2004 tsunami inflicted across the Indian Ocean needs all the help it can get.

However, as donors gather to discuss reconstruction aid for Haiti, the key question may not be how much they pledge, but whether their efforts are channelled in a way that avoids the failures of the past.

The Miami Herald

Rising Haiti hospital a symbol of future

September 13, 2010
By Jacqueline Charles

MIREBALAIS, Haiti -- When a new teaching hospital opens in this central Haiti town a little over a year from now, it will be far more than a 320-bed, six operating room facility.

Local and international doctors say it will represent a towering example of post-earthquake recovery.

``It's going to be a world-class hospital in the middle of central Haiti,'' said Dr. Paul Farmer, who has dedicated his life to improving healthcare for the poor in an impoverished Haiti and serves as deputy to United Nations Special Envoy Bill Clinton.

The hospital in the town of Mirebalais, 90 minutes north of quake-ravaged Port-au-Prince along a new asphalt highway through the central mountains, was in the planning stages long before the Jan. 12 quake.

EXPANSION SOUGHT

But after the quake killed an estimated 300,000 Haitians -- including nursing students attending classes -- and badly damaged both the nearby public hospital and medical school, Haitian officials asked to accelerate construction and expand the teaching hospital.

No problem, said Farmer, a Harvard medical school professor whom Clinton asked after the earthquake to help coordinate new healthcare facilities and medical care for the Interim Haiti Recovery Commission.

Farmer's Partners In Health, a nongovermental organization that runs about a dozen public hospitals with nearly all Haitian staffers along with Haiti's Ministry of Health, sought the blessing of the commission for the facility. Ground was broken for the hospital on Friday.

``Dr. Farmer's hospital ensures high quality training for more doctors and healthcare workers. It is an example of the significant opportunities that exist to help Haitians to build back better,'' Clinton told The Miami Herald. ``In the coming weeks, Prime Minister [Jean-Max] Bellerive and I are hopeful the Interim Haiti Recovery Commission will approve and fund many more reconstruction projects in order to help create a more prosperous future for the Haitian people.''

A SIGNIFICANT STEP

The hospital's construction is expected to take 18 months, and it is among 29 projects, totaling $1.6 billion, that were approved last month by the commission. Supporters say it's a significant step in what some have criticized as a slow recovery, and symbolizes where the Haitian government wants to go as it rebuilds: decentralizing the teeming capital by building facilities elsewhere, even in communities that were not badly hit by the disaster.

But the project also speaks to the ongoing challenges in achieving that effort. Only $10 million of the $15 million has been funded, and efforts are under way to raise the remaining money.

Despite a show of support for Haiti in the months after the quake, only 18 percent of the $5.3 billion pledged by international donors over the next two years has been disbursed, according to the U.N. Special Envoy's website.

Clinton, who co-chairs the recovery commission with Bellerive, has promised to personally lobby donors. He also has asked commission members to start approving projects in hopes of building donors' confidence and speeding up aid.

Still, the trickling of aid is frustrating, say those involved in rebuilding.

``Haiti is really difficult, but it's not an excuse not to work with the Haitian government, the Haitian people,'' Dr. David Walton, deputy director for Partners In Health, said as he prepped the site last week for the ground-breaking. ``The government is trying but it's difficult when you don't have the resources.''

Walton said it is possible to get things done in Haiti.

``If you have resources, if you have accountability, financial transparency and if you have will,'' he said. ``What Haiti needs is a major medical center in the Central Plateau that can serve complex medical cases. . . . Haiti cannot depend on and should not depend on aid groups to be able to provide medical care.''

TRAINING IS KEY

Haiti doesn't just need a large hospital in the Central Plateau, it also needs to train pharmacists, lab technicians and nurse practitioners, said Dr. Ariel Henry, a neurosurgeon and chief of cabinet for the Health Ministry.

``As a result of the earthquake, we lost health facilities, health training centers and human resources,'' he said, adding that Haiti already had a dearth of technicians and pharmacists before the quake.

Henry said the Mirebalais hospital, which will train these healthcare providers along with doctors and nurses, is among several the ministry plans to build. ``We don't want to put all of our assets in Port-au-Prince,'' he said.

Before the quake, the Mirebalais hospital was supposed to be a modest facility, not that much different from the community hospital Farmer designed in Lascahobas, another village in central Haiti.

That hospital, run by Haitians, cost $700,000. Farmer has always lauded the price in his speeches about how hospitals in Haiti do not need to cost tens of millions of dollars to build.

Then came the Jan. 12 earthquake.

``We just knew that it would not be a good learning environment for . . . clinical rotations,'' Farmer said about the quake-damaged Port-au-Prince general hospital. ``We went and talked to the minister [of health] and some of the deans, and they said build a big hospital, build it three times [larger than] you planned and make it a good teaching hospital.''

Pals reunited in struggle to walk again

Mar 23, 2010
By JoNel Aleccia

CANGE, Haiti -- Carmene Geurrier and Mike Shelove Julmiste were childhood friends before the earthquake, girls from Port-au-Prince who grew up knowing the same games and songs.

Now young women, they've forged an even tighter bond under nearly unimaginable circumstances: both are earthquake amputees, learning to walk on new limbs at a remote medical clinic in Haiti.

"When I'm alone, I'm stressing, but when I have a friend like her, I am happy," says Carmene, 16, through a translator. She lost both legs below the knee on Jan. 12, when her house collapsed.

"I feel the same," says her friend, who goes by Shelove, a 25-year-old who lost most of her left leg when her home crumbled around her.

The pair found each other again at Zanmi Lasante, a small hospital in the rugged mountains of Cange, nearly 40 miles from Port-au-Prince. **Like hundreds of other earthquake victims, they were brought here by worried family members because of the reputation of its founder, Dr. Paul Farmer, a Boston infection control specialist whose organization Partners in Health champions health care in Haiti and much of the developing world.**

Indeed, Shelove says it was "Dr. Paul" who told them to be patient and wait because a medical crew was going to bring them new limbs.

Last week it happened, when a crew from the Hanger Orthopedics Group stationed at the Hopital Albert Schweitzer in Deschapelles came to fit the girls with prosthetic legs.

"I feel OK now because I got my legs," says Carmene, who now sports clear plastic shoes with bows slipped over her two artificial feet. "But if I didn't get the legs, I would not feel good at all."

Before the quake, Carmene was a high school student and Shelove was studying at a local university. The disaster changed everything. Now Carmene lives with extended family in Mirabalais, a city near Port-au-Prince. Shelove's family went to live with extended family, too, but she doesn't know if there's room for her in the home. Like many Haitians, the young women don't speculate about the future, prefering to concentrate only on today. Right now, that means their new limbs.

Carmene is worried about her residual limbs, which are excruciatingly sensitive to the sockets of her prostheses. The slightest pressure makes her wince in pain. Shelove's limb is tender, too, but not so bad. And both girls are determined to wear them.

"They says they want to go dancing," says Will Millien, the handsome Haitian translator speaking to the girls. "I told them, 'I will take you dancing.'"

Helping amputees feel whole again is the reason these hospitals have partnered in rural Haiti, says Dr. Koji Nakashima, a physician in Cange.

Because Zanmi Lasante, which means Partners in Health in Haitian Creole, didn't already have a prosthetics center set up, they invited Hanger teams from the newly formed prosthetics lab at the Hospital Albert Schweitzer to make and fit limbs for amputees and to provide rehabilitation care afterward.

In Haiti, amputees without limbs are likely to be isolated; some never leave their homes.

"When someone gets a prosthetic, they go from wheelchair-bound to walking and from not working to working," Nakashima says.

Every weekend for a month, Hanger teams have made the arduous 100-mile round-trip drive to Cange through the lush Artibonite Valley and up into the rocky hills. Jay Tew, the prosthetics expert leading the project, sets up shop in a church sanctuary, where dozens of patients on mattresses and blankets have filled the tile floor and spilled out into the courtyard.

On this day, a couple dozen people arrive with the swaddled stumps that signal missing limbs. When Carmene and Shelove walk into the room under their own power, Tews stops and gives them hugs and a round of applause. It's a dramatic improvement from when he first met them to take measurements in early March.

"To have someone coming in walking on their own in a matter of two weeks, it made me cry," said Tew, wiping a few hasty tears. Not many amputees are so mobile so quickly.

The girls laugh and tease, strutting across the floor so Tew can see how well they walk. Amputation changed their lives forever, but getting a new limb will help them move forward with confidence -- and even humor.

Carmene, for instance, says she now has a whole new way to test potential boyfriends.

"If any guy is going to try to talk to me," she says. "I'm going to show him my leg first."

The New York Times

The Peanut Solution

September 2, 2010
By Andrew Rice

Like most tales of great invention, the story of Plumpy'nut begins with a eureka moment, in this case involving a French doctor and a jar of Nutella, and proceeds through the stages of rejection, acceptance, evangelization and mass production. The product may not look like much — a little foil packet filled with a soft, sticky substance — but its advocates are prone to use the language of magic and wonders. What is Plumpy'nut? Sound it out, and you get the idea: it's an edible paste made of peanuts, packed with calories and vitamins, that is specially formulated to renourish starving children. Since its widespread introduction five years ago, it has been credited with significantly lowering mortality rates during famines in Africa. Children on a Plumpy'nut regimen add pounds rapidly, often going from a near-death state to relative health in a month. In the world of humanitarian aid, where progress is usually measured in subtle increments of misery, the new product offers a rare satisfaction: swift, visible, fantastic efficacy.

Plumpy'nut is also a brand name, however, the registered trademark of Nutriset, a private French company that first manufactured and marketed the paste. It was not the intention of Plumpy'nut's inventor, a crusading pediatrician named André Briend, to create an industry around Plumpy'nut. Briend, his friends say, was always personally indifferent to money. (Also, apparently, to publicity — he declined repeated requests to be interviewed for this article.) One element of genius in Briend's recipe was precisely its easy replicability: it could be made by poor people, for poor people, to the benefit of patients and farmers alike. Most of the world's peanuts are grown in developing countries, where allergies to them are relatively uncommon, and the rest of the concoction is simple to prepare. On a visit to Malawi, Briend whipped up a batch in a blender to prove that Plumpy'nut could be made just about anywhere.

Others, however, quickly realized that the miracle product had more than just moral value. Nutriset has aggressively protected its intellectual property, and the bulk of Plumpy'nut production continues to take place at Nutriset facilities in France. (Unicef, the world's primary buyer, purchases 90 percent of its supply from that factory, according to a 2009 report prepared for the agency.) Internationally, there has been a vituperative debate over who should control the means of production, with India going so far as to impose sharp restrictions on Plumpy'nut, calling it an unproven colonialist import. Elsewhere, local producers are simply ignoring the patent. **In Haiti, two manufacturers are making products similar to Plumpy'nut independently of Nutriset: one is Partners in Health, the charity co-founded by the prominent global-health activist Paul Farmer.** Partners in Health harvests peanuts from a 30-acre farm or buys them from a cooperative of 200 smallholders. It's planning to build a larger factory, but for now the nuts are taken to the main hospital in Cange, where women sort them in straw baskets, roast them over an outside gas burner, run them through a hand grinder and mix all the ingredients into a paste that is poured into reusable plastic canisters. Peanuts in Haiti and throughout the developing world have a high incidence of aflatoxin, a fungus that can sicken children, especially fragile ones. But Partners in Health says the product, which it calls Nourimanba, is safe.

When I visited one of the charity's outpatient clinics in July, 1-year-old Elorky Decena was silent and listless as a nurse hooked a scale over the clinic's doorway and put him in an attached harness. A month before, he was found to have severe acute malnutrition, a condition characterized by extreme stunting and wasting that afflicts an estimated 20 million children worldwide. The nurse announced that he had gained more than four pounds on a diet of Nourimanba.

Patents are meant to offer incentives to innovators by giving them a time-limited right to exclusively exploit their ideas for profit. But many say that lifesaving products should be treated by a different set of rules. There has been a long and bitter argument, for instance, over the affordability of patented AIDS drugs in Africa. Critics have made a similar case against Plumpy'nut, which is fairly expensive, costing about $60 per child for a full two-month treatment. "We were concerned because of the way Nutriset was managing their intellectual property," said Stéphane Doyon, a nutrition specialist with Doctors Without Borders, a medical charity. "We felt that there was the possibility for the creation of a monopoly."

"Poverty is a business," Patricia Wolff, a St. Louis pediatrician, said. She founded Meds and Food for Kids, the other local producer of fortified nut paste in Haiti. When I first spoke with her in May, Meds and Food for Kids was struggling to raise money to expand its operations, and Wolff complained mightily about the difficulties she faced because of Nutriset's market dominance. "There's money to be made," she said, "and there are people who have that kind of way of thinking." Two months later, Wolff made a tentative deal for Meds and Food for Kids to become a Nutriset franchisee. In the end, she said, she couldn't afford to battle hunger on her own.

In the United States, Plumpy'nut's sole manufacturer and chief promoter is a 38-year-old mother of four from Barrington, R.I. Navyn Salem doesn't have a background in medicine or aid work. She first glimpsed the potential of Plumpy'nut three years ago on "60 Minutes." Since then, Salem has devoted herself to making the product for export to needy nations like Haiti. Though her Providence factory, a joint venture with Nutriset, has all the trappings of a business, selling its wares to relief agencies under the name Edesia Global Nutrition Solutions, the operation is registered as a nonprofit foundation and was established with seed money from Salem and her husband, Paul, a private-equity financier. Dancing along the nebulous line between capitalism and charity, Salem casts herself as a marketer, offering a neatly packaged solution to a tragic and no longer intractable malady. On a Tuesday in May, she brought her message of good news to a Mother's Day benefit in Midtown Manhattan.

"This is not my ZIP code," Salem said as she stood in the East Side Social Club, a wood-paneled restaurant, amid a jostling crowd of bejeweled women pinching noontime flutes of Champagne. She met one of the party's hosts, Lauren Bush, the

former model and niece of the most recent ex-president, a couple of years ago at a conference of the Clinton Global Initiative. Now Bush and her mother, Sharon, were selling a specially designed line of teddy bears — a big one called Plumpy and a small one called Nut — to raise money to purchase the product for children in Africa.

When it came time to eat their own meal, a three-course luncheon, the party guests found seats at tables set with elaborate centerpieces, made up of stuffed bears and Plumpy'nut packets. As volunteers sold raffle tickets for a Dior handbag, Salem delivered a practiced speech. Earnest and attractive, with wide brown eyes, she told the audience that her father, a member of an Indian merchant family, grew up in Tanzania. "There are over a billion people in our world that are malnourished," Salem said. "It's a shocking statistic. The good news is there's a very simple solution." And that, she said, was Plumpy'nut. "It's really revolutionary, because it doesn't need to be mixed with water or refrigerated," Salem continued. "And the most miraculous part is, it will transform a child from literally skin and bones to certain survival in just four to six weeks."

This transformation, seen in before-and-after photos — on one side a sick and wasted child, on the other, a chubby, smiling one — was the promise that captured imaginations far beyond the technocratic community of specialists that originally developed Plumpy'nut. "People love a silver bullet," says the prominent nutritionist Steve Collins. Salem's decision to devote a portion of her family's fortune to the cause was impressive, but she is hardly the only person who was touched by the substance's potential. At the benefit, many of the attendees said they had seen the same inspiring "60 Minutes" segment, in which Anderson Cooper compared the paste to penicillin, concluding that it "may just be the most important advance ever" in the realm of childhood malnutrition. After Salem spoke, she began squeezing dabs of Plumpy'nut onto plates and passing them around, assuring the partygoers that the brownish goo was surprisingly tasty, with the consistency and sweetness of a cookie filling. Everyone ate it right up.

Plumpy'nut proved so palatable and so valuable that it was only natural that other interests were now trying to take a bite. "You want to hear about the bad stuff?" Salem whispered. There was a lot to talk about. Outside the restaurant, beyond the protective cordon of appreciation, rival factions were fighting over a less innocent — though perhaps no less important — issue: who should profit? Plaintiffs were suing, accusing her partners at Nutriset of anticompetitive practices to protect their position atop a $200 million marketplace. Doctors, foreign-aid organizations and agribusinesses were staking competing claims, each invoking the interests of the world's most fragile children. "Forget all the politics," Salem pleads. "I'd like to erase them all." But try as she might, she can't wish away the questions of property and law.

Everyone, it seemed, wanted to own a bit of Plumpy'nut.

At the beginning, the problem was devilishly simple: malnutrition was killing millions in poor countries — it's thought to be responsible for a third of all deaths of children under 5. And yet the global medical community was expending little effort to develop improved treatments. In the early 1990s, the accepted regimen for severe acute malnutrition — a watery mixture fed through a tube — was 30 years old and was unable to prevent the deaths of 20 to 60 percent of patients in hospitals. Frustrated, a small group of doctors began searching for a better way to get nutrients into starving children. One of them was André Briend.

According to legend, Briend hit upon the inspiration for Plumpy'nut one morning at the breakfast table, when, after years of vainly mixing nutrients into cookies, pancakes and yogurt, he opened a jar of Nutella, and the idea came to him: a paste! Like most such stories, this one is not completely true — or rather, it elides many years of false starts, research, scientific collaboration and infighting. The first advance came in the form of F100, a dried high-energy milk that was fortified with a mix of vitamins and minerals that were designed to counter the specific biochemical effects of malnutrition in children. F100 had to be mixed with water, though, which in poor countries was apt to be rife with bacteria. It also tasted unpleasant. As a childhood-nutrition expert attached to a French government institute, Briend came up with the idea of mixing F100 together with peanuts, milk, sugar and oil. The concoction was full of protein and fat, which insulated its nutrients from oxygen and humidity and masked their unappetizing flavor.

The true advance lay not in the formulation, however, but in the way the paste could be put to work. Earlier treatments had to be administered in a hospital setting, which meant a long, expensive stay away from home for both mother and patient, so children were rarely brought in for treatment until they were already extremely weak and susceptible to all the pathogens that lurk in third-world health facilities. What Briend and a few other specialists envisioned was a

treatment that could be administered at home, by families instead of doctors. For medical professionals, this required a radical shift in mind-set. Briend searched the world for someone willing to conduct field tests, cautioning that collaborators in his experiments, as he put it in a 2000 message to a malnutrition Listserv, "should be ready to accept a road with trial and errors."

One doctor who decided to take a risk was Mark Manary, a pediatrician and professor, who was working at a hospital in Malawi. His malnutrition ward was crammed full of dozens of children lying on mats. "It was really an incredible burden," Manary recalled. "These kids are deathly ill, you're doing whatever you can for them, and you think you're on the right track, and then you come in the next morning and four of them have died." Manary emptied out the ward, sending his patients home with Plumpy'nut. Many malnutrition experts were horrified. "It seemed dangerous to them, and it made them afraid," said Manary, who recalled that one eminent figure stood up at a conference and said, "You're killing children." In fact, when the results were analyzed, it was found that 95 percent of the subjects who received Plumpy'nut at home made a full recovery, a rate far better than that achieved with inpatient treatment.

The Malawi test emboldened Doctors Without Borders, which recognized that treating children outside clinical settings would allow a vastly scaled-up response to humanitarian emergencies. In 2005, it distributed Plumpy'nut to 60,000 children with severe acute malnutrition during a famine in Niger. Ninety percent completely recovered, and only 3 percent died. Within two years, the United Nations endorsed home care with Plumpy'nut as the preferred treatment for severe acute malnutrition. "This is an enormous breakthrough," said Werner Schultink, chief of nutrition for Unicef. "It has created the opportunity to reach many more children with relatively limited resources." Nonetheless, Schultink estimates that the product reaches only 10 to 15 percent of those who need it, because of logistical and budgetary constraints.

Briend's invention may satisfy a need, the hunger of children, but that doesn't directly correspond to economic demand, which is set by buyers — the donor nations and international agencies that spend billions of dollars on food aid and famine relief. This is the gap Navyn Salem is hoping to fill. Her mission is threefold. First, her plant manufactures Plumpy'nut for sale. Second, she is trying to use publicity and humanitarian appeals to persuade the customer base — the foreign-aid donors — to allocate more money to purchase and distribute the product. Finally, and most ambitiously, she is advocating the use of Plumpy'nut and a number of spinoff products to address a wider array of challenges, including malnutrition prevention. The broadened market, in theory, could be enormous: The World Bank, in a recent report, recommended that aid agencies scale up their spending on such programs, which currently stands at $300 million annually, to $6 billion a year. The U.S. Agency for International Development, which administers the $2.2 billion Food for Peace program, has been examining the usefulness of Plumpy'nut and products similar to it. American food aid must comply with stringent regulations meant to encourage domestic procurement, a requirement Navyn Salem is perfectly placed to meet.

Salem's interest in philanthropy was intensified after reading a biography of Farmer, the crusading physician, with whom she subsequently traveled to Rwanda, but it took Plumpy'nut to galvanize her thoughts. "We talk about AIDS, tuberculosis and malaria and how detrimental they are, these terrible epidemics, but then I realized that malnutrition was killing more than all of them combined," Salem said. "And we know how to fix it." She didn't know much about famine relief or the insular community of nutritionists who deal with it, but she had a professional background in advertising and marketing, and she wanted to do something that drew on what she saw as her natural entrepreneurial strengths. "I thought, Let's figure out if we can run a business that saves thousands and thousands of lives," she said. Salem's factory, located in an industrial area of Providence just off Interstate 95, cost $2 million to start. In March, right around the time she opened for business, she gave me a tour. The front lobby was decorated with large photos of grinning African children that Salem took on her trips to Rwanda and Tanzania. We donned blue smocks, hairnets and booties and entered the sanitized factory floor, where two workers, a Burundian and a Liberian, were using scoops to weigh out portions of sugar. "Most of our production staff are refugees who were recently resettled in Rhode Island," Salem said. After the Plumpy'nut was mixed, it was run through overhead pipes into a contraption that squirted it into foil packets, which were sealed and ejected onto a conveyor belt, where workers packed them for shipping. In an adjacent warehouse, there were pallets of boxes labeled for delivery to Haiti, Yemen and Nicaragua.

Salem led me to a gleaming stainless-steel tank, which was about as tall as she was and hot to the touch. She opened a door on top, and a fragrant peanut smell wafted out as we craned to look in. "Here it is," Salem said. "The magic stuff."

That magic is the property of Nutriset. To trace how a family-run company based in a small town in the Normandy countryside ended up owning the patent to one of the world's most promising humanitarian interventions, you have to go back to André Briend. He never knew anything about manufacturing food, so at the time he was trying to demonstrate the worth of Plumpy'nut, he signed a consulting agreement with Nutriset, which specialized in making therapeutic milk products. He and the company's founder, a food scientist named Michel Lescanne, were listed as inventors on the 1997 French patent. The patent has since been registered in 38 countries, including much of Africa.

"Michel is a guy who probably holds hundreds of patents, he thinks up things all the time, but he didn't have a viable business" before Plumpy'nut, said Mark Manary, who now runs a nonprofit group that manufactures the product under license in Malawi. "So André and I were all about this as a therapeutic opportunity, and Michel was like, 'This is an entrepreneurial opportunity.' " Lescanne's expertise was invaluable when it came to engineering the taste, texture and shelf life of Plumpy'nut.

For its contribution, Nutriset has been richly rewarded. Last year, the company produced around 14,000 metric tons of Plumpy'nut and related products, more than a tenfold increase over the amount it made in 2004, registering $66 million in sales. The family-owned company has paid out millions in dividends, according to an internal document, although the company claims the money has largely been reinvested in expanding the business. The state institute where Briend did his research receives 1 percent of sale proceeds, Nutriset says, while the inventor himself has renounced any ownership interest.

A few years ago, after some pressure from buyers, Nutriset announced that it would take a more liberal stance on licensing the product — but only in the developing world. Its affiliate network has since expanded to 11 countries, most of them in Africa. But when it comes to Europe and North America, the company has been aggressive about protecting its interests. When Salem first approached Nutriset about obtaining a license to make Plumpy'nut, she says she received a frosty reception, even though her original idea was to build a factory in Tanzania, her father's birthplace. After meeting with Salem and her husband, the company relented, although the plan changed a bit in the process. The locus of their new joint venture, Edesia, was shifted to Rhode Island, so that it could satisfy domestic-sourcing requirements for U.S. government aid.

"Our idea with Edesia is for it to really be an incubator," said Adeline Lescanne, Michel's daughter and the deputy general manager of the company. She said the company was investing its profits in research into a new generation of ready-to-use therapeutic foods, or R.U.T.F., as they are called in the jargon of the foreign-aid community. The new lines would be designed to prevent malnutrition, not just cure it. "It's a kind of pity that there is not a lot of research on new R.U.T.F.," Lescanne said. "There are only people fighting to produce this product."

Nutriset's critics say that line of argument is disingenuous, because the Plumpy'nut patent is so broad as to encompass just about any kind of nut-based nutritional paste. "There are other people that would like to enter into the business," Ben Tabatchnick, who runs a New Jersey-based kosher soup company, said. "But everybody is afraid of being sued." Last year, Tabatchnick went to France to talk to Nutriset about his plans to develop ready-to-use therapeutic foods on a for-profit basis. "I had a meeting with them that lasted about 10 minutes, and they threw me out of the room," he told me. Afterward, Nutriset sent him a pair of ominous letters, indicating that it had found "some similarities" between Plumpy'nut and his product, Nutty Butta.

Nutriset has sent similar saber-rattling correspondence to a number of other potential competitors. Lescanne told me that Nutriset's vigilance over its intellectual property has a benevolent purpose. Between now and the time the patent is scheduled to expire, in 2017, the company wants to focus on building its network of affiliates in countries like Congo, Mozambique and Niger. (Salem's plant in Tanzania is supposed to open later this year.) "We have to protect this network," Lescanne said. "We are a bit afraid that big industrial companies will come." In recent months, to take one example, PepsiCo Inc. has talked publicly about playing "a more decisive role" in bringing ready-to-use foods to needy populations. This has raised hackles: in a recent journal article titled "The Snack Attack," three nutritionists warned that Pepsi-branded therapies would potentially be "potent ambassadors for equivalently branded baby foods, cola drinks and snack foods."

"What we don't want," Salem told me, "is for General Mills to take over and put our Ethiopian producer out of business." Opponents of the patent, however, say that Nutriset is just trying to avoid competition that would cut into its bottom line.

Recently, a handful of companies have set up shop in countries where, because of the vagaries of various treaties, the Plumpy'nut patent is not in force. In the United States, two would-be competitors have taken a more confrontational route. They filed a lawsuit with the federal district court in Washington, D.C., seeking to have the patent invalidated.

The plaintiffs are a Texas-based manufacturer called Breedlove Foods and the Mama Cares Foundation, the charitable arm of a snack-food manufacturer based in Carlsbad, Calif. Both are small nonprofit organizations with strong ties to Christian aid organizations. But Nutriset's defenders suspect that larger corporate interests are lurking in the background. In the French press, the patent dispute has been portrayed as a case of a plucky Gallic company besieged, as Le Monde put it, by " 'légions' Américaines."

In fact, there is a not-so-hidden instigator behind the case: the American peanut lobby. A few years ago, a Unicef official gave a presentation to an industry trade group, forecasting dramatically increasing demand for peanut pastes. That got the growers excited. They looked at Nutriset's patent and came to the conclusion that, as a technical matter, Plumpy'nut was really nothing more than fortified peanut butter. "People have been making this stuff for centuries," Jeff Johnson, a board member of the Peanut Institute, said. "It's nothing new." Johnson is the president of Birdsong Peanuts, one of the country's largest shelling operations. Through a friend, he heard about Breedlove Foods, which was based in Lubbock, close to one of his processing plants. Johnson met with the company and proposed a challenge to Nutriset.

"It's a cotton-pickin' shame that they decided to take the stance that they have with the intellectual-property issue," said David Fish, Breedlove's chief executive, whose lawsuit contends that the patent is hurting starving children. But even some Nutriset critics have questioned the motives behind the lawsuit, pointing out that America has a long and controversial history of dumping its agricultural surpluses on poor countries through food aid. "If you want to develop countries out of third-world status," Fish replies, "they've got to come out and compete on the open market."

Plumpy! Plumpy!"

With the shouted order from Rosemond Avril, an agent of a charity group, workers began unloading cardboard boxes full of foil packets from the back of a rusty blue truck. It was a sweltering Haitian morning, and next to a hive of canvas tents, the women of Bineau-Lestere were lined up beneath the branches of a gnarled quenepa tree. They were a handful of the millions displaced by last January's earthquake, which had turned the nearby city of Léogâne into a jagged pile of concrete. Their camp, thrown up amid fields of sugar cane, was surviving on aid. On this morning, the U.N.'s World Food Program was distributing Supplementary'Plumpy, a slightly weaker formulation of the original product, to mothers with children between 6 months and 35 months.

Haiti wasn't starving, but experts were still concerned about the perilous condition of its children. Even before the earthquake, an estimated quarter of them were chronically malnourished, and now many breadwinners were dead, livelihoods disrupted and much of the country's commercial infrastructure destroyed. By administering Supplementary'Plumpy to children in the age group most vulnerable to severe malnutrition, the World Food Program was trying to keep a bad situation from turning into a crisis. Across Haiti, the agency was distributing such aid to 500,000 people, and the results of a survey suggested that malnutrition levels had remained stable. "This is all new," said Myrta Kaulard, country director for the World Food Program in Haiti. "It's preventative action."

Darting around the scrum of women and toddlers, as a relief worker announced instructions in Creole through a bullhorn, Navyn Salem snapped pictures with her Nikon. She looked on with satisfaction as one jug-eared little boy ripped open a packet and squeezed the light brown paste into his mouth. She clicked the photo, and before long it was on its way to the Facebook page of Edesia Global Nutrition Solutions.

Salem had flown to Haiti a few days earlier aboard a private jet, lent by her husband, on a characteristically blurry mission: part sales call, part fact-finding tour. Edesia was sending its products to agencies in Haiti, the World Food Program among them, but what interested Salem most was the prospect of using ready-to-use foods to address conditions beyond severe malnutrition. She and Maria Kasparian, her second-in-command at Edesia, were shuttling from one charity to another in a loaned van, carrying boxes of free samples and brochures promoting three products designed to be taken as daily supplements. "Everyone knows Plumpy'nut," Salem said before the trip, "but what we're really trying to do is push these others, to address malnutrition sooner."

Scientists have shown that there is, in the words of The Lancet, “a golden interval” for childhood nutrition that occurs before the age of 2. “This is the period when brain growth is very extensive and babies are developing their immune systems,” said Kathryn Dewey, a professor in the department of nutrition at the University of California, Davis. Stunting that persists after age 2 is generally irreversible, while improved nutrition in early childhood correlates to greater educational success. One study, in Guatemala, showed that boys given a nutritional supplement as babies made 46 percent higher wages as men. Dewey has been testing whether Nutributter, one of Nutriset’s new (and patent-protected) products, might achieve similar results. “There has to be a way to break the cycle of poverty and malnutrition that has plagued these populations for hundreds and hundreds of years,” she said. “That’s the more grandiose vision of where this is headed.”

In Haiti’s Artibonite Valley, Ian Rawson, the managing director of the Hôpital Albert Schweitzer, took Salem to see malnutrition inpatients — “our failures,” he called them — in a dimly lighted ward where they lay beneath a mural of parrots. Many of the children were unnaturally small and had patchy, orange-tinted hair, a classic sign of protein deficiency. “This,” Rawson said, waving a packet of Plumpy’nut, “is our immunization.” He was applying for a U.S. government grant to distribute Nutributter in the surrounding mountains, where poverty is dire, 9 out of 10 adults can’t read and acute malnutrition rates can top 35 percent. “It seems simple to me,” he said. “What’s the downside to me giving every child who’s over 4 months old a tube of Nutributter per day?”

Advocates of the preventive approach foresee a future in which children around the world consume a daily packet of nutrient-filled paste. “It’s not just for poverty-stricken people,” Salem said. “It’s just like I give my children a multivitamin.” Of course, this changes the nature of the intervention from an emergency treatment to a habitual routine and also dramatically escalates its prospective cost to donors. As a practical matter, Salem says, supplements will probably have to reach children through consumer markets, perhaps with subsidies. Edesia is conducting testing in Tanzania to see whether Nutributter could be sold in stores.

Some experts, however, warn that enthusiasm may be running ahead of the science. “In their rush to be innovators, I think a lot of agencies are using ready-to-use supplementary foods without evidence,” said Steve Collins, who was a pioneering advocate of home-based care for severe malnutrition. “I wouldn’t want to see a new world order where poor people are dependent on packaged supplementary foods that are manufactured in Europe or the United States.”

His wariness reflects a larger ideological divide over the proper distribution of profit. Nutriset says it is committed to opening more developing-world franchises, a strategy that brings down shipping costs and hence prices, but the majority of its network’s inventory still comes from France, and now, with the entry of Edesia, Nutriset is going to be expanding exports from the United States. Collins asks, “How are they addressing the need for poor people in Haiti not to be dependent on outside intervention in the first place?”

This question hung, unanswerable, over Salem’s journey through Haiti. Salem went there with a promise to donate a shipping container filled with $60,000 worth of Nutriset-patented products to Partners in Health, the charity run by her friend Paul Farmer. While grateful, the organization still preferred to manufacture its own product, Nourimanba, with the profits accruing to local farmers. But even this program was more a principled exercise than a development strategy. Haiti’s endemic problem of malnutrition wasn’t something you could solve with peanuts. Partners in Health also took Salem on a couple of home visits. At a one-room shack in Cange, a mother presented her 3-year-old daughter, saying she had gained 11 pounds on a regimen of Nourimanba. But the mother complained that there was no help for other serious problems she faced, like the fact that she had no job and the tin roof of her shack leaked.

Out in the hills, down a muddy path shaded by coconut palms, the health workers checked in on a small wooden farmhouse. Two children living there were on a regimen of ready-to-use food — and six were receiving nothing. The older ones watched as their little sister wolfed down an entire cup of peanut paste for the benefit of the visitors. The children’s grandmother, who was looking after them, was asked why malnutrition had been diagnosed in these two and the others not. She said she couldn’t really say, except that there simply wasn’t enough food to go around. There was no foil-wrapped answer to the maddening persistence of poverty. All that existed was a determination to meet the challenge with all the fallible tools of human ingenuity.

“We’re trying to put ourselves out of business,” said Salem, still brimming with optimism, after the trip. “That would be the best-case scenario.”

Andrew Rice is a contributing writer and author of “The Teeth May Smile but the Heart Does Not Forget,” about a Ugandan murder trial.

Giving Donations that Transform Haiti

February 24, 2010
By Katherina Rosqueta and Carol McLaughlin

Haiti has already begun to fade from the headlines. But for individual donors, the real opportunity to have impact has just begun.

As Haiti transitions from rescue and relief to recovery and rebuilding, the most lasting change will come from nonprofits with at least one of two characteristics. The first is specific expertise in moving from immediate disaster relief to mid-term recovery to long-term development. The second is experience and a track record of results operating on the ground in Haiti. Both of these characteristics indicate a capacity for sustainable impact. In other words, supporting these models ensures that the impact of your donations will stick long after the headlines and the celebrity appeals end.

The extreme poverty that existed in Haiti before the earthquake has made all efforts to help - including philanthropic ones - especially challenging. Haiti will need much more than high impact philanthropic capital to address its needs. However, the models and agents we describe below are focused on areas that represent the three pillars of effective development: health, education and

livelihood. All address both mid-term recovery and long-term development, and all have operations on the ground in Haiti.

Health - Comprehensive primary healthcare systems in Haiti have demonstrated impact in improving the health and well-being of the populations they serve, especially children. These programs utilize community health workers, mobile clinics and health educators to reach each household. They deliver both effective prevention, like immunization and clean water, and medical treatment. In addition, they are linked to quality clinics and referral hospitals when more advanced care is needed, such as trying to save a mother's life during complicated child birth. By emphasizing primary and preventive care, these programs can be not only highly effective but also highly cost-efficient. **Two organizations currently implementing successful systems in Haiti are: Hôpital Albert Schweitzer and Partners in Health. Philanthropic capital can strengthen and replicate these models throughout the country.**

Education - In areas affected by the earthquake, the focus now is to move beyond basic child protection and emergency schooling to a more permanent education system. With an estimated 40 percent of the population lacking literacy skills prior to the earthquake and many schools destroyed in the last month, the education system needs not only physical rebuilding, but also investments to improve the quality and reach of schools. New teachers will need to be recruited to replace those who died. All teachers will need improved professional development and training to address the psychosocial needs of traumatized children. As in every country, a better educated society will be essential to effective economic development and a more accountable government. Two organizations that were first on the scene to address the needs of children are: Save the Children and the International Rescue Committee. They have already been planning for transitions to temporary and permanent schooling.

Livelihood - Long-term poverty reduction in Haiti will depend on developing the human capacity, resource base, and environmentally sustainable opportunities for Haitians to earn a living and take care of themselves. This last issue is important as Haiti has one of the highest rates of deforestation in the world. Two models that philanthropists can support are cash-for-work programs and graduated micro-finance programs focusing on the marginalized poor, especially rural women. Cash-for-work programs address multiple levels: near-term, they're a way to clear the rubble and get young men actively engaged in clean-up operations; mid-term, they get cash into the economy and build self-sufficiency; and long-term, they provide job skills and community bonds needed for lasting recovery. Mercy Corps' cash-for-work program was instrumental in Aceh after the Tsunami. They now have a new program underway in Haiti. Graduated microfinance programs target the most marginalized by providing not only access to loans and financial services, but also access to basic literacy and business skills, start-up assets, like cows and chickens, and access to markets so that local enterprises can succeed. Fonkoze is Haiti's largest micro-finance organization. Its mission is to build the economic foundation for democracy in Haiti by providing the rural poor - mostly women - with the tools they need to lift themselves out of poverty. They offer a full range of financial services to the rural-based poor, currently reaching more than 225,000 savers and borrowers.

Every disaster is different. However, these models and agents have all been able to match their activities to the specific needs on the ground in Haiti. Equally important, they quickly involved Haitians in their own recovery and rebuilding. Research, experience from other disasters, and common sense all point to the latter as key to sustainable impact. And ultimately, that's what most donors aspire to - a positive change that continues even after they've moved on. Attention is already moving on from Haiti. By supporting these models, donors can make sure their impact sticks.

Los Angeles Times

Aid workers scramble to contain Haiti cholera outbreak

October 23, 2010
By Joe Mozingo

Doctors and aid workers scrambled Friday to rein in a cholera outbreak in central Haiti that has killed 140 people, while warning that the crisis probably would get worse in a country where tent camps are still teeming with people displaced by the January earthquake.

"There's no reason to anticipate that this wouldn't spread widely," said Joia Mukherjee, chief medical officer for Partners In Health, a Boston-based relief organization that runs three hospitals in the area.

The acute bacterial illness, spread primarily through contaminated drinking water, has struck more than 2,000 people throughout the farming valley along the Artibonite River, with the highest number in the port city of St. Marc.

Officials feared the disease could reach the capital, Port-au-Prince, 55 miles to the south, where hundreds of thousands of people are living in fetid conditions in the camps.

This is the first outbreak of cholera in Haiti in more than a century. It is unclear whether the massive displacement of people to the Artibonite Valley after the earthquake may have created the unsanitary conditions that allow such a disease to spread. But Haiti's public water system has long been one of the worst in the world, and health officials have perennially warned of an epidemic.

The World Health Organization says less than half the country uses "improved drinking water sources," and a 2008 Partners In Health report found that 70% of Haitians lacked continuous direct access to clean water.

Cholera causes such severe diarrhea and vomiting that people can die of dehydration in little more than a few hours. It spreads rapidly when infected fecal matter enters the water supply.

Speaking via a teleconference, Mukherjee said officials have confirmed that the water of the Artibonite River was one source for the contamination, but expected there to be others.

"The wells in St. Marc are too shallow and contaminated with sea water as well as surface waste water," she said.

Despite fears that the disease could reach the densely populated capital, Mukherjee said it was harder to end an epidemic in rural areas, where people are scattered and get their water from myriad sources. Most of the displaced people in tent camps in Port-au-Prince have access to clean water provided by relief organizations, said Julie Schindall, spokeswoman for Oxfam, which she said provides an estimated 315,000 people with clean water.

The cluster of international groups responsible for water and sanitation in the wake of the earthquake met in St. Marc on Friday to coordinate a response.

"It's going to take a serious mobilization," Schindall said. "Luckily, we have a lot of stock in the country."

Jon Andrus, deputy director of the Pan American Health Organization, said the disease was relatively simple to treat, with drinkable salt solutions that help rehydrate patients and reduce the risk of severe diarrhea. The best way to prevent infection is to keep food and water clean and wash hands often.

He said Haitians may be more vulnerable to widespread infection because they lack resistance to the disease. It was unclear how the bacterium was introduced after so long an absence.

Andrus said the first "suggestion" of the disease emerged Sunday, with reports of an abnormally high number of diarrhea cases in the area. It was later determined to be cholera.

He said his group was sending epidemiologists from Port-au-Prince and outside Haiti to deal with the outbreak.

Cholera kills between 100,000 and 120,000 people worldwide every year, often in regional epidemics. This month, an outbreak in central Africa has killed 1,879 people. The disease was absent from the Western Hemisphere until 1991 when it killed nearly 3,000 people in Peru and spread throughout Latin America.

Haiti's cascading crises come down to lack of clean water

November 19, 2010
By Donna Leinwand

Aid workers in Haiti say the government has done little to improve water and sanitation since a Jan. 12 earthquake, making it likely that the cholera epidemic there will continue to spread.

"The situation has deteriorated. We really need a massive push of political will," says Joia Mukherjee, medical director of Partners in Health, which is helping the Haitian government halt the outbreak that has killed more than 1,100 people. "This can't just be about handing out water purification tablets."

DISEASE: Cholera likely to grip Haiti for months

Haiti's leaders must expand the country's treated water and sewer systems to prevent future outbreaks of waterborne diseases, Mukherjee says.

Oxfam, an aid group focused on water and sanitation, says it's still operating in emergency mode instead of creating permanent water and sewer systems.

"The government does not have a plan," says Oxfam spokeswoman Julie Schindall. "We need them to make decisions."

Installing permanent systems is less costly than delivering emergency water, Schindall says. A $5 million water system that Oxfam built recently in Cap-Haitien serves 100,000 people and will last

decades, Schindall says. In contrast, Oxfam has spent $30 million in nine months providing emergency water from tanker trucks and water bladders to 316,000 people, she says.

"Putting in the most basic infrastructure is what will keep people safe in Haiti," she says.

The U.N.'s water and sanitation group had planned water and sewer projects to expand the piped water system and move Haitians away from emergency water. They await government approval.

"I think the cholera epidemic is taking our eye off that right now," says Mark Henderson, chief of the UNICEF Water, Sanitation and Hygiene program in Haiti. "It's definitely set us back."

Political pressure following the outbreak may jolt the government into action, he says.

"They understand that water is a basic need. They recognize it's a good vote-getter," Henderson says. "But sanitation has never been seen as a sexy thing."

Before the quake, more than a third of Haitians lacked access to clean water.

Haiti has a national water and sanitation authority, but the office's reach is limited.

Many people purchase their water from privately owned kiosks and water trucks, paying by the bucket.

Many of those informal water supplies are not chlorinated, says Henry Gray, emergency water and sanitation coordinator for Doctors Without Borders, who tested five private supplies this week and found only one had been treated.

"Latrine building in Port-au-Prince will be a massive undertaking," Gray says. "It's got to be an absolute priority."

Access to clean water has declined since the initial surge after the earthquake, says Louise Ivers, chief of mission in Haiti for Partners in Health. After the earthquake, hundreds of aid groups set up temporary systems or trucked in water to for nearly 1.5 million Haitians left homeless in Port-au-Prince. Water provision was "one of the strongest successes after the earthquake" that emerged in Port-au-Prince, Mukherjee says.

"It's not surprising that there's a large diarrhea outbreak," she said.

After the earthquake, with people living in densely packed camps, the U.N.-led groups in charge of sanitation "gave up on meeting the international standard of 20 people per latrine," Ivers says. "They couldn't find the physical space. There was no place to dig the latrines."

Less than one-fifth of the population has access to a simple latrine or toilet, Henderson says.

In the Artibonite area, where the cholera epidemic began, most people use the Artibonite River for bathing, drinking and going to the toilet, and do not have access to chlorinated water that could kill the cholera bacteria. Many of Port-au-Prince's slums have no running water or sewer systems.

"The conditions in which people live here make them incredibly vulnerable," says Imogen Wall, spokeswoman for the United Nations Office for Coordination of Humanitarian Affairs. "Sanitation in the camps has been a concern since Day One."

The Philadelphia Inquirer

With them all the way

March 11, 2010
By Carolyn Davis

Mar. 11--Naomi Rosenberg was washing dishes in her Center City apartment when she got a text message from a friend at Partners in Health, the international medical-aid organization she worked for in Haiti.

"Turn on the TV," the message read.

Rosenberg flicked on the news the evening of Jan. 12.

"The second I heard 'natural disaster' and 'Haiti,' I knew it would be bad," she says. "Bad things that happen in the world get magnified in a place as poor as Haiti."

Unfortunately, Rosenberg was right. A 7.0-magnitude earthquake leveled most of the capital of Port-au-Prince. An estimated 223,000 people died and countless others were injured as poorly constructed buildings collapsed over several days. About a million people are still homeless.

As she sat in her apartment watching scenes of destruction, the 28-year-old, second-year Penn medical student didn't ponder her next move.

She called the Boston headquarters of Partners in Health (PIH) and offered to help, acting on a conviction that she and her older sisters learned from their parents.

"When things happen," Rosenberg explains, "you show up."

Rosenberg did far more than show up. She found local hospitals willing to take patients, arranged takeoffs and landings in two countries, and navigated federal agencies and immigration laws. She is still guiding patients through the health-care system.

And she's put medical school on hold.

Growing up in Bethesda, Md., Rosenberg always considered a career in medicine. You could call it a genetic predisposition: Her father, Steven Rosenberg, is chief of surgery at the National Cancer Institute and her mother, Alice, is an HIV/AIDS nurse at the National Institutes of Health.

In her early 20s, while a premed student at Bryn Mawr College, the direction of Rosenberg's life changed after she read Mountains Beyond Mountains by Tracy Kidder, a book about physician Paul Farmer's drive to bring top-notch health care to the poor in Haiti and elsewhere.

Farmer's philosophy of accompanying patients through treatment and healing, of walking others through times of need, inspired her, as did his approach of engaging entire communities in those efforts.

Rosenberg ended up traveling the world with Farmer as his assistant. Now, Farmer is a fan of hers.

"She has this ability that is both rare and necessary," he said after returning from Haiti recently. "She understands the magnitude of a problem like an earthquake, and then locally, she's driven to follow through on details for patients."

Rosenberg went to Boston the day after the quake, then returned to Philadelphia to find hospitals able to accept critically injured victims.

She asked the hospital she knew best -- the Hospital of the University of Pennsylvania (HUP) -- and turned to a pair of its influential physicians.

"Would you be able to get HUP to accept trauma cases for free care if they can be transported out of Haiti in the next 24hrs? Perhaps 2-4 cases?" Rosenberg wrote in an e-mail to Richard P. Shannon, chair of the University of Pennsylvania's Department of Medicine, and Roger A. Band, assistant professor of emergency medicine.

They answered yes. So did Children's Hospital of Philadelphia and St. Christopher's Hospital for Children.

Her apartment became a logistical hub as she juggled calls with federal officials from several agencies, PIH colleagues, and the evacuation team. Over the next two weeks, she orchestrated two trips and the transport of 11 Haitians.

Erik Bartkowiak, an emergency-flight nurse who donated his services and equipment, was awed by her efforts.

"I've been doing these international repatriations for 12 years and they are not easy in normal circumstances," Bartkowiak says. "Somehow this 28-year-old girl with no experience in this whatsoever was able to . . . get these people into the United States."

The three women and four children, each escorted by a parent, arrive at local hospitals and Rosenberg throws herself into accompanying them through the next stage.

Rosenberg, who speaks Haitian Creole, interprets questions from the doctors. Because of their crush injuries, the women would have to undergo leg amputations. Rosenberg is waiting for them in the recovery room after surgery, "just to be with them when they wake up."

As they convalesce, Rosenberg turns her attention to preparing a house in Germantown, lent by a local Haitian church, where the quake survivors will live while receiving outpatient care. She manages the PIH budget for renovations and living expenses. PIH also will give her a paycheck at some point.

It's late February and Rosenberg sits at a table in the HUP cafeteria nibbling sushi from a plastic to-go container as she checks e-mail on her laptop.

Celine Gay, 27, calls Rosenberg to ask if she is coming to her room before Gay is discharged.

"M'ap vini, cheri," Rosenberg says. I'm on my way, dear.

As Rosenberg walks there, she talks on the phone to a hospital worker who wants her to sign papers and then to the ambulance company that will take Gay and another woman to the Germantown house.

When Rosenberg reaches the hospital room, Gay is anxious. A nurse goes over discharge papers with Rosenberg, who stops the conversation to translate into Creole. Gay relaxes.

Afterward, Rosenberg heads to Good Shepherd Penn Partners, which operates a rehabilitation hospital at 18th and Lombard Streets, where 21-year-old Sherline Pluriose also awaits discharge.

Most of Pluriose's belongings are in hospital-provided plastic bags on the floor.

"This is my worst nightmare right here -- moving with 200 bags," Rosenberg says half-jokingly. "I can't blame anyone other than me. I should have known to buy extra suitcases."

Rosenberg sits down heavily on a folding chair at the table in the Germantown kitchen. She's tired.

"I don't sleep well," she says. "I have earthquake nightmares."

Her parents understand the emotional toll.

"It's hard to imagine it wouldn't have a severe emotional impact on her," says her father. "But she's strong and she keeps going."

Her mother says her youngest always had a tenacious streak.

"She wasn't well-coordinated as a child, so trying to catch a ball was hard. Her vision wasn't good," she remembers. "That didn't stop her from playing on a softball team."

Rosenberg's current team is made up of workers, volunteers, and friends of PIH. Support staff such as local contractor Israel Martinez (a "real hero," says Rosenberg), who renovated the house in less than a week, delivering far more than what PIH paid him and his crew to do.

She also counts on HUP nurses Darlene Rosier and Kerlange Mentor, Haitian Americans who helped treat the women patients and also befriended them.

The "volunteers extraordinaire," as Rosenberg calls them, still visit the women at the house and help however they can.

"We're friends now, we're part of the family," Rosier says of her fellow Haitians.

Nearly two months after the quake, there have been some unexpected health problems, but all of the airlifted patients have been discharged from the hospital.

Recently, Gay nimbly leaned on a crutch as she swept the kitchen floor and chatted with the others, none of whom knew each other until they met in Philadelphia.

Five-year-old Given Dorsinde, who suffered burns and broken bones in the earthquake, was discharged this week. Betina Joseph, 5, who was near death in Haiti, survived tetanus and is full of playful energy.

Fifteen-month-old Angelo Joseph is healthy and tottering around the house after a near-fatal bout with pneumonia. His father, Maudelaire Joseph (no relation to Betina), watches over him and helps in the house, quietly mourning his wife's death.

He searched for days through rubble for her. Only her Haitian identity card was found.

Joseph, in broken English, says he is grateful to everyone in Philadelphia who has helped him and his son. He gives special thanks to Rosenberg: "My son is safe now, so I am safe."

Rosenberg will wait until January to resume school and begin her clinical rotations. For now, she is not finished accompanying her Haitian patients.

"People say, 'Naomi, detach.' I'm not a martyr, I know how to take care of myself," she says. "But that doesn't include not showing up

The New York Times

In Haiti, Mental Health System Is in Collapse

March 19, 2010
By Deborah Sontag

PORT-AU-PRINCE, Haiti — Inside this city's earthquake-cracked psychiatric hospital, a schizophrenic man lay naked on a concrete floor, caked in dust. Other patients, padlocked in tiny concrete cells, clutched the bars and howled for attention. Feces clotted the gutter outside a ward where urine pooled under metal cots without mattresses.

Walking through the dilapidated public hospital, Dr. Franklin Normil, the acting director, who has worked there for five months without pay, shook his head in despair.

"I want you to bear witness," he told a reporter. "Clearly, mental health has never been a priority in this country. We have the desire and the ability, but they do not give us the means to be professional and humane."

As disasters often do in poor countries, Haiti's earthquake has exposed the extreme inadequacies of its mental health services just at the moment when they are most needed. Appalled by the Mars and Kline Psychiatric Center, the country's only hospital for acute mental illness, foreign psychiatrists here have vowed to help the Haitian government create a mental health care system that is more than just an underfinanced institution in the capital city.

"Conditions at Mars and Kline are particularly bad, although this kind of place is not unique to Haiti," said Dr. Giuseppe Raviola, director of mental health and psychosocial services for the Boston-based Partners in Health, which runs 10 hospitals in Haiti. "Still, now that we've

seen the hospital in the capital city, it is clear that that we have to treat people in their communities."

Ultimately, international experts are encouraging the Haitian Health Ministry, which they say is receptive and eager for help, to incorporate mental health care into the primary health care system and to make it available throughout the country.

Right now, though, the need for psychological first aid and emergency psychiatric treatment is so acute that foreign psychiatrists are seeing patients, setting up programs and rapidly training Haitian doctors, nurses and community workers in everything from psychopharmacology to group relaxation techniques. (Before the quake, there were only about 15 psychiatrists in all of Haiti.)

The foreign psychiatrists emphasize that they have found Haitians to be impressively resilient, but the disaster has nonetheless set off reactions ranging from anxiety through psychosis. Most worrisome are cases like that of Guerda Joseph, a 41-year-old woman who tumbled into a catatonic depression shortly after she was pulled from the rubble of her home. Mute and nearly immobilized ever since, she lies on floral sheets at the General Hospital, her Bible tucked beside her pillow, her 25-year-old adopted son by her side day and night.

More common, though, is what Dr. Lynne Jones, a child psychiatrist and disaster expert with the International Medical Corps, calls "earthquake shock," a persistent sensation that the earth is still shaking, which makes the heart race and causes chest pain.

"This is an understandable response, and it's important to let people know, 'You are not crazy,' " Dr. Jones said. "I use a kind of metaphor: 'Your body has a very effective fire alarm. One of the reasons you're alive today is that it went off during the earthquake. You ran out of that building. Great, you survived. Unfortunately, the fire alarm is now sensitive and goes off when you don't want it to, or maybe it never shut off.' "

For those with a history of mental illness, the earthquake has been especially destabilizing. Many lost homes, caretakers and medication supplies, and the institutionalized were displaced, too.

Mars and Kline, partly damaged, evacuated most of its 100 acutely ill patients; only some have returned. And the sole hospital for chronic mental diseases, Défilé de Beudet in Croix-des-Bouquets, seriously damaged, shifted scores of patients to the grass outside.

Inside Mars and Kline's walls, neighbors have established a tent city, festooning the 52-year-old psychiatric hospital's facade with laundry. Their presence has created a security nightmare for the institution's guards, said Louisner Aubin, the administrator, given that patients have returned from the earthquake especially agitated and sometimes violent.

"We have to lock up the worst cases to keep the worst from happening," Mr. Aubin said.

Also in the courtyard are two psychiatric triage tents where more than 100 people are showing up daily, reporting extreme stress and post-traumatic symptoms of nightmares, memory lapses, sleep disturbances and loss of appetite, Dr. Normil said. Some, with psychoses, have been admitted, and more will arrive needing admittance, he said.

“We’re in a crisis situation,” he said. “Even before the earthquake, we did not get the resources to feed or clothe our patients properly. We had barely any staff, and these are patients who could be rehabilitated if we had the means.”

Leaving Mars and Kline to walk to the nearby General Hospital, Nicholas Rose, a psychiatrist from England, said, “It’s straight out of Hogarth, really,” referring to the 18th century engravings of an insane asylum by the artist William Hogarth.

In and around the two hospitals, apparently mentally ill men wander the streets, ragged and filthy. One sits naked atop a pile of rubble, another wears caked mud.

At the General Hospital, foreign psychiatrists say that they are seeing several new cases daily of psychosis, severe depression and other disorders. Guerline Présumé, a formerly mild-mannered young mother, was admitted a few weeks ago for what was diagnosed as a manic disorder. On the day of the earthquake, she ran from a collapsing house that killed her older sister and disappeared, screaming, into the streets. It took her husband a month to find her; when he did she was muttering and spitting obscenities.

“The earthquake drove her crazy; it’s that simple,” her husband, Wilkinson Charles, said, adding that he feared she had been “taken advantage of” while living without him on the streets.

Many with less severe issues are seeking help at the medical clinics in the big tent cities, like the one in Pétionville, where Dr. Jones and a psychiatric colleague, Peter Hughes, ran a mental health clinic one day last week while simultaneously training a Haitian internist.

“Remember, these are not our patients, these are your patients,” Dr. Jones said to Dr. Charles Samuel, the internist. “We are going to teach you so that you can carry on.”

The doctors saw Jean Pierre Francillon, shy and smiling, who was suffering high blood pressure and complained of trembling and heart palpitations; Ketie Kledano, 52, who said she was anxious, plagued by headaches and could not sleep or eat; and Naomi Joseph, 8, who wore a pink camouflage “USMC Cutie on Duty” T-shirt and, according to her mother, “spits, spits, spits” all day long.

There were some cultural and linguistic barriers. After Dr. Samuel said of Mr. Francillon, “The truth is what he’s talking about is not serious. It’s a reality that goes along with being Haitian,” Dr. Hughes tried another approach. He explained the theory of the bodily fire alarm and told Mr. Francillon, “You’re not mad,” which the Creole interpreter delivered as, “You’re not angry.”

Leading Mr. Francillon to a cot, where he slipped off his mud-caked black loafers, Dr. Jones guided him through a relaxation exercise. Trying to get him to visualize a calming moment, she asked, “Have you ever sat in the ocean and had the water wash over you?”

“Not often,” he said.

Q&A: Addressing Mental Health and Trauma in Haiti

May 3, 2010
By Talea Miller

Eddy Eustache is a priest and psychologist who serves as director of mental health and psychosocial services for Partners in Health in Haiti. He responded to the NewsHour's questions by e-mail, from Port-au-Prince.

Q: What are the most common mental health challenges you are seeing in Haiti at this point?

Almost four months after the earthquake we are seeing people having various kinds of emotional distress responses. These include difficulty sleeping, heart palpitations, somatic complaints, and significant sadness, worry and anxiety. Some of these can be seen as normal reactions to a highly abnormal situation. However, the level of distress for many is severe. We also see people who have developed psychotic reactions, and other more acute mental health problems, since the earthquake.

One major challenge [to addressing mental health needs] is a general lack of services in Haiti to address significant mental health problems. Haiti had few mental health professionals, and limited organized mental health services prior to the earthquake. There was not a clear understanding of the prevalence of mental health problems in Haiti prior to the earthquake, but we can expect that the mental health dimensions of the earthquake, overlaid on the pre-existing issue of poverty, will have significant ramifications for mental health. Our hope is to further develop the services needed to assist with such problems, in a culturally appropriate way, for the long-term.

Q:Can you give examples of some of the cases you are seeing?

There are people walking and lying in the streets who are hallucinating, disoriented and frightened, some likely unwell prior to the earthquake, but some also exacerbated by the current circumstance.

We have had one instance of children jumping out of school windows when a truck passed by, startled by the rumbling of the ground, and requiring medical attention for their injuries. When we have visited schools we have met many children who were living in Port-au-Prince, now living in rural areas, who have been very unsettled both by experiencing the earthquake itself, but also by the loss of family members, displacement and the general level of uncertainty in their lives.

In our clinics we have seen many people presenting with physical symptoms that most likely represent emotional distress, but are also associated with medical illness, lack of water, food, shelter, and sense of safety. Everyone has been profoundly affected by the earthquake, the loss is incomprehensible, and people are coping as well as they can in the current situation.

Q: How are mental health workers trying to address the needs?

Interventions are needed that respect people's capacity to recover from such an event, that do not pathologize normative responses to such a terrible circumstance, that do not risk harm to individuals, that have some evidence for their efficacy, and that are appropriate to the Haitian context.

At Zanmi Lasante [Partners in Health] we have expanded our team to 17 psychologists from three prior to the earthquake, and to more than 50 staff focused exclusively on mental health and psychosocial services. We have been working … to provide communal opportunities for mourning, to develop community-based supportive interventions in collaboration with schools and churches, and we have expanded basic clinical services.

This has included training of doctors and nurses in management of acute mental health problems, and planning for expansion of the system of care to include community health workers attuned to mental health, and development of effective referral networks to providers.

Q: How much attention is mental health receiving from NGOs and the government?

Haiti has an important opportunity to develop community mental health services, and the Haitian Ministry of Health has expressed a strong interest in developing such services. Mental health is one significant issue among many. Basic needs must be met, and these include shelter, nutrition, and health. The government and NGO's are working to meet these, and there has also been general agreement that working to meet mental health needs is a high priority.

Q: For a disaster on this scale, what can we expect in terms of mental health challenges six months from the earthquake, and down the road a year or two?

We have never dealt with a natural disaster of this scale in Haiti… we can expect many people, once their basic needs are met, to recover from the losses involved. But we can also expect that current events may be unprecedented in terms of promoting emotional difficulties in the population. The slower the reconstruction effort, particularly with regard to addressing basic needs, the higher the risk is and will be for the development of mental health problems.

The Philadelphia Inquirer

Mending bodies and changing attitudes in Haiti

May 16, 2010
By Michael Matza

LASCAHOBAS, Haiti, May 16, 2010- She awoke before dawn in the one-room shack she shares with four family members and began to dress.

She straightened the bandage on the stump of her left arm and donned a denim skirt and white sleeveless blouse.

She slipped on sandals and pink stud earrings.

Then she walked half a mile up the dirt road to the village center and squeezed into a cab for the jarring ride to get a new left arm.

"It's a big day for me," said Sonia Donatien, 32, anticipating the two-hour trip to the regional hospital where American prosthetists are mending victims of Haiti's earthquake. "I lost an arm. I am going to replace it."

Three months ago, Donatien's crushed arm was removed in a delicate operation by University of Pennsylvania Health System surgeons on a relief mission. Now, in a matter of hours, she would get the first prosthetic arm delivered in Haiti since the quake.

The Jan. 12 cataclysm devastated much of the country. It killed more than 230,000 people and left thousands of victims whose crushed or severed limbs had to be surgically removed.

Handicap International, the French medical group working with the World Health Organization and the Haitian government to coordinate amputee care, puts the number of amputees, including people who lost fingers or toes, at 2,000 to 4,000; other aid groups say the total is at least 6,000. Even before the quake, Haiti had an amputee population of about 80,000, almost none of whom had prosthetics.

In a shattered country where able-bodied people have trouble carrying buckets of water or squeezing through the stalls of jammed outdoor markets, amputees are especially vulnerable. The earthquake destroyed the country's only two prosthetics workshops.

Streets here teem with cars and pedestrians. Sidewalks are rare, let alone curb cuts, wheelchair ramps or handicap parking. Disabled people often are beggars and outcasts, derided as kokobe, Creole for "broken body," because they cannot find work.

"The stigma is strong," said psychologist Luana Forestal, a counselor for amputees at Haiti's Hospital Albert Schweitzer.

For that reason, the signature wound of the quake also has produced a broad effort by foreign volunteers, using donated materials and expert staff from overseas companies, to introduce first-world prosthetics, physical therapy and enlightened attitudes about public health.

These partners are rebuilding women and men torn apart by the quake's violence and ravaged by subsequent infections. But the long-term goal is to train local technicians and physical therapists to create a prosthetics industry that can be self-sustaining in Haiti, because patients who get prostheses now will need refitting throughout their lives.

Relief workers say it is too early for a precise breakdown of the injuries, although preliminary surveys indicate lost legs exceed lost arms nearly 6-1. Legs were particularly vulnerable because the tremors that knocked people to the ground left them prone and defenseless against falling debris.

Many lower-extremity amputees already have been fitted with temporary legs by the foreign volunteers and are learning to walk. The top priority is to make them ambulatory.

"The approach to rehab has to be tailored to the environment," said Col. Jennifer Menetrez, the U.S. Army's top surgeon in Haiti and a participant in the national commission roundtables on amputees. "Here, if you can't walk, you're done. Just try to use a walker or a wheelchair."

Working with the Army's Joint Task Force Haiti, Menetrez is assigned to Port-au-Prince through the end of June. She is director of the Center for the Intrepid at Fort Sam Houston in San Antonio, Texas, a rehabilitation facility for soldiers with severe war wounds, including amputations and burns.

Menetrez said about 1,000 U.S. soldiers had lost limbs in the wars in Iraq and Afghanistan; Haiti, by contrast, suffered about twice that number of amputations in the worst earthquake to hit the region in more than 200 years.

Prostheses for upper extremities are harder to fabricate because of the number and complexity of the joints involved. Depending on where an arm is severed, prosthetists may need to try to mimic the movements of a shoulder, elbow, wrist and fingers, all joints of complex and fluid movement. Even with the infusion of foreign expertise, Haiti lacks the capacity to build arms that mimic that range of motion.

Into that vacuum stepped the Hanger Orthopedic Group (NYSE:HGR) , a publicly traded manufacturer of orthotics and artificial limbs with 690 patient-care centers across the United States.

Like other prosthetic companies volunteering in Haiti, Hanger's initial concentration was on legs, and it fabricated more than 70 in its first three weeks on the ground. Because the human body is accustomed to balancing on two points, a provisional leg that provides basic support can be simpler to build, and easier for a patient to learn to use, than an arm.

But Hanger also took on the challenge of building Donatien's $8,000 arm at one of its branches in Lafayette, La., a squat, white stone building down the street from Cajun take-out joints, with exam rooms in front and a machine shop in the back.

Hanger donated Donatien's arm as part of a million-dollar relief contribution. Prosthetists at the company say they believe it is the first arm fitted in Haiti since the quake.

Antoine Engrand, chief of mission for Handicap International in Haiti, said he knew of no others.

A long way from Louisiana, in her dusty village that was spared by the earthquake, Donatien collected her thoughts on this morning in early April, ahead of what felt to her almost like an introduction. She would meet not a person, but a part of her body, a new arm. She said she was "happy" and "proud" to head the list.

"It is a grace from God," she said, setting out from her small farming and trading community.

"And by God's grace I lost just one arm. Some people lost arms and legs."

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Three months have passed since those 35 seconds of tectonic terror. The three-story Port-au-Prince house where Donatien worked as a housekeeper was destroyed when its stone pillars gave way, causing floors and ceilings to pancake. Donatien, rail thin, was resting on a bed on the third floor when the roof fell in. She was buried in the rubble between the second and third floors for two days, her left forearm and hand crushed between concrete blocks.

Emilio Paris, 53, a cook in the house across the street, recalled how eventually he heard stirring and saw a figure covered in chunks of yellow-painted cinderblock and plaster dust.

"Sonia is not dead! Sonia is alive!" he remembered shouting to neighbors, six of whom joined him in her rescue. They yanked away rubble and dragged her out over crumbled concrete, which stripped skin from her back and shoulders.

With no place to go, Donatien, whose parents died when she was a child, spent uncomfortable nights in the courtyard of the undamaged house across the street. Like others who felt the aftershocks and feared more toppling, she was afraid to sleep indoors. By day she sought treatment at emergency clinics for her hand, which had turned black and had no feeling. Overwhelmed aid workers checked for broken bones, found none, and advised her to see a surgeon _ if she could find one.

A daughter of the family Donatien worked for gave her $45 in cab fare to get to the respected 105-bed hospital in Cange, a three-hour drive north of the capital and well beyond the damage zone centered in Port-au-Prince. It was a hospital Donatien knew well. Four years earlier her daughter, Soleikah, was born there.

The hospital, Zanmi Lasante, began 25 years ago as a church clinic and has expanded through its affiliation with the well-known Boston medical relief group Partners in Health.

The hospital held mixed memories for Donatien. Soleikah was born a twin. But five days later, while still in the hospital, her sister died. Donatien never named the child.

With her arm lying lifeless on her lap, the journey to the hospital aboard a truck mounted with bench seats was a painful ride. Hundreds of thousands of city dwellers whose houses were destroyed had begun an exodus to the provinces. Many rubble-heaped roads were impassable. A trip that should have taken three hours took eight.

She was relieved, finally, to see the stone wall around Zanmi Lasante's campus. After an initial evaluation, she was admitted to the hospital, where hundreds of wounded lay on stretchers and mattresses on the floor.

"There was swelling, loss of sensation, and dead tissue on her fingers," said Fredly Petiote, the Haitian doctor who examined Donatien and recommended amputation before the likelihood of a massive infection put her life at risk.

Donatien was afraid, so doctors began with a conservative approach, a fasciectomy: slitting open the arm to cut away dead tissue before washing the wound and closing it. Although the procedure went smoothly, it did not produce improvement.

In a church chapel converted into a recovery area, Donatien was mulling her dreaded options when an accident of timing brought the most rarefied of medical expertise right to her bedside.

Her admission coincided with a relief mission by a nine-member team of doctors and nurses from the Hospital of the University of Pennsylvania Medical Center in late January. Wearing scrubs and draped with stethoscopes, they trooped toward her in the crowded church on their initial rounds.

Penn orthopedic surgeon Samir Mehta, a superconfident 34-year-old who a year earlier had repaired the broken hip of Vice President Joe Biden's 91-year-old mother, Catherine, explained to Donatien that the gangrene in her lower arm and hand could spread to her vital organs.

She faced a stark choice: lose the limb, or very likely lose her life. Fearing disability and disfigurement, Donatien hesitated again. But a day later, after concluding that God had spared her for a reason, she chose amputation. Mehta and his team removed the arm in a two-hour operation.

Right-handed, Donatien was relieved not to lose her writing hand. But in the recovery room still woozy from anesthesia she signed her name "Donassien," and it was reported that way in some early hospital records.

She was discharged from the hospital Feb. 14 and, with the surgical staples still in her stump, traveled an uncomfortable hour's drive on a rutted road to her native village, Lascahobas, to recuperate. She survived on handouts she got from an aunt in a nearby village.

Donatien moved into the cramped, tin-roof shack she shares now with her daughter and three grown cousins. Physical pain and depression about her future sabotaged her sleep.

One-armed, she could still cook on the open coal fire that is the household's only stove. She could bathe herself and her daughter in the nearby river. But other tasks, like braiding her hair, or washing laundry in the river, were suddenly beyond her. Occasionally, she had unnerving phantom sensations, like the urge to scratch an itch on a forearm that wasn't there.

Back in the United States, Hanger public relations director Jennifer Bittner read about Donatien's surgery in the Jan. 31 Philadelphia Inquirer and shared the story with the company's top executives. They stepped forward to help her through the Haitian Amputee Coalition, a joint effort they are heading to provide free prostheses for quake victims.

In March, Hanger sent an advance team with tons of equipment to build a state-of-the-art prosthetics lab at Hospital Albert Schweitzer, in Deschapelles, about two hours northwest of the hospital in Cange. Hanger representatives reached out to Donatien, and she was among the first patients at the company's weekly mobile clinic.

Which is how, on a sunny Saturday in March, Hanger's lead prosthetist in Haiti, John "Jay" Tew, 38, a Baton Rouge native with a soft voice and soulful touch, took measurements of her stump and of her sound arm so that the dimensions of the new arm would be appropriate for her body. Using a thin tape, he measured the circumference of her wrist. He measured the distance from her elbow to the tip of her middle finger. He measured the width of her palm.

The next day, Tew shipped the measurements and a plaster cast of Donatien's stump on Hanger's biweekly flight to the United States. They were routed to a Cajun colleague known for his expertise in building arms.

In Lafayette, John "Tra" Harris, 41, went to work. He put hours into the arm's construction, using Tew's measurements of Donatien's residual limb to create a custom-fitting socket.

Fit and patient acceptance of the limb are the most important considerations, followed by functionality, he said, because if the arm is uncomfortable or unpalatable, the patient may just put it in a corner and never use it.

A single-arm amputation is a particular challenge, he said, because the patient can work around the disability by relying on the sound arm. Double-arm amputees often are more motivated to use prostheses, he said, because without them they are helpless.

"You want (the prosthesis) to be as light and strong as possible," said Harris, cradling the arm as he worked on it.

Harris, a former military policeman who was assigned to the U.S. Army's 82d Airborne Division during Desert Storm, built Donatien's arm on a plaster mold using woven Kevlar, carbon-fiber fabric, and liquid resin to bond the layers. In the world of prostheses, human skin tones are rated zero (the whitest white) to 18 (the blackest black). To match Donatien's chocolate complexion, he tinted the resin with No. 16 dye.

"I love arms," said Harris, a pickup-driving good old boy with a taste for Marlboro Lights. "Arms are challenging. Arms make you think."

The state of the art in high-tech prosthetic arms are $35,000-plus myoelectric prostheses driven by tiny motors controlled by muscle contractions and the body's electrical impulses. But such gadgetry is impractical in Haiti, Harris said, where many areas lack electricity, and batteries are not easily recharged.

Having lost his right thumb in a winch accident in the Army, Harris speaks from experience when he says, "There always is a depression when you lose a body part, because you can't do what you used to do. ... I thought I'd never use my hand again."

But after many operations, his deformed hand is functional and strong.

"Adapt," he said, as he boxed Donatien's arm for shipment to Haiti. "Adapt, and overcome."

From Lafayette, the arm was shipped via UPS next-day air to Bloomington, Minn., arriving hours before Dale Berry, Hanger vice president of clinical operations, was scheduled to leave. Hurriedly, Berry cleared space for the arm in his baggage and rushed to the airport, making the flight with no time to spare.

Meanwhile, Mehta, the HUP surgeon, had returned to work in West Philadelphia. He told friends he felt changed, inspired but also worried by what he saw in Haiti.

"I wonder what it is that we (did there) _ how it even makes any bit of difference when there is no follow-up really, no prosthetic care, no therapists to do crutch training," he wrote in a journal that he shared as a blog.

He just happened to be at a World Cafe fundraiser for Haiti in March when he learned through contacts that Donatien would get an arm. Speaking from the stage of the benefit concert, he told the crowd of several hundred people he was overjoyed.

"I did what needed to be done," he said later of the amputation. "I also knew that in a place like Haiti, there was a good chance she would never get an arm ... that she might simply fade to black."

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Pressing forward to her appointment with her new arm, Donatien switched vehicles at a transit stop in the provincial town of Mirebalais and took a seat in a "tap-tap" taxi crowded with 14 people, including the driver. The battered Mitsubishi SUV looked like a human sardine can on wheels. "How many people fit in a tap-tap?" goes a Haitian joke. "Two more."

By sheer coincidence, Donatien squeezed in next to Chupet Aurice, whose 6-year-old son, Stanley, was perched on her lap. Crushed by a collapsed wall, the boy's right leg had to be amputated below the knee. He, too, was headed to Hanger's mobile clinic in Cange, at Zanmi Lasante, the hospital where Donatien's surgery was performed.

The rest of the week, Hanger's operation is based at Hospital Albert Schweitzer. The 100-bed hospital on a former banana plantation was founded in 1956 by Dr. William Larimer Mellon Jr., a Pittsburgher whose father founded Gulf Oil. It is the main medical facility for more than 300,000 impoverished Haitians in a central valley that was largely spared by the quake.

Jesus was stenciled in small block letters on the windshield of Donatien's tap-tap. On the back window: La Promesse de Dieu _ "the promise of God." The driver had to roll-start the jalopy because its ignition was broken.

Louis Metayer, an official in Haiti's Secretariat of State, is in charge of his country's portfolio on the disabled.

"Even before the disaster," he said, 80 percent of the nation's estimated 80,000 prequake amputees "could not afford even a minimum fee for a prostheses." That meant anyone missing a leg usually spent a lifetime on crutches; a missing arm remained a stump.

Quake victims are the urgent focus now, he said, but any long-term plan for a self-sustaining prosthetics industry in Haiti needs to encompass all of the country's amputees.

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Donatien's sweaty ride on unpaved roads eventually wound past Lac Peligre, a vast lake and its massive hydroelectric dam completed in 1971 as a gift to Haiti from the United States.

Donatien was silent for most of the trip _ lost in thought about what her new arm would look like, she said later. But the sight of the lake perked her up.

"Those are fisherman," she said, pointing to a cluster of rowboats. Little Stanley leaned forward to have a look.

The first person Donatien ran into after finally arriving at Cange was her daughter Soleikah's godfather, Prosper Desjardins, an oxygen technician at the hospital. The childhood friends, who met at school in Lascahobas, were happy to see each other again.

He took a step back to take in the injury that had destroyed the symmetry of Donatien's body.

"Be strong," he said embracing her. "It is life."

She smiled and hugged him.

On the patio, where the weekly clinic is held, Donatien joined two women, ages 25 and 33, originally from Port-au-Prince. The older one's right arm was amputated above the elbow. The younger one's right leg was amputated below the knee.

After a few minutes, Tew appeared. A Hanger manager on leave for three months from his Baton Rouge practice to run the Haiti operation, he entered carrying a black duffel bag stuffed with tools and Donatien's new arm.

Dressed in tan scrubs, Tew sat shoulder to shoulder with Donatien on the patio's wraparound stone bench. He nonchalantly removed the arm from the bag and laid it on his lap.

For its introduction to Donatien, the brown limb was dressed in a sleeve of white gauze. All eyes turned toward the arm. Suspense filled the air, as when an artwork is unveiled. As Tew peeled back the gauze, Donatien cast a sidelong glance at the arm, averted her eyes, looked back at it, and then glanced briefly at her stump, sizing up how it would fit.

Through an interpreter, Tew reassured her.

"If something is not the right length or doesn't look just right for you, don't worry," he said. "We are going to make it better."

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The first attempt to insert Donatien's residual limb into the socket of her prosthesis failed because the soft tissue at the end of her stump bunched up, hindering her ability to push.

Patiently, Tew dusted the stump with baby powder to make it glide more easily and tried again.

"Pull up, then push down," he instructed her, blending English with a dash of French. "Push, Sonia, poussez."

Before trying a third time, Tew took away the arm and used a portable power drill to open a small hole near the hinge that serves as the elbow joint. He threaded a long sleeve of gauze through the hole, then

slipped Donatien's residual limb into the open end of the gauze as though guiding a foot into a sock. Thus arranged, he inserted her stump into the prosthesis and used a push-pull motion to tug her limb completely down into the socket.

"Is that you?" he said, wiggling his pinky in the hole to confirm that the stump was properly seated.

Sweat glistened on Tew's forehead as he helped Donatien put on her light, long-sleeve jacket. With only her prosthetic hand showing at the end of the sleeve, she looked balanced and whole again. Together she and Tew took a walk on the hospital grounds so she could try out her new body image.

"Can I hold your hand? Do you have a boyfriend? I don't want to get beat up," Tew, who is married, gently teased.

He showed her how she could use the prosthetic hand to grip her purse, leaving her sound hand free for dexterous tasks like writing, turning pages, or dialing a cell phone.

Even when she learns to master her prostheses, he said, she will probably have less than 20 percent of the function of her natural arm. But she will be able to use the artificial limb to grip or stabilize items and her sound hand for intricate work.

"I'm getting a good vibe of acceptance," Tew said. "She's looking at it. She's touching it. She's comparing the hands. She's not saying, 'It hurts. Get it off.' "

The fit of the arm and of the shoulder-holster-style harness that secures it will require more tweaking. For now, Tew just wants Donatien to get used to wearing it, so he did not connect the thin cable that will control the opening and closing of the hand. That will be for a future appointment. Just start wearing it "an hour in the morning, an hour in the afternoon, and an hour in the evening," he told her.

She left the hospital wearing the arm and found it "easy" to maneuver when she slid into a less-than-typically crowded tap-tap for another bumpy hour's drive back to Lascahobas.

She has kept to the three-hour-a-day regimen, even though Soleikah was initially afraid of the arm. "But little by little, and more or less," Donatien said, the child is coming around.

Beyond preparing her daughter for school, and picking her up at noon, Donatien has little reason to leave the house. Her only recreation is on Sunday mornings when she goes to church.

Through the hospital in Cange, a newly hired physical therapist will teach her to make the most of the arm's functionality.

Unemployed now in a chronically poor and shattered country, she doesn't know where her life will take her.

Her first meeting with her new arm is just the start of a relationship. It will be months before their ultimate compatibility is known. She is impatient to have the cable hooked up so she can make the arm move. But she is grateful to have come this far and is beginning to feel whole again in a land where amputees don't usually get that chance.

"With the help of God, I feel very fortunate," she said. "Other people lost more than I did."

THE WALL STREET JOURNAL.

Cholera Hits Haiti, and Public-Health Experts Worry it Will Spread

October 22, 2010
By Katherine Hobson

When the earthquake in Haiti hit in January, experts told the Health Blog that health problems from poor sanitation and crowded conditions would likely continue well into the future.

As the WSJ reports, what public-health experts say is the first big post-quake disease outbreak has now been confirmed: a cholera epidemic in the Artibonite region of the country. The area has become home to a lot of earthquake refugees, and even before the quake obtaining clean water was a problem, the paper says, citing a spokesman for public-health group Partners in Health, which has a longtime presence in Haiti.

The Associated Press reports that the director of Haiti's health ministry said at least 142 people have died and more than a thousand hospitalized. The president of the Haitian Medical Association tells the AP the concern is that it will spread within the region or move to another one.

David Darg, from the humanitarian organization Operation Blessing International, writing on Reuters' AlertNet blog, describes a "horror scene" at St. Marc hospital:

I had to fight my way through the gate as a huge crowd of worried relatives stood outside, while others screamed for access as they carried dying relatives into the compound. The courtyard was lined with patients hooked up to intravenous (IV) drips. It had just rained and there were people lying on the ground on soggy sheets, half-soaked with feces. Some children were screaming and writhing in agony, others were motionless with their eyes rolled back into their heads as doctors and nursing staff searched desperately for a vein to give them an IV. The hospital was overwhelmed, apparently caught out suddenly by one of the fastest killers there is.

The World Health Organization says the disease, characterized by acute diarrhea, can be treated with oral rehydration salts in 80% of cases. Clean water supplies and good sanitation are key to preventing and containing the disease.

The New York Times

Haiti Fears Cholera Will Spread in Capital

October 23, 2010
By Randal C. Archibold

MEXICO CITY — With the number of dead rising above 200, health officials battling a cholera outbreak in Haiti grew ever more pessimistic Saturday that the disease could be contained to a rural area and braced for a medical disaster in the capital.

Haitian officials have confirmed 208 dead and a total of 2,674 cases, but with people streaming into hospitals and clinics and suspected cases far from the outbreak's epicenter — in St.-Marc, 60 miles north of the capital, Port-au-Prince — doctors were certain the toll would rise.

Five Port-au-Prince residents were found to have the disease on Saturday, said Imogen Wall, a spokeswoman for the United Nations Office for the Coordination of Humanitarian Affairs. But they acquired it in the region outside the capital where the bulk of the cases are, and so it remained unclear if the disease was spreading in Port-au-Prince. Ms. Wall said all five patients were receiving treatment in isolation.

An International Red Cross spokeswoman, Sophie Chavanel, who arrived Friday night in St.-Marc, said by telephone Saturday that doctors and nurses were rushing about, trying to treat people weakened with the severe vomiting and diarrhea that are the disease's hallmarks.

"It is difficult to see," said Ms. Chavanel, part of a team bringing drinkable water, water purification kits, plastic sheets, tents, mattresses and other supplies to the area. "It is really heartbreaking, actually."

Health officials were investigating cases in several towns near Port-au-Prince, where 1.5 million people displaced by the January earthquake live in tent encampments with the kind of questionable sanitation and contaminated water in which cholera, a bacteria carried in human feces, flourishes.

The Associated Press reported that those suffering from the disease included 50 inmates in the Mirebalais prison, about 30 miles northeast of Port-au-Prince.

It is possible that people with diarrhea caused by other germs suspect they have cholera, an acute bacterial infection that results in a far more severe form of diarrhea that quickly dehydrates and kills its victims unless they are treated, primarily with plenty of water and antibiotics, at the onset.

Authorities have braced for months for water-borne diseases in Haiti, given persistent sanitation problems. But they were not preparing specifically for cholera, which last appeared in Haiti 50 years ago.

There are an estimated three to five million cholera cases and 100,000 to 120,000 deaths every year worldwide, according to the World Health Organization. Outbreaks have been reported this year in Cameroon, Chad, Niger, Nigeria, Pakistan, Papua New Guinea and Zambia.

Ms. Wall and representatives of relief organizations said there was enough clean water for the sick and, for the most severe cases, antibiotics for now. A public awareness campaign aimed at getting people to diligently wash their hands after going to the bathroom is under way.

But a major concern is that Haitians, who fled the capital in droves after the earthquake for places like St.-Marc, often go back and forth and from village to village to live with or see relatives, raising the likelihood that the disease will spread.

“Our single greatest challenge is containing this,” she said.

Andrew Marx, a spokesman for Partners in Health, a nongovernmental organization that works closely with the Ministry of Health in rural areas, said that it had been warning of such a calamity away from the capital but that authorities had focused disease prevention mostly on Port-au-Prince.

“We tried to make the case not to focus exclusively on Port-au-Prince,” he said, noting that considerable effort has been made to provide clean water in the capital, but rural areas remain lacking. The St.-Marc River has tested positive for cholera.

Relief workers said rural hospitals and clinics were overwhelmed, particularly in St.-Marc. “There are significant numbers of patients in St. Nicholas Hospital in St.-Marc, which does not have the capacity to handle a cholera emergency,” Federica Nogarotto, a Doctors Without Borders coordinator in St.-Marc, said in a statement.

She said that it was important to keep those with cholera away from other patients, and that work was under way to set up an isolated cholera center.

Relief workers said additional supplies were being flown in, in anticipation that the number of cases would spiral upward.

Terrifying race against time with cholera in Haiti

October 24, 2010
By BBC Staff

A cholera outbreak in Haiti has killed more than 200 people in northern and central Haiti. The BBC's Laura Trevelyan has visited the Saint Nicholas hospital in Saint-Marc, a port town in Artibonite department:

Every corner of this open air courtyard is filled with patients.

A woman weeps, her two children just confirmed as having cholera.

A father cradles his two-year-old, as the mother tries to get their unresponsive son to drink the rehydrating fluid which will help keep him alive.

An elderly woman lies motionless on a camp bed, covered with a blanket. She looks emaciated.

Everywhere I look, I see eyes which have sunk back into their sockets - the sign of advanced dehydration from diarrhoea.
Crowded households

A few hours on an intravenous drip can cure people in this state - or it may not be enough.

A young boy is sleeping, his breathing shallow - his mother watches intently.

Dr Koji Nakashima from Partners in Health, a group working with the Haitian health authorities throughout the country, has spent all day administering intravenous drips to patients.

"The terrifying thing about this disease is how quickly it can kill," he says.

"Patients come in and they're unresponsive. They don't have the resources to get here quickly - they come by donkey, on foot. It is a very challenging environment."

His colleague Dr Louise Ivers has been helping to manage admissions to the hospital.

People are coming in earlier on in the stages of cholera, she says, so there seem to be slightly fewer severe cases than there were. But the people keep coming.
Child with cholera is comforted by a woman in hospital in Grand-Saline, Haiti, 23 October 2010 The doctors say cholera can kill very quickly if patients are is not treated properly

Although the Artibonite river has not been officially confirmed as the source of the outbreak, she says that when the first patients started arriving on Tuesday, staff noticed a pattern: all those infected had used the Artibonite river, whether for play or washing.

This central region of Haiti was not directly affected by the earthquake in January which killed about 300,000 people. But many who lost their homes came here to live.

Dr Ivers says that meant already-crowded households have been taking on even more people, leading to stressful conditions.

The earthquake did not cause the cholera epidemic - but it certainly contributed to the conditions which have allowed it to spread.

The question now is how to contain the disease.

I have brought hand sanitiser and baby wipes - thinking that might help. The doctors explain that as the disease is transmitted by faeces, made watery by the diarrhoea, I must try to ensure that my boots are clean.

Haiti has not seen a cholera outbreak in 100 years, and that is partly why this one is spreading so fast: there is no immunity.

The country has been disproportionately affected by political clashes, natural disasters from tropical storms to earthquakes - and now this.

All eyes now are on the migration of the disease, as it moves towards the capital Port-au-Prince.

Rebuilding Haiti, Better Than Before

October 28, 2010
Interview with Neal Conan

NEAL CONAN, host:

This is TALK OF THE NATION. Im Neal Conan in Washington.

Nine months after a catastrophic earthquake leveled much of Port-au-Prince, hundreds of thousands of Haitians still remain homeless, rubble still litters many neighborhoods, and now the country is grappling with its first cholera outbreak in decades, centered of the coastal city of Saint-Marc, 40 miles north of the capital.

Many aid groups continue to provide essentials: food, water, shelter, medical care. Others, though, focus on the long haul and work to rebuild systems to support local farmers or develop schools to help meet the demand for medical and mental health professionals.

If you've been to Haiti recently, did you see progress? Can Port-au-Prince be rebuilt better? 800-989-8255. Email us, talk@npr.org. You can also join the conversation on our website. Thats at npr.org. Click on TALK OF THE NATION.

Later in the program, Ask Amy's Amy Dickenson on productive ways to ask for an apology. If you've tried to solicit an I'm sorry, did it work, or are you still waiting? Email us your story, that's talk@npr.org.

But first, rebuilding Haiti, and we begin with Joia Mukherjee, chief medical officer for the group Partners in Health, also a professor with Harvard Medical School. She joins us now from member station WBUR in Boston. And Dr. Mukherjee, thanks very much for being on TALK OF THE NATION today.

Dr. JOIA MUKHERJEE (Harvard Medical School): You're welcome, Neal. Thanks for having me.

CONAN: And I know you've been coordinating Partner in Health's response to the cholera outbreak. Any signs that the illness is spreading into Port-au-Prince?

Dr. MUKHERJEE: No, we've been quite fortunate so far. I think there have been a few cases in Port-au-Prince, but we haven't seen spread within Port-au-Prince as of yet.

The coordination, I just want to make it clear, that is going on, on the ground by our Haitian team. I'm sort of helping to support what they need, but they have just done amazing work in reaching out to communities to prevent the spread even within our own catchment area of Saint-Marc and prevent the spread elsewhere in Haiti.

CONAN: And I'm told that cholera, though once you've got is quite terrible and easily spread, on the other hand is fairly also easily treated and prevented.

Dr. MUKHERJEE: Yeah, very easy to treat. All you do is rehydrate someone. You sometimes may use antibiotics, but it's not the mainstay of treatment. The mainstay is just making sure people don't die of dehydration.

The difficulty is it is a rapidly dehydrating, diarrheal disease, so much quicker than the other forms of diarrhea we commonly see in Haiti and elsewhere.

Prevention is soap, water, purifying, you know, water with chlorine tablets. I mean, it's fairly straightforward. But getting to all of the areas where people live is the big challenges, delivering those messages and the tools for prevention.

CONAN: Now, Partners in Health has been in Haiti providing services for two decades, including responses to crises like this cholera outbreak. But I wonder, has the earthquake provided an opportunity to help rebuild a more robust health system for the future?

Dr. MUKHERJEE: Not yet, Neal, and I hope that it will. I mean, we are, ourselves, working closely with the Ministry of Health to build a very large, state-of-the-art teaching hospital in central Haiti. But the medical school, the university hospital, the nursing school - all of those remain nearly incapacitated, if not totally incapacitated.

The facilities throughout Haiti are really under-funded, understaffed. We're very fortunate that we have been working for so long that the 10 facilities where we work in Haiti, we have staff, we have supplies. I'm very proud to report that we've not had a single stock-out since the beginning of this epidemic, and yet it's our warehouse, jointly operated between Partners in Health and the ministry, that's supplying all of the affected areas in Haiti.

So I think, you know, we know how to rebuilt systems, but that money has not been flowing reliably into Haiti as of yet. It has been pledged, but we have not seen a lot of movement for it on rebuilding or building the health infrastructure of Haiti.

CONAN: Where were those pledges from, other countries, including the United States?

Dr. MUKHERJEE: Yes, and I think it's it behooves all of us who care about global poverty, and Haiti in particular, to really track that money and say who's pledged what. And, you know, some of it is now posted on the website of the Office of the Special Envoy of the U.N., who's pledged what.

But it's a very small amount of money that's actually gone to Haiti and even a smaller amount that's gone to the government of Haiti, who is actually charged with providing the majority of public services, obviously.

CONAN: And if the, well, inadequate facilities that were there have now been destroyed and are not up and running, clearly this is going to be a continuing problem for years ahead, until they are up and running.

Dr. MUKHERJEE: Absolutely, absolutely. And we believe that there are really two discrete but interconnected aspects to this that need to be simultaneously done.

One is to develop a robust public system because that's the only system that will get as far as Haitians are living, where they are, you know, villages, towns.

And the second is really to mobilize the community to be agents of health. And we believe that paying people to do that work is also a way of giving employment and improving the economy. And the service sector can be a robust engine for economic development, as well.

And so another thing that's really been remarkable to me during this cholera outbreak, and again, this is I just got off the phone with our director of the program in the Artibonite at Saint-Marc, in Saint-Marc, Dr. Patrick Almazor, and he has told me that none of our HIV-infected patients have gotten cholera.

And that is because they're getting excellent community-based care. They have people that are working with them at the home level. They're giving them messages of general health and hygiene, helping them with water and food security.

Similarly, the kids that we're taking care of in our malnutrition program, none of those kids have gotten cholera. So these are groups that in general we would consider quite vulnerable to contracting cholera and dying from cholera, and yet in these two very vulnerable groups, we have had adequate prevention even without the additional effort we've put in, just because our community-based system works.

CONAN: We're asking those of you who have been to Haiti recently to call us and tell us: Have you seen progress? 800-989-8255. Email talk@npr.org. Dominic's(ph) on the line, calling from St. Louis.

DOMINIC (Caller): Yes, hi, how are you?

CONAN: Good, thanks.

DOMINIC: My brother's been to Haiti twice, recently. He went in March, after the earthquake, and he just got back last month. So I was asking him about how did it go. And he said, well, Haiti looks - Port-au-Prince look like, as if the earthquake just had happened in July.

I mean, nothing has changed from when he left. To him, he hasn't seen any changes from March, when he was there, to last month.

CONAN: Dr. Mukherjee, I know you've been there recently. What do you see?

Dr. MUKHERJEE: I agree with Dominic's brother. There's not a lot of forward movement. There's still a lot of rubble that hasn't been cleared. There are still huge numbers, hundreds of thousands of displaced people living in absolute squalor.

And I think again, you know, hopefully if there is one small, positive thing that can come from this epidemic I hate to even, you know, sort of conflate positivity with such a terrible thing, but it will be refocusing people's attention on the living conditions in Haiti and to say yes, there was an outpouring of support and sympathy, but where is that money, and let's figure out a real tracking system with real accountability both for governments that pledge the money but for NGOs that have received the money, as well. I don't see massive changes since January 12.

CONAN: Dominic, thanks very much for the call.

And finally, Dr. Mukherjee, a lot of people, as you say, transparent systems would make people more confident. You work with the Ministry of Health and have for a long time. Are they reliable partners? Does money vanish?

Dr. MUKHERJEE: Sure, they are reliable partners, and sure, money vanished. I think if if the crisis on Wall Street taught us anything, it should be that where there is money, there is corruption and that third-world governments don't have a lock on corruption, nor do governments have a lock on corruption, that the reason we are able to prevent corruption in most wealthier countries more easily than poor countries is because we put money into systems.

And once systems and regulation starts to fall apart, then corruption will occur, or corruption will become rampant. And so the government of Haiti is a very at least in the Ministry of Health very reliable partners we have.

But they need help - just as much as they need help with medicines and protocols, they need help with the systems of accounting and reporting. And they've asked for our help and been very open about, you know, us accompanying them as, you know, the government doing it, but we can help develop systems, we can help with accounting.

The I'm an AIDS doctor. If I went to central Haiti and dumped a bunch of anti-retrovirals in a town, I wouldn't be doing my job. My job is to help design systems and train people how to use those systems. And I think we should look at foreign aid that way.

Rather than just say governments are corrupt, say governments have inadequate regulation and systems, and let's help them both get the money and manage the money.

And I think we can do that, and we've done that successful for many years in Haiti. We're doing it in Rwanda and Lesotho and elsewhere.

CONAN: Dr. Mukherjee, thanks very much, and good luck you.

Dr. MUKHERJEE: You're welcome. Thank you, Neal.

CONAN: Dr. Joia Mukherjee, chief medical officer for the international nonprofit Partners in Health, joined us today from member station WBUR in Boston.