EMERGENCY
Hundreds of Thousands Have Fled Violence in Western Sudan
Now the Threat of Widespread Famine Looms
An ongoing conflict in the Darfur region of western Sudan has displaced up to 800,000 people. Logistician Jean-Sébastien Matte and nurse Coralie Lechelle volunteered there with Doctors Without Borders/Médecins Sans Frontières (MSF) from December 2003 to March 2004. After the Sudanese authorities suddenly forced the closure of a camp for displaced people in the city of Nyala, MSF opened programs in the much smaller town of Mornay, where the pair struggled to provide assistance and treat civilians wounded during increasingly frequent attacks in and around the town. This is Matte’s account of his mission in Sudan.

It was around 11 o’clock at night when the bombs and gunfire erupted on the outskirts of Mornay. I could see 12 distinct columns of smoke saturating the sky. It was the first week of February, less than two months since I had arrived in Khartoum. But so much had changed—so quickly.

I touched down in Khartoum on December 28 and spent seven days there waiting for my travel permit so I could join the Doctors Without Borders/Médecins Sans Frontières (MSF) team of four international staff in Nyala. I met up with the team just as the Sudanese authorities were pressing for the relocation of a group of 10,000 internally displaced persons (IDPs) who had gathered there and in nearby Intifadah camp to a new location about 10 miles away in Belel. Children under five were estimated to be dying at a rate of 6 per 10,000 per day—six times the death rate used to designate an emergency. The team was providing basic food assistance and health care services to the population. Most of the IDPs had nothing more than sticks to create shelter for themselves. The temperatures could reach 90 degrees during the day, then fall to 40 degrees at night.

The IDPs in Nyala and nearby Intifadah camp represented just a fraction of the people forced from their homes since fighting broke out between rebel and government forces in the greater Darfur region of western Sudan in February 2003. When I arrived in Darfur, the United Nations was already estimating that more than 700,000 people—roughly equal to the population of San Francisco—had dispersed across a region two-thirds the size of France, and an additional 140,000 refugees had fled to Chad.

The conditions in the new location, Belel, were abysmal—three latrines and one manual water pump for thousands. The area was completely exposed to attacks from the Janjaweed, the horseback-riding militias that have unleashed a scorched-earth campaign against the civilian population throughout Darfur. Despite these conditions, the authorities were determined to relocate the IDPs. We had just set up a clinic in Nyala when the authorities swept into the camps with trucks, brandishing Kalashnikov rifles and menacing the civilians with threats of burning the area if they did not move to Belel.

I could only imagine the fear they felt.

Most, if not all of them, had fled to Nyala and Intifadah after seeing their villages burned. Over the next 24 hours, all but about 500 of the 10,000-plus people vanished into the bush. Some were trucked to Belel while others fled on foot.

With no one left to help, all we could do was pack up and prepare to reach other towns in desperate need of assistance. An MSF team went to evaluate the towns of Mornay, Zalinge, and Garsilla—all swollen with an influx of people driven from their villages. It was decided that Coralie Lechelle, a French nurse, and I would make our way to Mornay to provide assistance.

We pulled together a team of 10 national staff (5 drivers, 2 nurses, a medical assistant, and 2 translators) and set off for Mornay in a convoy of two MSF cars and five trucks loaded with drugs, logistical supplies, and food. We dropped our materials in Zalinge, northwest of Nyala, and headed to El Genina, the regional capital of West Darfur, to get permission to work in Mornay.

I will never forget what I saw next.

Village after village along the road to El Genina had been burned to the ground and abandoned. Fleeing civilians lined the road. Only three villages remained standing and their inhabitants appeared to be waiting out the situation.

Once we reached El Genina, the authorities gave quick approval for us to work in Mornay. We rushed back through...
Mornay to tell civilians that we would return to provide assistance. They begged us to return quickly. On the road back to Zalinge we saw that the villagers from Tulu, Salulu, and Mara were fleeing with all the possessions they could carry to Mornay or Zalinge. The Janjaweed had told them that they would return to destroy their villages.

We got back to Zalinge, where we spent the night. The next morning we reloaded the trucks and got back on the road to Mornay. Again we drove through Tulu, Salulu, and Mara—all three were aflame. Fires were burning on both sides of the road. A group of 20 or so Janjaweed was shooting in the air. We just hit the gas.

We finally arrived in Mornay, a two-square-mile town nestled between a dry riverbed and mountains, which is home to some 3,000 people in peacetime.

The next morning we began our work. Day one we set up a pharmacy. Then we screened 5,000 children for malnutrition—one in ten was malnourished. When we arrived, about one-third of the families had stocks of sorghum (a cultivated grain). We started to treat the most severe cases of malnutrition. Then over the next three days we vaccinated 5,000 children against measles—a disease that thrives on malnourished children living in close quarters. We established a clinic.

**Then the bombs started falling around Mornay.**

The town of Mornay had contained 20,000 IDPs before the bombing started. Over the next 10 days, the population exploded to 45,000. All through the night, Coralie and the national staff treated war wounded. We received 80 wounded people, including children. People arrived with bullet wounds or beaten. Some had been whipped by Janjaweed. At least 17 women had been raped. To get to Mornay, many had traveled by foot for hours or even days, carrying only a small bag of food at most.

When I wasn’t helping in the clinic or trying to obtain information on the security situation, I walked through the town asking new arrivals about their villages and what had happened to them. They said that hundreds from each village had been killed. They told stories of children strangled, women burned alive, and men shot to death. Out of any group of 20 people, maybe one was an adult male. Most of the men had been killed or had stayed back to watch over food supplies. But the majority of the people had no idea what had happened to their sons, husbands, and fathers.

There was the constant fear that Mornay would be next; that they would “clean” the town of all its inhabitants as had happened in countless other villages. Coralie and I spoke
almost every hour. We were constantly assessing the danger and in contact with the MSF headquarters in Paris by satellite phone. Every night we contemplated leaving. But there was a unanimous decision among the team to stay. We were surrounded by need.

Finally, on February 16 the bombing stopped. By then there were close to 60,000 people in Mornay. We were working against impossible odds. The streets were littered with dead donkeys, sheep, and cattle. None of the people had food for their animals, and it was still too dangerous for them to venture outside of the town. I spent a good part of my days leading efforts to bury the dead animals to prevent outbreaks of disease.

We were treating 300 severely malnourished children and providing supplementary food to 1,200 more. Eventually a water and sanitation team was able to reach Mornay, and with their help we were able to provide 500,000 liters of water per day to the population, or 10 liters per person.

When Coralie and I left Darfur in mid-March there was still so much work to be done. MSF teams were able to reach areas where nearly 115,000 people had been struggling to survive, but we still have no idea about the hundreds of thousands of others.

**EMERGENCY UPDATE:**

**FAMINE LOOMS IN DARFUR**

A recent MSF nutritional survey of children and their caregivers in five locations in Darfur, where nearly 150,000 displaced people have sought refuge from extreme violence, shows that the whole population is on the brink of mass starvation.

The survey revealed a global acute malnutrition rate of 21.5 percent among the population (20 percent is an indicator of an emergency). The study found the mortality rate for children under five years of age to be 5.2 deaths per 10,000 people per day while the rate for those over five years of age was 3.6 deaths per 10,000 people per day. Both rates are more than double the emergency thresholds, and although most of the children died of hunger, diarrhea, or malaria, 60 percent of all deaths for those over five years of age were caused by violence.

As of June 1, there were nearly 50 MSF international volunteers in Darfur working alongside hundreds of Sudanese staff. MSF is providing medical and nutritional assistance to people in Mornay and 10 other locations throughout Darfur, where 300,000 displaced people have sought refuge. Teams are treating more than 1,000 children in therapeutic feeding centers and an additional 3,500 in supplementary feeding programs. MSF is already distributing high-energy foods to children under five years of age and providing water and sanitation services. MSF has been treating measles and is preparing for malaria and cholera outbreaks.
Two young men, equipped with a flashlight and an iron rod, are looking for two-inch-long bugs in all 72 of San Simón’s houses. The villagers in this remote corner of Bolivia call the men vinchuqueros, a play on the local word vinchucas, for the insects that carry the parasite for Chagas disease. The disease is one of Bolivia’s biggest killers.

The vinchucas climb high up the clay walls inside of houses and fall onto the exposed arms of sleeping children. After a bug bites and defecates on the skin, the victim unknowingly scratches the parasites into the bloodstream.

The initial symptoms are minor—fatigue and stomach pain. Sometimes 10 or 15 years pass before symptoms appear. But once Chagas has taken hold of its victim, fatigue increases and can prevent him or her from performing even the slightest task. Heart failure is the usual cause of death.

The vinchuqueros, Félix and Raúl, sometimes walk for up to seven hours before reaching a home. They and other vinchuqueros count the children in each household; spray the roofs, mud walls, rooms, and floorboards with insecticide; and check for the insect in food supplies, beds, parcels, wardrobes, and cracks in the walls to kill the bugs and destroy their nests. The work is all part of a Chagas-prevention and treatment program that Doctors Without Borders/Médecins Sans Frontières (MSF) opened last year in Entre Ríos, in southern Bolivia’s O’Connor province. The disease affects 30 percent of all children under 14 in the area.

The prevention program is essential because after receiving the current treatment, “children can get infected again that very evening, while sleeping at home,” says Francisco Román, field coordinator in the Entre Ríos municipality.

Children have only a 60 to 80 percent chance of recovering from Chagas, according to Dr. Fernando Parreño, the pediatrician working for the project. “As they get older, though, the side effects of the medicines they need to take increase while the efficacy decreases,” says Parreño.

TRAGIC DISTINCTION

Bolivia holds the unfortunate record for Chagas infections in Latin America. The disease is endemic in 60 percent of the country. Half of the population—some 3.5 million people—is at risk, and Chagas is responsible for 13 percent of Bolivia’s total deaths.

When MSF arrived in Entre Ríos a year ago, the infestation rate for Chagas was 19 percent. Only when the infestation rate dips lower than 3 percent can treatment be started; otherwise re-infections will outpace the treatment.

“Starting treatment was out of the question,” says Román. “However, by fumigating and repairing each and every household the chance of infection has decreased considerably.”

Currently, MSF is the only organization offering treatment to children under 14, the age group for whom treatment is most effective.

So far in Entre Ríos alone, the MSF team has offered treatment to the 606 children who have tested positive for Chagas. MSF’s goal is to treat 2,000 children and cover the 103 communities within O’Connor province.

If MSF did not pay for the medicines, families of children with the disease—that is, those who could reach the pharmacy—would have to pay $50 per child, a prohibitive amount in a country where most people live on less than a dollar per day.

CHAGAS DISEASE (South American Trypanosomiasis)

CAUSE: Parasite Trypanosoma cruzi. Transmitted by the bite of a reduviid bug (kissing bug).

SYMPTOMS: Fever, fatigue, swollen lymph glands, enlarged liver and spleen. Symptoms may go unnoticed until the chronic stage, at which treatment is ineffective and fatal heart disease occurs.

PREVALENCE: 16 to 18 million people are infected with Chagas disease in Central and South America; of those, 50,000 die each year. The disease decreases life expectancy by an average of nine years.

TREATMENT: Nifurtimox and Benznidazole. However, neither medicine is ideal because of their low efficacy during the chronic phase of the disease or against resistant strains; because of side effects that deter many patients from continuing treatment; and because of the long treatment period (30 to 60 days), which requires specialized medical supervision.

MSF RESPONSE: MSF is operating Chagas-prevention and treatment projects in Bolivia, Guatemala, and Nicaragua, targeting children under 14. On the global level, the Drugs for Neglected Diseases Initiative, a collaboration of health and research institutes from Brazil, France, India, Kenya, and Malaysia, with MSF’s support, is working with drug companies to ramp up production of Nifurtimox and Benznidazole, and to increase new research and development into treatment for the disease.
TARGETED: CIVILIANS BEAR THE BRUNT OF ONGOING VIOLENCE IN NORTHERN UGANDA

Children abducted. Women and girls raped. Civilians murdered. More than 1 million people forced to flee their homes. The 18-year war between the Ugandan government and Lord’s Resistance Army (LRA) continues to take its toll on civilians.

In February, an attack attributed to the LRA on a camp for internally displaced people outside the town of Lira in northern Uganda left 60 wounded and nearly 200 people dead. The attack is an example of the increasing violence in the north that has forced 20,000 to 40,000 people to remain in camps in and around the town of Soroti, and more than 300,000 people to inhabit nearly 50 camps around Lira.

“We are seeing a huge emergency—one of the worst in Central Africa,” said Catrin Schulte-Hillen, who is responsible for MSF’s programs in Uganda.

She added: “Assistance has been inadequate. Sometimes people have been killed after leaving camps to search for food.”

EMERGENCY RESPONSE

In response, MSF has launched several emergency programs for displaced people in northern Uganda. Following an influx of 100,000 people into Soroti in the summer of 2003, MSF provided medicines and staff to the pediatric ward of the local hospital and to four outpatient clinics, which were overwhelmed by the three-fold increase in the population. MSF also trained community health workers to monitor the health situation in 11 camps, and set up a therapeutic feeding center (TFC) in the hospital compound to care for severely and moderately malnourished children.

“Life is difficult here,” said Abiro Paulina, a mother of five seeking treatment at a clinic in Soroti. She fled her village last August after an attack attributed to the LRA. “Since January, when we were given 100 pounds of maize and one bucket of beans, we have not received any food. Now we look for small jobs in the houses or shambas (fields) of people in Soroti to earn a bit of money to buy food at the market. In late January, I went back to our village to see if there was any food there in the fields. I found some cassava, but all the houses in our village had been looted. In the village of my parents, nearby, all the houses had been burned down.”

MSF has now handed back the management of the pediatric ward and the TFC in Soroti to the Ugandan Ministry of Health. MSF continues to support two of the four outpatient clinics there and to perform more than 1,500 consultations each week. Currently, MSF is assessing the needs in other camps.

“We are seeing a huge emergency—one of the worst in Central Africa.”

In the town of Amuria where 30,000 displaced people have settled, MSF is providing 700 consultations every week. Because of poor security, MSF has been able to access only 20 camps in Lira. Volunteer teams provide basic health care,
Every night, they arrive in droves in the northern Ugandan town of Gulu. Up to 12,000 children, some as young as two years old, walk several miles from the villages and camps for internally displaced persons surrounding Gulu, hoping to find shelter for the night. The next morning, they set out again en masse to attend school near their homes, only to return again later that night.

“You can see the distress in the kids eyes. They are really tired but can’t sleep.”

“It’s shocking to see this massive flow of little kids carrying blankets, sleeping bags, even mattresses,” says Bastien Vigneau, director of operations for MSF’s projects in Gulu.

They are called the “night commuters,” a euphemism that obscures the cruel reality of 50,000 children taking part in such an exodus each night. They seek shelter in town centers out of the sheer terror of being attacked or kidnapped by soldiers from the Lord’s Resistance Army to serve as soldiers, porters, or sex slaves.

Gulu is home to 30,000 people, and its well-stocked markets bustle with economic activity during the day. By nightfall, though, the streets are deserted, and the gates of Lacor Hospital on the northwest fringes of town close at 9:00 pm on a sea of nearly 5,000 children gathered in the hospital’s central square.

Every night in the square, an MSF team treats up to 600 children for scabies, a severe skin disorder caused by burrowing mites, which is exacerbated by crowded living conditions. Half the children eat only one meal a day.

“You can see the distress in the kids’ eyes,” says Vigneau. “They are really tired but can’t sleep.”

SEEKING SHELTER FOR THE NIGHT

HIDDEN TRAUMA

Much of the distress felt by the displaced cannot be measured by medical exams. Hidden behind the blank stares of the fathers and mothers whose children have been abducted or killed, the women and girls who have been raped, the boys who have escaped from the frontlines, and the men who have been beaten lies the story of a traumatized people. MSF runs a project in Lira to provide treatment for mental trauma.

According to Lynne Chobotar, a mental health coordinator for MSF in Lira, about 80 percent of the children being counseled in the camp in Erute know at least one person who has been abducted.

“After the first few sessions, some people said to me, ‘I used to suffer from insomnia. But when I talked to you, I can go home and sleep afterwards,’” said Komekech Charles, a social worker from a neighboring district who works for the MSF mental health project in Lira.

NO END IN SIGHT

“The situation will remain precarious,” said Shulte-Hillen of MSF.

“There appears to be no end to the violence against civilians. People have missed the most recent planting season so they will need aid for months to come.”
EMERGENCY RESPONSE

During a humanitarian emergency, a matter of hours can make all the difference in responding to people’s needs. Over three decades, Doctors Without Borders/ Médecins Sans Frontières (MSF) has developed more than 50 ready-to-be-dispatched medical and logistical kits that can be combined to respond to most emergencies. These kits contain all of the medical and non-medical supplies necessary to provide a wide range of emergency medical tasks.

In September 2003, MSF sent an exploratory team to assess the condition of Sudanese refugees flooding into eastern Chad, specifically in and around the Chadian border towns of Tine and Birak. The refugees were fleeing the conflict in the Darfur region of Sudan. The following is an account of MSF’s response to this emergency, from the initial assessment, through the arrival of relief supplies, to the distribution of aid to the refugees. It is a typical example of how MSF reacts to emergencies.

ASSESSING THE NEEDS
After hearing about the influx of Sudanese refugees into Chad, on September 6 MSF dispatched a nurse and a logistician to assess the situation. They found approximately 11,000 refugees, 75 percent of whom were women and children, dispersed around Tine and Birak, with little or no access to food, potable water, or shelter. The refugees were at risk of contracting diarrhea and other waterborne diseases because they were relying on river water to drink. They were also in danger of contracting respiratory infections due to the harsh desert climate, where temperatures soared during the day and plummeted at night. The team found no local supplies of medicine, and surveys indicated that there was significant risk of an outbreak of measles or meningitis because very few of the refugees had been vaccinated. In Tine, many of the children suffered from malaria. The team determined that malnutrition rates, while not yet alarmingly high, had the potential to increase if the food supply did not improve.

PLANNING A RESPONSE
The assessment team reported back to the MSF team in the Chadian capital, N’Djamena, that personnel and supplies were needed to mount an emergency intervention to provide medical care, vaccinations, and food and water for the Sudanese refugees. Within days, MSF dispatched an 11-person team—doctors, nurses, logisticians, and administrators—to lead aid operations.

ORDERING KITS
On September 17, an MSF-chartered cargo plane left for N’Djamena from Ostende, Belgium—where one of MSF’s three logistical centers is located—with 33 tons of humanitarian aid and 11 international MSF volunteers. The cargo included material to build two health centers as well as kits to provide 10,000 people with medicine—including measles vaccines—and therapeutic food for malnourished children for a period of three months. The plane also carried three 4-wheel-drive vehicles and equipment to provide clean water, including pumps, pipes, tanks, and water-purification chemicals.

DELIVERING SUPPLIES
The plane arrived the same day in N’Djamena. The cargo was immediately unloaded and put on another plane for Abeche, the provincial capital in eastern Chad, then driven for another seven hours to Tine and Birak.

BUILDING HEALTH CENTERS
On September 25, MSF opened its first health centers in Tine, and four days later, a therapeutic feeding center for severely malnourished children. Four tents were set up to provide consultations for thousands of refugees living in camps outside the town. The tents housed a consultation room, pediatric unit, pharmacy, and inpatient areas. “The bad quality of the water was probably the reason for the high number of patients we saw with diarrhea,” said MSF nurse Fabienne Gaborieau. “People here have to drink the unfiltered water they found digging in a dry riverbed.” On September 29, MSF opened a health center in Birak.

MASS VACCINATIONS
In October, the teams launched measles vaccination campaigns in Tine and Birak. Measles is the leading cause of death among refugee children because it is very contagious and spreads easily in overcrowded settings. Measles also exacerbates malnutrition. Initial immunization is standard procedure in any refugee situation, and children from six months to 15 years of age are targeted. The vaccine must be kept cool or it will lose its efficacy. (See “Cold Chain” on page 10.)

SITUATION UPDATE
Twenty international and 46 national staff are now working in eastern Chad. Doctors and nurses are mainly treating people for diarrhea, severe respiratory infections, conjunctivitis, intestinal parasites, rheumatism, and urinary infections. In Tine, teams perform 350 consultations per week in addition to more than 300 consultations performed through mobile clinics in surrounding villages hosting pockets of refugees. The Birak therapeutic feeding center has been admitting two or three new children each week. MSF is also working in the Iriba district hospital and running a nutritional center, where there are currently about 120 children receiving therapeutic or supplementary feeding. Around Adre, MSF works in four clinics along the border and supports the town’s hospital. In mid-April, MSF vaccinated 70,000 people against meningitis.
Sudanese refugees in Chad lack adequate shelter.

Refugees line up to receive treatment at an MSF health clinic in Tine.

An MSF volunteer weighs a refugee child in Birak, Chad.

Aid supplies are unloaded from a plane in Chad’s capital city, N’Djamena, and put on another plane to Abeche, the provincial capital in eastern Chad.

Refugees have almost no access to safe drinking water.

MSF staff unload supplies in Tine, Chad.

An MSF volunteer checks the nutritional status of a refugee child in Tine.
EMERGENCY HEALTH KIT
Designed to provide health care for 10,000 displaced people for 3 months.
**Items include:** 250 pairs of surgical gloves, 3,000 Amoxicillin tablets (250 mg each), 50 surgical knives, 100 tongue depressors, 3,000 disposable needles, 1,000 gauze compresses, 1,000 folic acid tablets (5 mg each), 6 thermometers, 50 morphine injections, 4 stethoscopes, 100 meters of umbilical cord tape, 20 safety boxes for used syringes and needles.

SUPPLEMENTARY FEEDING KIT
Contains all the equipment needed to weigh, measure, register, and feed 250 moderately malnourished children.
**Items include:** 600 blue ID bracelets, 400 plastic spoons, 3 cooking pots, 300 small plastic bowls, attendance sheets, 2 hanging scales, 10 pencils, 1 MSF nutritional guidelines book, 2 calculators, 4 clipboards, 1 kitchen scale, 100 bracelets to measure malnutrition.

A KIT FOR ANY EMERGENCY
MSF has developed more than 50 kits, including a basic medical kit, an emergency medical kit, a vaccination kit, and a surgical kit. These kits contain all the medical and logistical supplies, from syringes to surgical instruments, and from all-terrain vehicles to tents and radios, that MSF field teams need to run an aid operation. MSF has made the kits uniform and functional in any climate, no matter whether the teams are operating in the cold of the Afghan winter or the heat of the Ethiopian summer. An MSF team administering measles vaccinations in Chad receives the same supplies as a team immunizing children in Afghanistan. The kits allow MSF teams to work quickly and effectively in any crisis.

For example, to furnish medical assistance to a displaced population of 30,000 people in an isolated area, MSF might elect to deploy three emergency health kits each containing enough supplies to care for 10,000 people for a period of three months, as well as various kits providing energy sources, all-terrain vehicles, office supplies, satellite communications equipment, and other equipment and tools.

COLD CHAIN: PRESERVING VACCINES IN THE FIELD
Many vaccines, such as those for measles and polio, must be kept frozen or within a constant temperature range or they will lose their effectiveness. Measles vaccines must be kept between 35 and 46 degrees Fahrenheit—no simple task when they are being transported along dirt roads in the harsh desert climate of Chad. This situation calls for what is commonly known as a “cold chain.” A cold chain is a continuous system of conservation and distribution of vaccines, at a precise temperature, from the factory to the field. MSF has developed a vaccination kit that has enough supplies for five teams to immunize 10,000 people. Included in this kit are ice packs, coolers, generators, gas-powered refrigerators, freezers, and thermometers to maintain the cold chain.
When clinicians, health officials, pharmaceutical-industry representatives, activists, and others descend on Bangkok, Thailand, for the XV International AIDS Conference in July, they will hear a clear message from Doctors Without Borders/Médecins Sans Frontières (MSF): If current efforts to increase and maintain effective treatment are to succeed, people living with HIV/AIDS in developing countries need access to simplified, affordable medicines and new diagnostic tools.

Today, MSF is providing antiretroviral (ARV) treatment to more than 13,000 people living with HIV/AIDS in more than 20 countries. The organization expects to be treating 25,000 in 25 countries in Africa, Asia, Latin America, and Eastern Europe by the end of 2004. MSF’s ability to increase the number of patients on treatment is predicated on using fixed-dose combinations (FDCs) of ARVs—that is, pills containing two or three AIDS drugs in one tablet.

Years of activism and the introduction of generic competition have pushed down the prices of FDCs to as little as $140 per person per year—compared with $10,000 to $15,000 just three years ago. Taking fewer pills a day also makes it easier for patients to adhere to their treatment regimen and hopefully helps reduce drug resistance.

But first-line FDCs are not enough. The nature of the HIV virus often requires changes in therapy, usually after the first two years of treatment. The switch to second-line therapy is effective if done in time. While there has been great progress in reducing the cost of first-line treatment, the cheapest second-line treatment regimen is still well over $1,100 per person per year.

Second-line treatment recommended by the World Health Organization can cost as much as $5,000 to $6,000 per person per year. There are few generic second-line drugs and no FDCs, and without competition, brand-name drugs remain out of reach. For special populations, such as pregnant women and children with HIV/AIDS, there are even fewer choices of appropriate, affordable drugs.

In Bangkok, MSF will present data from its treatment projects and lead skills-building workshops on patent and procurement issues. Plans are well underway for an MSF community satellite meeting called “What Leads to Change and What Needs to Change: Breaking the Rules for Treatment Access,” where local and international experts will work together to find creative solutions to overcoming new and ongoing barriers to HIV/AIDS treatment.

It is fitting that MSF return to Bangkok to confront barriers to treatment for HIV/AIDS. It was in Thailand, in the year 2000, that MSF first began providing ARV treatment in response to the demands of people living with HIV/AIDS. It was also in Thailand that MSF started confronting the complex ways in which drug company prices, patents, and international trade rules conspire to keep lifesaving medicines out of reach for poor people. Today, MSF is providing ARV treatment to approximately 1,000 people who are living with HIV/AIDS in Thailand.
Africa’s annual meningitis season is coming to an end, and luckily few major outbreaks have occurred. But there is still no sustainable supply of vaccines against the bacteria that could still decimate countries in the continent’s so-called “meningitis belt.” Worse, vaccines that offer long-term protection against meningitis will not be available until at least 2008.

**MILLIONS AT RISK**

The “meningitis belt” stretches across sub-Saharan Africa from Senegal in the west to Ethiopia in the east. Each year, meningitis kills more than 170,000 people and puts some 300 million people at risk. Doctors Without Borders/Médecins Sans Frontières (MSF) vaccinates three to five million people against meningitis every year.

The highly contagious bacteria causes sudden and intense headache, fever, nausea, vomiting, photophobia, and stiffness of the neck. Death can follow within hours of the onset of symptoms.

Without treatment, meningitis can kill up to 50 percent of those infected. Even when the disease is treated with the right drugs, fatality rates can reach 10 percent, with one in five patients suffering permanent neurological damage such as deafness or mental retardation.

In children—the group most vulnerable to meningitis—the current vaccines only provide immunity for two to three years. The result is an annual battle to stop the next epidemic. And new strains are making it tougher to keep ahead of this battle.

**W135: EMERGING STRAIN**

In February 2002, MSF teams were responding to an outbreak of meningitis in Burkina Faso when they began to realize that the standard vaccine was not working. A new strain of meningitis, known as W135, had struck Burkina Faso. It presumably originated in Saudi Arabia and was transmitted to the Burkina Faso population through pilgrims traveling to and from Mecca. The outbreak infected almost 13,000 people and killed more than 1,400.

W135 had never before hit Africa on such a large scale. Burkina Faso remains the only country to have faced an epidemic of the new meningitis strain. But there is a real threat of W135 epidemics breaking out in neighboring countries.

**DEVELOPING A VACCINE**

After months of negotiations led by the World Health Organization, the drug company GlaxoSmithKline (GSK) agreed to develop and license a new vaccine that would protect against three strains of meningitis, including W135, for use during the 2003 epidemic season. The first round of production was largely funded by the Bill and Melinda Gates Foundation. Two million doses of the new vaccine were used in Burkina Faso for epidemic control in 2003.

It was estimated that six million doses of vaccine would be needed for the 2003-2004 epidemic season—an amount that GSK produced for African countries at one euro per dose. MSF was able to purchase two million doses from GSK with the help of an anonymous donor. But the estimated need for the next five years could range from 20 to 50 million doses if a large outbreak occurs. At the moment there are no funds available to ensure a sustainable supply of the vaccine.

“The threat of an epidemic involving W135 meningitis in Africa remains very real,” says Graciela Diap, MD, medical director of MSF’s Campaign for Access to Essential Medicines.

“If governments and international agencies start reacting only once an epidemic is there, it will be too late. Immunization needs to be begun at the very outset of an epidemic to be effective. Thousands of lives are at risk because of this shortsightedness.”
In the Shadow of ‘Just Wars’: Violence, Politics, and Humanitarian Action

Edited By Fabrice Weissman
Cornell University Press 2004

In April, Doctors Without Borders/ Médecins Sans Frontières (MSF) published the book In the Shadow of ‘Just Wars’: Violence, Politics, and Humanitarian Action. In this new collection of essays, MSF challenges the international community’s complicity in crises that are killing vast numbers of people around the world. From the devastating wars in Chechnya, Colombia, and Algeria, to the famines of North Korea, Sudan, and Angola, to the ‘just wars’ of Iraq, Afghanistan, Indonesia, Kosovo, and Sierra Leone, millions of lives have been deemed expendable in the name of political interests.

The first section of Just Wars analyzes 11 major crises and the international reactions—or lack thereof—they have aroused. The second section includes essays that explore issues affecting humanitarian action. Contributors examine questions such as: How can humanitarian organizations best aid and advocate for those most at risk? How is humanitarian action compromised when aid agencies agree to work alongside the US government in its ‘just wars’ in Iraq and Afghanistan, or with the United Nations in Angola and Sudan?

Just Wars is the fourth edition in MSF’s book series Populations in Danger. Among the contributors are MSF’s Rony Brauman, Fiona Terry, and Fabrice Weissman, and journalist David Reiff.

MSF launched the book in the United States at an event in New York hosted by Pulitzer Prize–winning author Samantha Power and Brauman, which attracted over 300 people.

Just Wars can be purchased at booksellers nationwide.
On the Medical Frontlines:
Practicing Medicine Overseas

MSF kicked off its 2004 speaker series with an event at New York University Medical Center aimed at encouraging more doctors to volunteer with the organization. More than 150 attendees gathered to hear pediatrician Sonia Cheng, MD; physician Benjamin Wan, MD; and surgeon Mary Ann Hopkins, MD talk about their experiences working for MSF in Angola, Sudan, Liberia, Sri Lanka, and Burundi. Medical professionals had a chance to ask questions about what it was like practicing medicine in a foreign country and how the MSF physicians had made time within their busy careers to volunteer.

One Patient at a Time:
Dr. Sanjay Gupta Talks to Doctors Without Borders

On June 17, Sanjay Gupta, MD, Senior Medical Correspondent for CNN, will moderate a discussion about MSF’s response to infectious disease in some of the world’s most neglected communities. Joining Dr. Gupta will be MSF International Council President Rowan Gillies, MD, along with MSF field volunteer physicians Lulu Oguda, Unni Karunakara.

INCREASING ACCESS TO EFFECTIVE MALARIA TREATMENT

From April 29 to 30, MSF, the World Health Organization (WHO), Unicef, and the Mailman School of Public Health at Columbia University co-organized “ACT Now: An International Symposium on Malaria.” The symposium was convened to tackle the urgent need for new malaria medicines to replace old treatments that are no longer effective.

One million people—mainly children under five—die each year from malaria. Artemisinin-based combination therapies (ACTs) have shown remarkable effectiveness in treating the disease. However, high costs and limited production, combined with political intransigence, have slowed progress on making ACTs available to the millions who need them.

The symposium brought together experts to discuss ways to make ACT accessible now. Countries such as Zambia and Vietnam, 2 of the 30 countries that have adopted ACT as national treatment policy, shared their experiences in moving to ACT. Manufacturers of ACT from Asia and Europe identified obstacles to scaling up production, such as a lack of concrete commitments from purchasers. In a joint statement the co-organizers agreed that they “recognize that expanding access to ACT is increasingly a matter of life or death for people at risk of malaria, and therefore are committed to discontinuing support for the use of ineffective medicines and actively working toward implementation of ACT as quickly as possible.”

MSF will continue to share results from malaria treatment programs and to maintain pressure on Unicef and WHO as well as other institutions that have made public statements supporting ACT.
ARJAN ERKEL FREED AFTER 20-MONTH ABDUCTION

On Sunday, April 11, 2004, after 20 months as a hostage in the Northern Caucasus, MSF aid worker Arjan Erkel was released. For Arjan's family and friends and the entire MSF community, the news brought enormous relief. Erkel, 34, was serving as head of mission in Dagestan when he was abducted there on August 12, 2002.

"MSF is extremely happy that Arjan is finally back home," said Dr. Rowan Gillies, president of MSF’s International Council. “But it must be remembered that a huge price was paid not only by Arjan but by countless others as well. Arjan’s kidnapping led to drastic reductions of aid to displaced and war-affected people throughout the region. It reinforced the climate of intimidation against humanitarian actors that has existed in the region for years.”

Arjan is now home in Holland with his family.

Arjan Erkel speaking to the press in Moscow, a few hours after his release.
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TREATING HAITI’S WAR WOUNDED

Early this year, MSF sent emergency medical teams and 16 tons of medical equipment to Haiti to address casualties resulting from violent civil unrest. MSF was particularly concerned about wounded civilians being denied services at local health centers because of their political affiliation or their inability to pay for treatment. Philippe Hamel, MSF’s head of mission in Haiti, explained, “We aim to ensure free access to treatment for all wounded, regardless of their political background or financial means.”

MSF CONFRONTS MEASLES EPIDEMIC IN NIGER

In April, MSF teamed up with the Niger Ministry of Health to launch a measles vaccination campaign in the capital, Niamey, after an outbreak of more than 20,000 cases and 149 deaths. MSF sent 150,000 vials of measles vaccine as well as syringes to the national supply. Vaccination teams, each composed of two doctors, a nurse, and two MSF logisticians, together with Nigerian health workers, vaccinated children in all of the city’s 30 health centers.

MSF also distributed 15,000 measles-treatment kits, including 1,500 special kits for severe cases. The most seriously ill children were given food supplements to combat malnutrition, which often accompanies measles.

EMERGENCY RESPONSE TO EARTHQUAKE IN MOROCCO

Several hours after a devastating earthquake ripped through Al Houceima, Morocco, in February an MSF emergency-response team arrived on the scene. In the following days, MSF continued to make assessments and to ship in emergency provisions, distributing several thousand blankets and more than 400 tents for those made homeless by the earthquake.

MSF MOURNS KILLING OF FIVE STAFF IN AFGHANISTAN

As this issue of Alert goes to press, it is with great sadness that MSF reports the brutal killing of five colleagues in northwestern Afghanistan on June 2.

Hélène de Beir of Belgium, project coordinator; Willem Kwint of Holland, logistician; Egil Tynaes of Norway, medical doctor; Fasil Ahmad of Afghanistan, translator; and Besmillah of Afghanistan, driver; were all committed to bringing humanitarian assistance to people in distress.

MSF extends our heartfelt sympathies to their families and friends. The volunteers were killed in an MSF-marked vehicle while traveling on the road between Khairkhana and Qala-I-Naw in the province of Badghis. Their vehicle was ambushed and shot at from various directions.

MSF strongly condemns this brutal attack. For the time being, MSF has suspended activities in Afghanistan to evaluate how the organization can continue to offer medical assistance to people in desperate need under these insecure conditions.

MSF started working in Afghanistan in 1980. Prior to the killing of our colleagues, MSF was working in 12 of the country’s 32 provinces with activities ranging from primary health care to supporting hospitals and mental health projects. MSF has been assisting people in Badghis province since 1999 and started running an outpatient department in Khairkhana in 2001. In February 2004, MSF started a tuberculosis treatment program and currently MSF has 45 patients undergoing treatment for the disease. MSF recently opened a maternal and child health facility.