Assistance in Darfur Hanging by a Thread
Dear Friends,

In the mid-1990s, Rony Brauman, MD, former president of Doctors Without Borders/Médecins Sans Frontières (MSF) in France, coined the expression “humanitarian space.” He defined this concept as “a space of freedom in which we [humanitarian aid providers] are free to evaluate needs, free to monitor the distribution and use of relief goods, and free to have a dialogue with the people.”

The existence of “humanitarian space” ensures that aid actually reaches and benefits those who need it most. It is never easy to achieve, as groups involved in a conflict, whether government or rebel forces, often seek to divert aid to their benefit or block it altogether, even attacking field staff. In the constant struggle to earn and to maintain “humanitarian space,” we must engage in a continuous dialogue with armed groups, many of which have committed massive crimes. In these politically charged environments, our independence and the strictly humanitarian character of our work are the best assets we have to gain acceptance for our presence and action.

In some of the most acute crises, such as in the Darfur region of Sudan, “humanitarian space” is under serious threat. More than three years after the first major attacks on civilians began in Darfur, nearly two million people remain internally displaced and another 200,000 are still refugees in neighboring Chad. In the Operational Outlook feature of this issue of Alert, we look at some of the many challenges facing MSF staff as they try to maintain vital medical programs amid increasing violence in the region. A peace agreement between one rebel faction and the government in May was hailed as a political breakthrough, yet on the ground the situation has actually worsened. While displaced people, living in what amount to open-air prisons, continue to rely on humanitarian assistance, it is increasingly difficult to deliver aid as serious security incidents affecting aid workers, including MSF field staff, escalate.

In Colombia, the focus of our Situation Report, MSF teams continually negotiate access to civilians in rural areas under control of various armed groups, at least three of which are considered terrorist organizations by the US government (the guerrilla groups FARC and ELN and the paramilitary AUC). Colombia’s decades-long conflict has displaced almost three million people within the country, causing a significant impact on their access to medical services and traumatic effects on their mental health.

The threats and challenges to our humanitarian work are serious. However, there is a human imperative to reaching those who are deliberately targeted, victimized, or abandoned in armed conflicts, and that is our priority. In these highly politicized contexts, it is our conviction and experience that independence and neutrality remain our strongest resources for helping people in urgent need.
Unable to defeat the rebel movements that emerged in the Darfur region of western Sudan in 2000, the Sudanese government started punishing the rebels’ base of social support. In May 2003, the government launched widespread attacks against the civilian population, accusing it of supporting the rebellion in Darfur. The army and paramilitary forces—often called janjaweed—carried out assaults on the Fur, Massalit, and Zaghawa populations. Killing, burning of villages, looting, torture, and rape caused huge population displacements. By the end of 2004, nearly two million people had been forced to flee their villages to take refuge in Chad or in towns controlled by the army. Despite the signing of a peace agreement in early May, violence has escalated. While the government and rebels have clashed and attacks on civilians have continued in certain areas of Darfur, fighting between different branches of the rebellion has increased, plunging Darfur into deeper insecurity.

More than three years after the start of the violence, Darfur is the site of Doctors Without Borders/Médecins Sans Frontières’ (MSF’s) largest aid effort worldwide. MSF has posted more than 2,500 staff in 30 locations across the three states of Darfur in an effort to meet some of the vast medical needs. MSF is also assisting Sudanese refugees who have crossed into neighboring Chad. Michael Neuman, program officer for the US section of MSF, describes the evolving humanitarian situation in the region and the difficulties of carrying out humanitarian operations there.

The situation in the state of West Darfur, where I was the head of mission for MSF in February, illustrates the daunting task of assisting the conflict-affected Darfuri population. MSF is trying to meet the ongoing medical needs of hundreds of thousands of displaced people who are too scared to return to their homes and continue to live in camps that amount to open-air jails. At the same time, MSF needs to remain flexible enough
to respond to emergencies both in and outside of the camps. The past few months have tested MSF’s flexibility. Our teams have responded to several intense bouts of violence in all three states of the Darfur region. On May 8, MSF treated 46 wounded people following an attack on the town of Labado in South Darfur state. The MSF team worked through the night operating on gunshot wounds to abdomens, shoulders, arms, legs, and chests. An MSF team in Muhajariya, also in South Darfur, received a steady influx of casualties during the month of April, admitting 127 patients with violent trauma.

When the town of Golo in North Darfur state and its surroundings were attacked at the end of January, uprooting 60,000 people who fled to the neighboring mountains, MSF teams were forced to evacuate the town. Since then, MSF has been trying to reach the displaced in the face of numerous attacks on vehicles operated by humanitarian aid agencies, including several of MSF’s. In recent weeks in Darfur, a spate of serious security incidents affecting MSF and other organizations has impeded movements and limited the possibility of providing assistance.

The violence has spilled over into Chad. The same paramilitary forces that launched attacks in Darfur have been implicated in fighting in eastern Chad. This fighting, combined with the emergence of various rebel groups in eastern Chad that are seeking to overthrow the government in N’Djamena, has increased the instability for the local population and the more than 200,000 Sudanese refugees living in camps there.

During the second week of May, at least 10,000 people fled attacks on villages in southeastern Chad and crossed the border to take refuge in Um Dukhum, a small town in the southwestern corner of Darfur, located near the junction of Sudan, Chad, and Central African Republic. Most of the new arrivals were Chadian, but the displaced also included Sudanese who had fled the conflict in Darfur up to three years ago.

The refugees told MSF that their villages in Chad had been attacked, usually in broad daylight, and that their animals, food stocks, money, and even their clothes had been looted. The MSF team in Um Dukhum treated more than 20 people with violence-related injuries, including those caused by gunshots, axes, swords, and beatings. Following their arrival, the MSF team provided basic medical assistance, vaccinated 5,200 children against measles, and supplied plastic sheeting for temporary shelters.

BEARING AN INCREASING WORKLOAD

Beyond the ongoing violence, MSF is facing the possibility of fewer aid agencies operating in Darfur. MSF is not an exception, having been forced to suspend some of its activities in recent weeks. Some aid agencies have had to evacuate certain regions of Darfur due to insecurity and attacks. Moreover, for months, nongovernmental organizations that depend on government funding have been forced to cut back their programs. If other aid agencies reduce the scope of their programs, if the quality of the water delivered becomes inadequate, if malnutrition rates increase, if epidemics emerge, MSF teams may have to compensate, and our own capacity is already reaching its limits. In March alone, MSF vaccinated 100,000 people following an outbreak of meningitis in Zalengei in West Darfur.

Funding streams for organizations that rely on government support have been tenuous at best. The US Agency for International Development/Office of Foreign Disaster Assistance has reduced its 2006 fiscal year budget by 40 percent. The funds were only later replenished through an emergency spending bill. These uncertainties can lead to serious breaks
in the pipeline of aid for a displaced population that is almost exclusively surviving on humanitarian assistance.

In April, the World Food Program (WFP) announced that it was halving its food allocations for the displaced because of large funding shortfalls. WFP received increased funds after this announcement, but it is still incapable of providing full food distributions. Other than these food distributions, displaced Darfurians have virtually no resources to ensure their survival. People cannot farm because of the insecurity that reigns outside the camps. At most, they can earn a little money selling firewood gathered in the nearby bush, but even there they risk being attacked.

And the toughest months lie ahead. The months of July to October bring both the “lean” period and the rainy season. The first is characterized by limited food in the markets and among families who are still able to farm and would ordinarily be in a position to help their neighbors. The rainy season is traditionally associated with an increase in potentially life-threatening diarrheic illnesses.

Over the past year, temporary breakdowns in the food distribution system have resulted in a significant increase in malnutrition. In Mornay, where 75,000 displaced people are housed, the number of admissions for severe malnutrition in the MSF hospital rose from 10 to 20 admissions per month from January to May 2005 and from 80 to 120 admissions per month from July to October. This increase, which coincided with delays in food distributions to the camps, is too great to be the result of seasonal fluctuation.

THE IMPORTANCE OF INDEPENDENCE

One of the challenges of working in Darfur is to overcome barriers to assisting affected populations, including nomadic communities. Nomads are often perceived to be the perpetrators in the fighting—members of the janjaweed. This is true for some but not all. Indeed, some nomadic communities have been hurt by the fighting. Their migration patterns have been disrupted; they sometimes lose access to water and medical care. In response, MSF has helped repair water pumps and runs mobile clinics.

The case of nomads illustrates the fact that, to work efficiently in Darfur, one has to spend time there to understand the relations among the different groups and authorities. Much of MSF’s safety in the region depends on our capacity to be accepted by the groups involved—or simply affected by—the conflict. Therefore, much time and energy is spent explaining MSF’s role and objective of providing independent humanitarian assistance.
As Colombia enters its fifth decade of violent conflict, this man’s story is tragically common. Almost three million people have been displaced inside Colombia since 1995, as a result of a conflict—fueled by the narcotics trade—that pits the government against two heavily armed guerilla groups, ELN and FARC, and also involves paramilitary forces. Massacres, executions, intimidation, and fear have become inescapable parts of everyday life for civilians living in conflict-affected rural areas.

Doctors Without Borders/Médecins Sans Frontières (MSF) focuses much of its aid efforts on reaching these isolated people through mobile medical clinics in several of the hardest-hit regions. In addition, MSF has established health centers in several of the major urban slums where many of the displaced have settled.

RURAL AREAS: LIVING UNDER CONSTANT THREAT

“Conflict in Colombia is fairly low intensity,” says Paul McPhun, MSF’s head of mission for projects in the provinces of Norte de Santander, Cordoba, and Sucre, three of the areas in which MSF runs mobile and fixed medical clinics. “It’s not open warfare with aerial bombings and big open clashes between armed groups and the government. In fact, an area might remain relatively stable for two months, but then the next three or four months could be incredibly conflicted. There’s always that uncertainty in this context, and that’s very difficult for people.”

People who live in conflict zones in rural Colombia are often thought to be supporters of the armed groups that operate locally. This perception not only puts their lives in immediate danger but also limits their ability to travel safely, even in cases of medical emergency. One community leader, who was later murdered, told MSF: “There are people here who don’t get out of town because they feel they might be caught on the road or that there might be paramilitaries in civilian clothes, so they are afraid,” he said.

The conflict has kept even basic health care away from these isolated communities. Immunization programs fail to reach rural Colombia, with coverage rates for diseases such as polio as low as one percent. MSF sees many rural residents who suffer from parasitic diseases and skin infections associated with poor and unhygienic living conditions.

In the province of Tolima, home to more than one million people, MSF mobile teams bring medical and psychological assistance to those living in the conflict zones. Tolima province and the western part of Cundinamarca province comprise a strategically important area because the main roads leading from Cali and Medellin to Bogotá pass through them. All armed groups are active in the region. In 2004, MSF carried out an average of 2,000 consultations a month in Tolima, including more than 100 monthly mental health consultations.

MSF mobile clinic teams also reach communities in Norte de Santander province and Cordoba province in northern Colombia every six to eight weeks, depending on the needs and the degree of difficulty in reaching the areas. To get to these isolated communities, MSF teams travel by four-
wheel-drive vehicle, on foot, on mule, or by canoe. During their two- to three-day mobile clinic visits, MSF staff members see an average of 90 patients a day.

The mobile teams often treat people suffering from cutaneous leishmaniasis, a parasitic disease that can produce multiple skin ulcers on the exposed parts of the body, such as the face, arms, and legs, causing serious disability and leaving the patient permanently scarred. Since this disease is confined to remote rural areas, it is commonly thought to affect members of the guerrilla—armed groups. Therefore, medicines needed to treat it are controlled by the Ministry of Social Protection and are not available from private pharmacies—the only source of medicine for many rural communities.

The ongoing threat of violence takes a heavy toll on the mental health of the populations of these rural areas. MSF medical staff hear complaints of headaches, neck, or back pains, “burning in the stomach,” and difficulty sleeping among patients who after physical examination appear healthy. These complaints, repeated over time by the same patients, highlight the psychosomatic disorders associated with the stress generated by the armed conflict. Boys and girls in MSF programs usually incorporate depictions of weapons, combat helicopters, or massacres in their artwork.

FLEEING THE VIOLENCE

Fleeing the conflict-affected areas does not guarantee safety. Moreover, many of the displaced eventually settle in urban slums such as Soacha on the outskirts of the capital, Bogotá, and Sincelejo, capital of the northwestern Sucre province, where they endure squalid living conditions and very limited access to medical and counseling services. Violence they thought they had left behind also exists in these slums.

“The armed groups have influence all over Colombia, not just in rural areas,” says McPhun. “Living under constant threat crosses frontiers and territorial control.”

MSF runs a health center in Sincelejo, to which an estimated 100,000 of the city’s 270,000 residents have been displaced. Many of them live in precarious one- or two-room houses made of cane and mud or plastic sheeting. Most of these houses lack water or electricity. In many of the slums, there is no sewage system, and often human waste ends up in nearby streams or on plots of land where children and animals play.

Waterborne illnesses such as diarrhea, parasitic diseases, and hepatitis A were the cause of 14 percent of the 5,294 consultations completed by MSF in Sincelejo over the last six months of 2005. Many cases go undiagnosed or untreated. “It’s also a dengue endemic area,” says McPhun, referring to the severe, flu-like
illness, which is transmitted to humans through the bites of infected female *Aedes* mosquitoes. “An awful lot of these cases just go undetected. We’ve had more cases of dengue come through our clinic doors than the entire department registered this year.”

MSF has found extremely low levels of immunization among the patients visiting its clinics in slum areas, highlighting the poor levels of basic care among those displaced by violence. Immunization estimates by the health authorities in Sincelejo confirm MSF data and show a bleak 8.9 percent coverage for polio, 14.6 percent for BCG (tuberculosis), 9.5 percent for MMR (measles, mumps, rubella), 8.9 percent for DPT (diphtheria, pertussis, and tetanus), and 8.9 percent for hepatitis B.

Mental trauma is one of the most undiagnosed and untreated illnesses among the displaced living in urban slums. Half of the consultations by MSF psychologists in the urban slums in Sincelejo and Ovejas are triggered by experiences of violence. Of those, 41 percent are related to acts of violence perpetrated by armed groups involved in the conflict. Many of MSF’s patients have witnessed directly the murder of a family member (37 percent) or have had close relatives disappear through forced displacement (10 percent). In Sincelejo, there is only one psychiatrist and one psychologist working for the ministry of health and serving a population of 800,000 people.

**RETURNING HOME**

For displaced people, making the decision to return home is extremely difficult. In fact, only 12 percent of displaced Colombians have expressed the desire to return to their places of origin, according to CODHES, a Colombian nongovernmental organization. For most of those who talk to MSF, safety remains the main concern. “In the city you had to endure hunger,” said one man who returned to his community. “You had to pay for everything—water, rent, food. It was really hard to live borrowing everything, working without pay. Here, on the other hand, the land is really good, although people live in fear and there are always rumors that somebody is going to get killed.”

Return can be a traumatic experience in itself. “People basically go back to nothing,” says McPhun. “Then on top of that, they have to suffer the mental trauma of returning to the site where the massacre was committed.”

MSF has established a health center in the village of Saiza in Cordoba province, a “return” community that was abandoned after a massacre in 1999. After some of
the town’s people were executed, the community had been ordered to leave or face the consequences. As in many other villages in Colombia, no one chose to stay behind.

Over the next five years, what had once been a social and commercial center for the region became a ghost town. Harvests were lost, the jungle overtook the streets, and roads deteriorated. The health center and the school fell apart and the church remained closed. Nevertheless, in 2003, after failed attempts to settle in urban slums in nearby cities, the first families decided to return. The joy of being “home” quickly mixed with the distress of finding a town that had fallen into ruin.

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“When we arrived, we were scared by everything, continuously remembering what had happened,” says one community member. “We didn’t sleep at all. I didn’t go back to my house because it had been burned. We stayed together and people didn’t go out. We were afraid, and we’re still afraid. There are rumors that one or another is coming to kill someone. I would probably leave again because why live with so much fear?”
Frank Baudino, MD, a family physician from Merced, California, spent six months, from October 2005 until April 2006, working in the Doctors Without Borders/Médecins Sans Frontières (MSF) hospital in Akuem in southern Sudan. The hospital is the only free health care provider for hundreds of miles in an area that is home to more than 300,000 people. Every month, MSF treats thousands of people for malnutrition, malaria, tuberculosis, and other conditions. The following is an account of his time in Akuem.

All we saw were scattered huts as we flew over Sudan’s northern Bahr el Ghazal state on the way to the tiny airstrip that abuts MSF’s hospital in the remote village of Akuem. It was my first assignment with MSF after practicing as a family physician in northern California for nearly 30 years.

As I stepped off the plane last October—the end of the region’s rainy season—children surrounded me. I was pointed toward a small herd of goats near a dirt path that led to the entrance of the hospital. I saw hundreds of people crowded in the waiting area outside the hospital compound. It was just a mass of humanity waiting to be treated. I had to remind myself that I wasn’t alone and that I was part of a team trying to meet the overwhelming needs of this population.

FINDING A ROUTINE

My job was to supervise the therapeutic feeding center and provide medical support to the hospital’s inpatient ward. I walked every day to the center about one mile away—my main form of exercise—and often crossed paths with “old friends”—former patients from the hospital. I couldn’t speak the local language, Dinka, but I learned a few words and phrases to greet my friends.

Working with the Sudanese medical assistants, I did rounds in the feeding center’s 12-bed intensive-care unit. These children were not only severely malnourished but also suffered from concomitant infections like a malaria, tuberculosis, or bloody diarrhea. Many of them were incredibly anemic with hemoglobin levels of less than five grams per deciliter of blood. Such severe anemia would knock anyone—let alone a child—right off their feet. These children would spend several weeks or months at the center to complete their rehabilitation.

I was quite struck by the great lengths to which the mothers would go to seek out treatment for their children. The medical charts would have “two days footing” or “three days footing” marked on them to illustrate how far the mother had walked to bring her child to the hospital.

CONFRONTING MALARIA AND MENINGITIS

Malaria was a constant menace. All the children with fevers were sent for testing at the malaria tent, which was essentially a table under a tree. Using a rapid blood test called Paracheck, a malaria diagnosis could be confirmed in 15 minutes and treatment started immediately with artemisinin-based combination therapy. Most of the children would start to perk up within a day.

There were mothers who arrived with their children unconscious or convulsing from meningitis. I did spinal taps to confirm the diagnosis and then started them on treatment with antibiotics right away. Even the ones we were able to save sometimes suffered neurological damage. Some lost the ability to walk or talk. And right around the time I left in April, MSF launched a massive meningitis vaccination campaign in response to an epidemic.
GROWING NEEDS

When I first arrived, there were between 30 to 40 admissions to the inpatient feeding center each month. When the “lean season” (the period when families begin to run out of food from the previous harvest) approached in March, our admissions shot up to nearly 200 acutely malnourished children. A nutritional survey conducted by Tear Fund, another nongovernmental organization, in April revealed an estimated 6,000 children in need of nutritional assistance. By the end of May, MSF had treated more than 2,000 acutely malnourished children through its inpatient and outpatient feeding centers in Akuem and outlying areas.

Complicating the limited food supplies, tens of thousands of Sudanese were returning to the area from as far away as the capital, Khartoum, after having fled during the country’s long civil war. The majority arrived in the area with little or no food to sustain themselves. I went out once with the outreach teams, and we found several thousand returnees just lying under trees. As I left, the teams were working hard to prepare for the increased medical and nutritional needs resulting from the flow of returnees to the area.

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LASTING MEMORIES

I will never forget many of the patients, particularly a three-year-old girl in Bed No.7 in the feeding center. She was intractably vomiting for days. We had her on intravenous fluids. She was hanging on. Then one day she stopped vomiting and started to improve. One morning, I approached her bedside and she must have gotten scared because she started to cry for her mother. Then her mother said to her in Dinka, “Don’t be frightened. This is your father who has rescued you.” It was such a profound statement of thanks. It will stay with me forever.
EPICENTER: Confronting Meningitis in Northern Nigeria

Poor radio contact. No cell phone coverage. Limited access to electricity and water. A vaccine that needs to be constantly kept cold. These were some of the obstacles that Doctors Without Borders/Médecins Sans Frontières (MSF) emergency teams had to overcome to launch a vaccination campaign in response to a meningitis epidemic in Jigawa state in northern Nigeria.

The "Meningitis Belt"
Northern Nigeria falls within the African region known as the "meningitis belt," which stretches from Senegal in the west to Ethiopia in the east, and is highly prone to epidemics.
PEAK SEASON FOR MENINGITIS

In late January, the first meningitis cases began appearing in Jigawa state. There was reason for particular concern because northern Nigeria falls within the region of Africa known as the “meningitis belt.” This region, which stretches from Senegal in the west to Ethiopia in the east, is highly prone to epidemics. Outbreaks typically occur during the dry season, between December and June.

Left untreated, bacterial meningitis is fatal in approximately 50 percent of cases. Even if the disease is diagnosed early and treated with appropriate drugs, such as the antibiotic chloramphenicol or ceftriaxone, the case fatality rate remains 5 to 10 percent, and survivors sometimes suffer from deafness or mental retardation. Emergency vaccination campaigns are the most effective means of limiting the spread of epidemics. This year, MSF had already carried out vaccination campaigns in Burkina Faso, Chad, Ethiopia, Guinea, Kenya, Niger, and Sudan by the time the crisis emerged in Nigeria.

Epidemics in the belt tend to occur in cycles, with large outbreaks striking every 8 to 10 years. Immunity to meningitis is unlike that of many other diseases because, whether it has been achieved through vaccination or previous infection, it wears off in three to five years. Eventually a population’s collective immunity—known as herd immunity—decreases and creates the conditions for isolated cases to spark an epidemic.

CONFIRMING AN EPIDEMIC

Meningitis epidemics can spread quickly, so it was crucial to determine whether the cases in Jigawa were part of a normal seasonal increase or a large-scale outbreak. Because the supply of meningitis vaccine is limited, doses are released only when an epidemic threshold has been crossed. To make this determination, MSF dispatched teams to health centers to begin to determine the numbers of cases. They didn’t focus only on the patients in the hospital but also looked at recent patient records to see whether cases had gone undetected. In high risk areas, the typical epidemic threshold is 10 cases per 100,000 people per week. That threshold was crossed in mid-April.

Lumbar puncture samples were sent to labs in Oslo, Norway, to determine the specific strain of meningitis. The results showed the source of the outbreak to be the A strain, the most common of the four epidemic meningitis strains. Now the team had to determine how many people would need to be vaccinated.

OBTAINING VACCINES

The scope of the vaccination campaign was huge. MSF first had to determine the number of people aged 2 to 30 years old—the population at greatest risk in the affected areas of Jigawa. But data in the meningitis belt is often hard to come by or incomplete.

“You are working in some places where you have nothing in terms of population figures,” says Laurent Dedieu, MSF logistical supervisor for Nigeria, who coordinated the supplies for the campaign. MSF estimated it would need 180,000 doses for the campaign.

Knowing that MSF had recently completed a successful vaccination campaign in neighboring Niger, the team in Jigawa asked for the remaining 40,000 doses, which could be delivered quickly. The remaining stocks were sought through the International Coordinating Group.
MENINGITIS

Cause: Bacterium Neisseria meningitidis. Strains A, B, C, Y, and W135 are the most common. Infected people typically carry the disease without showing symptoms and spread the bacteria through coughing and sneezing.

Symptoms: Meningitis causes sudden and intense headache, fever, nausea, vomiting, photophobia, and stiffness of the neck. Death may occur within hours of the onset of symptoms.

Prevalence: Meningitis occurs sporadically throughout the world, but the vast majority of cases and deaths are in Africa. Epidemics regularly hit countries in the area referred to as the African “meningitis belt,” which stretches across the continent from Senegal to Ethiopia. The total population at risk in these countries is around 300 million.

Treatment: Without treatment, bacterial meningitis kills up to 50 percent of infected people. Even if the disease is diagnosed early and treated with appropriate drugs, such as chloramphenicol or ceftriaxone, the case fatality rate remains 5 to 10 percent. As many as one out of five survivors will suffer from neurological after-effects such as deafness or mental retardation.

Vaccination: Timely mass vaccinations are the most effective means of limiting the spread of epidemics. The World Health Organization (WHO) has estimated that mass immunizations have managed to prevent up to 70 percent of expected cases in individual meningitis outbreaks in Africa.

LOGISTICS OF THE CAMPAIGN

MSF launched the vaccination campaign in early May. Working closely with local Nigerian medical staff, eight teams were dispatched to a dozen districts in three local government areas to announce the campaign to the communities and coordinate it. Another two teams focused on treating active cases of meningitis. In all, MSF treated 527 people with meningitis.

One of the greatest challenges for the team was maintaining the vials of vaccine within a temperature range of 34 to 40 degrees Fahrenheit in a region where temperatures can reach 120 degrees during the day. MSF brought in refrigerators, cold boxes, coolers, and thousands of ice packs, and used a generator from the ministry of health to maintain the cold chain—the continuous system of preservation and distribution of vaccines at a precise temperature from the factory to the field.

“You need big-time freezers,” says Michael Mills, MSF’s field coordinator for the Jigawa vaccination campaign. “You need uniform ice packs. You don’t just open the freezer to see if they’re frozen or not. You have to set a schedule for when you unlock the freezer, to rotate the ice packs. It’s a science.”

Teams visited as many as 33 locations a day to ensure that they reached all of the target population in the area. The teams sometimes had to go to extreme lengths to remain in contact. “I once had to drive 50 miles to get to a point where I had radio contact with the field coordinator to make a decision about the strategy for the next day,” says Amy Segal, a logistician with the team.

By late June, the teams had vaccinated nearly 150,000 people against meningitis, providing them with up to five years of immunity against future outbreaks of meningitis A or C.
In addition to the vehicles for transporting the vaccination teams, here is a sampling of the materials used to carry out the meningitis immunization campaign and to treat active cases in Jigawa, Nigeria:

- 3,600 vials (180,000 doses) of meningitis A & C vaccine
- 200,000 vaccination cards
- 1,000 doses of ceftriaxone antibiotic
- 3,000 doses of oily chloramphenicol antibiotic
- 3,500 ice packs
- 25 cold boxes
- 7 freezers
- 6 refrigerators
- 20 vaccine carriers
- 1 17-KVA generator.
CHOLERA OUTBREAK IN ANGOLA

In February 2006, Doctors Without Borders/Médecins Sans Frontières (MSF) teams responded to the worst cholera epidemic ever to hit Angola. Between February 13, when the first cases appeared in Boa Vista—one of the poorest and most overcrowded shantytowns surrounding the capital, Luanda—and late June, the outbreak sickened more than 42,000 and killed more than 1,350 people. Each day during the height of the epidemic, there were between 500 and 700 new cases and 10 deaths in Luanda. In the end, 12 out of 18 provinces in Angola were affected. The epidemic finally began to ease at the end of June.

“Compared to other epidemics, these are extremely high figures,” says David Noguera, MSF’s emergency coordinator in Luanda. “In Lusaka [Zambia’s capital], where we worked earlier this year, 6,000 people were struck by an epidemic of cholera. Here, the tail end of the epidemic alone will affect almost 10,000.”

MSF worked with Indonesian health authorities to locate patients who were discharged too quickly from hospitals in the days following the earthquake. Together with Indonesian health workers, MSF medical teams carried out home visits in the most affected villages, and by late June had identified 70 additional patients in need of physical therapy. Another 20 patients needed additional surgery. MSF also opened two outpatient clinics in the Bantul area, an area hit hard by the earthquake.

In addition, MSF distributed hygiene kits (containing soap, sheeting, and utensils) and basic reconstruction kits (containing hammers, saws, drills, and nails) to approximately 1,000 families in Bantul.

EMERGENCY DESK

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In February 2006, Doctors Without Borders/Médecins Sans Frontières (MSF) teams responded to the worst cholera epidemic ever to hit Angola. Between February 13, when the first cases appeared in Boa Vista—one of the poorest and most overcrowded shantytowns surrounding the capital, Luanda—and late June, the outbreak sickened more than 42,000 and killed more than 1,350 people. Each day during the height of the epidemic, there were between 500 and 700 new cases and 10 deaths in Luanda. In the end, 12 out of 18 provinces in Angola were affected. The epidemic finally began to ease at the end of June.

“Compared to other epidemics, these are extremely high figures,” says David Noguera, MSF’s emergency coordinator in Luanda. “In Lusaka [Zambia’s capital], where we worked earlier this year, 6,000 people were struck by an epidemic of cholera. Here, the tail end of the epidemic alone will affect almost 10,000.”

MSF worked with Indonesian health authorities to locate patients who were discharged too quickly from hospitals in the days following the earthquake. Together with Indonesian health workers, MSF medical teams carried out home visits in the most affected villages, and by late June had identified 70 additional patients in need of physical therapy. Another 20 patients needed additional surgery. MSF also opened two outpatient clinics in the Bantul area, an area hit hard by the earthquake.

In addition, MSF distributed hygiene kits (containing soap, sheeting, and utensils) and basic reconstruction kits (containing hammers, saws, drills, and nails) to approximately 1,000 families in Bantul.

EMERGENCY DESK
22,000 people. In Luanda, MSF set up 10 cholera treatment centers with a total of 700 beds in the most affected parts of the city, treating 16,000 people. MSF also ran or supported eight oral rehydration points for those with less severe cases. In other affected provinces, MSF maintained treatment centers, carried out water-and-sanitation activities, and conducted activities to raise public awareness about cholera prevention.

MALNUTRITION ON THE RISE IN SOUTHERN SOMALIA

In June, MSF teams saw a sharp increase in patients suffering from severe malnutrition in the town of Dinsor, in Somalia’s Bay Region. Despite recent rains that were expected to help the July harvest and ease access to water for villagers and livestock, a growing number of children are continuing to suffer from lack of food. A therapeutic feeding program run by MSF in its health center in Dinsor has admitted more than 600 patients since the beginning of 2006, 10 times the number admitted during the same period last year.

The Dinsor health center is the only comprehensive health facility in Bay Region, where nearly 650,000 people are struggling daily to attain quality medical care. Many patients travel long distances on poor roads and through numerous militia checkpoints to get treatment.

“The structural deterioration of the health situation for average Somalis, year after year, is extremely worrying, and the tense political environment can only cause more concerns for the coming months, at a time when the southern part of the country is facing a serious food and water crisis due to the effect of several years of drought,” says Bruno Jochum, Somalia program manager for MSF.
This fall, Doctors Without Borders/Médecins Sans Frontières (MSF) will launch a United States tour of *A Refugee Camp in the Heart of the City*. Guided by MSF aid workers, visitors to this outdoor educational exhibit are asked to imagine that they are among the millions of people fleeing violence and persecution in places such as Colombia, the Democratic Republic of Congo, and Sudan.

An estimated 33 million people around the world have been forced to flee their homes and live in temporary shelter; nearly two-thirds of them are displaced within their own countries. The exhibit is made up of materials used by MSF in its emergency medical work around the world, including emergency refugee housing, a food-distribution tent, water pump, health clinic, vaccination tent, therapeutic feeding center, and cholera-treatment center. It addresses questions that refugees and displaced persons must ask themselves such as: Will I be safe? What will I eat? How do I find water? Can I get medical care? And where will I live?

**2006 TOUR DATES**

Central Park, New York City, NY  
September 15–17

Prospect Park, Brooklyn, NY  
September 20–24

Piedmont Park, Atlanta, GA  
September 27–October 1

Centennial Park, Nashville, TN  
October 4–8

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In Karbi Anglong district in India’s northern Assam state, a Doctors Without Borders/Médecins Sans Frontières (MSF) field staff member speaks to residents about malaria transmission and prevention as part of a local malaria public-awareness project. People living in Assam are continuously affected by political violence in the region. MSF provides basic health care to people who are displaced by the conflict and living in makeshift camps as well as to residents of remote communities. Lack of access to health care and ineffective malaria treatments have led to high death rates in Assam. MSF expects to treat 50,000 people for malaria there in 2006, using artemisinin-based combination therapy, now widely considered the most effective treatment.