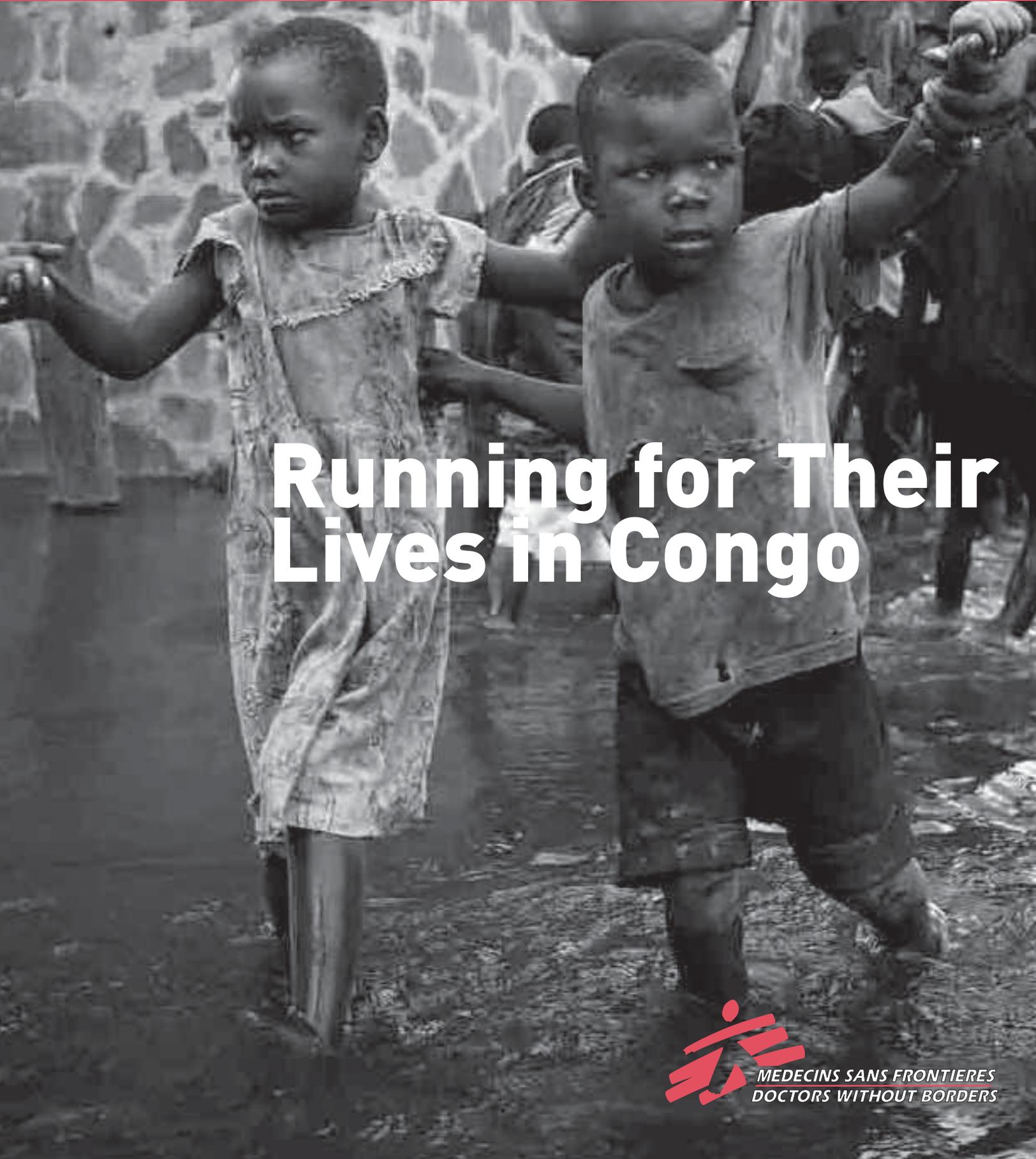


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ALERT



Running for Their Lives in Congo



MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

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HUMANITARIAN SPACE

Dear Friends,

It is with great sadness that I must inform you of the death of two Doctors Without Borders/Médecins Sans Frontières (MSF) aid workers in Nigeria in a plane crash on December 10, 2005. Hawah Kamara, 49, and Thomas Lamy, 30, were on a flight from the Nigerian capital, Abuja, heading to Port Harcourt in southern Nigeria, where MSF has a surgical program. The brutal loss of Hawah, a long-time and much beloved staff member of MSF-USA, and Thomas, an experienced MSF aid worker, has left all of MSF deeply saddened. They will be terribly missed.

The ideals that Hawah and Thomas represented live on in the dedicated MSF teams working in the Democratic Republic of Congo (DRC). From treating victims of violence in the war-torn northeastern Ituri region to providing antiretroviral treatment to people living with HIV/AIDS in the capital Kinshasa, MSF teams are active throughout much of this vast country.

Neither the three-year-old internationally-backed peace process nor the presence of UN peace-keeping forces has improved living conditions or security for many Congolese. In the "Situation Report" feature in this issue of *Alert*, we shine a spotlight on the catastrophic emergencies unfolding in the DRC's Katanga and North Kivu provinces, which have been virtually invisible to the outside world. MSF is providing medical and nutritional care to tens of thousands of civilians who have been violently displaced in these two provinces.

Much of Katanga's lush land goes uncultivated because civilians are too afraid to plant their crops. They are caught up in fighting between the Congolese army, known as the FARDC, and the so-called Mai-Mai militias, who were nurtured to oppose the Rwandan-backed forces that invaded the DRC in 1997 and have since withdrawn from the area. Now the FARDC's efforts to reign in its former Mai-Mai allies have given rise to a mix of robbery, rape, and extortion of civilians, while Mai-Mai militias also kill, rape, and loot the population that it was hastily spawned to protect. Assistance to those most affected by this violence is woefully inadequate.

Beyond the report on Katanga and North Kivu, you will also notice several additional new features in this issue, such as a "Field Journal" from one of our surgeons in Pakistan. We hope these features will give you a more complete picture of MSF's field operations and the challenges that our teams confront as they assist hundreds of thousands of people affected by armed conflicts, epidemics, and natural and man-made disasters around the world.



Nicolas de Torrenté

Executive Director

US Section of Doctors Without Borders/Médecins Sans Frontières (MSF)

Cover:

A family of displaced Congolese civilians crosses a river to reach safety in Dubie, Democratic Republic of Congo © Per-Anders Pettersson/Getty Images

Opposite page:

Forced to flee fighting between the Congolese army and Mai-Mai militias in Katanga province, 20,000 displaced people arrived on foot in the town of Dubie. © Per-Anders Pettersson/Getty Images

RUNNING FOR THEIR LIVES: CIVILIANS VIOLENTLY DISPLACED IN THE DRC'S KATANGA AND NORTH KIVU PROVINCES



Katanga province is home to perhaps the most forgotten crisis in the Democratic Republic of Congo (DRC). Since peace was declared two years ago, there have been several waves of violence in Katanga instigated by fighting between the Congolese army, known as the FARDC, and the Mai-Mai, a militia created to oppose invading Rwandan government forces in 1997 that now preys on the population. FARDC military operations against Mai-Mai groups have displaced civilians as well, with soldiers committing robbery, extortion, abuse, and rape.

Since last August, fighting between the FARDC and the Mai-Mai, and among competing Mai-Mai militias, has violently displaced more than 100,000 Congolese. Already impoverished and traumatized, these civilians are now struggling to survive in the surrounding forest, makeshift camps, and overcrowded towns. They are enduring cholera

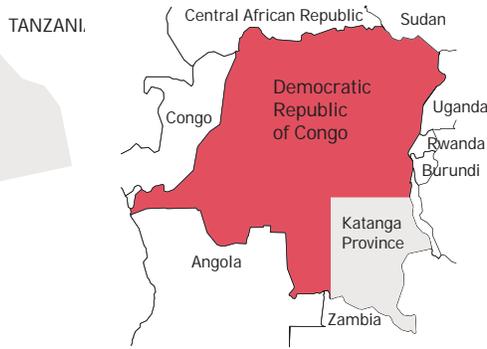
outbreaks, malaria, and inadequate shelter and food supplies. Doctors Without Borders/Médecins Sans Frontières (MSF) teams are bringing relief to tens of thousands of the displaced.

"In the forest we suffered a lot, sometimes we had only 1 meal per week...sometimes I had to walk for 20 miles or more before finding some flour."

—A man from Katanga with seven children; one of whom died in the forest.

In North Kivu province, despite a heavy deployment of UN peacekeeping contingents, insecurity and violence have set the entire region ablaze. In just over one month, heavy fighting in the Rutshuru and Beni regions have led to more than 80,000 people being displaced.

MAP OF KATANGA WITH UPDATES ON AREAS LISTED



KIKONDJA: FIGHTING CHOLERA

In 10 days in January, 340 patients were admitted into two cholera treatment centers set up by MSF in Kikondja and Mangi, and 12 died. The last epidemic in this region was in 2002, when MSF teams treated 4,470 cholera patients in eight months.

NYONGA: SHIPWRECKED IN THE SWAMP

In January 2006, MSF began assisting more than 35,000 displaced people who have settled in this mosquito-infested swampy area, many of them surviving on the fish they catch each day. MSF teams run a 10-bed health center, have vaccinated 8,000 children against measles, and have distributed relief items such as fishing nets, plastic sheeting, blankets, mosquito nets, cooking sets, and jerry cans to the most vulnerable families.

MITWABA: "ANOTHER CHAPTER TO THEIR HISTORY OF SUFFERING"

A camp for displaced people, Mazwombe, near the Mitwaba region of Katanga, was attacked in early December. Some 3,000

people who were living in the camp were forced once again to flee for their lives. "Houses have been burned, including the MSF health center, one person has been killed and several wounded," says Laurence Saily, coordinator of the MSF emergency team in DRC. "... another chapter to their history of suffering."

"I remember the long lines of parents waiting patiently so their children could be vaccinated against measles. I listened to their harrowing stories... the family members who were killed, the sexual violence endured, the incessant fear and exhaustion from constantly running for their lives.... They told me how they were hungry and lived in constant fear.... These people seemed to have no expectations of being helped. They were tired, and grateful to receive anything at all."
—Helen O'Neill, nurse and deputy director of MSF's programs in the DRC, speaking to the UN Security Council on January 21.

NYUNZU: REACHING THE VULNERABLE AND ISOLATED

MSF is supporting the Nyunzu Referral Hospital and three health clinics within a 35-mile radius of the hospital.

"In the areas farthest away, which we intend to reach, tension is high between the Mai-Mai groups and army, which seeks to disarm them. In this context,

robbery and abuse of civilians often occurs," says Cameno Dieg, an MSF coordinator based in Lubumbashi, the provincial capital.

DUBIE: "THEY ARRIVED IN HUGE NUMBERS WITH NOTHING"

In the past two months, more than 18,000 people have traveled more than 90 miles in their effort to escape violence in the province. They have now settled in the village of Dubie. MSF has constructed three separate camps, doubled the daily water supply, distributed essential items such as plastic sheeting for shelter and utensils for cooking, and is running mobile clinics and vaccinating children against measles.

"They arrived in huge numbers with nothing, sometimes without even any clothes... We also noticed that there were very few children under one year of age. These are the most vulnerable and most had simply not survived their ordeal," says Goedele Van Bavel, MSF project coordinator.

"We lived in the bush for six months because we were too scared to go back to our village. I lost my wife because there was no medicine. I have only one child left, the other four are all dead." —Ngombe Kangula, former chief of Kitondwa, a village in Katanga province, now seeking safety in Dubie.



Top:
In a makeshift camp in Dubie, a crowd of displaced children wait to be vaccinated against measles by MSF. © Per-Anders Pettersson/Getty Images

Right:
In Dubie, an MSF national staff member vaccinates a girl and her younger sister against measles. © Per-Anders Pettersson/Getty Images

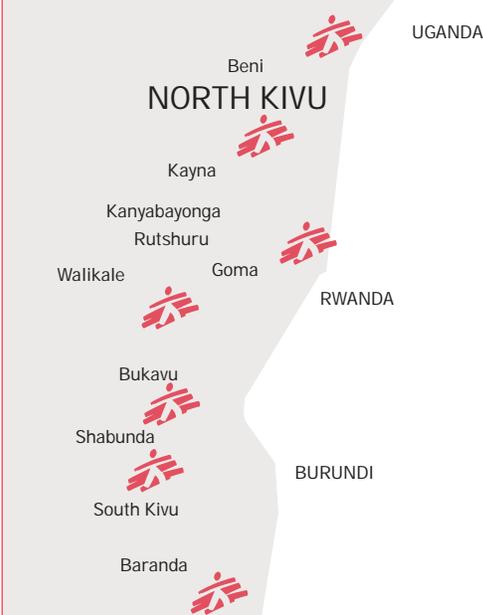
Left:
MSF physician Chris Lenzen checks on a young patient during the night. © Per-Anders Pettersson/Getty Images

Bottom:
MSF staff discuss logistical needs on the grounds of Nyunzu Hospital. © Veronica Nicola



MAP OF NORTH KIVU WITH UPDATES ON AREAS LISTED

0 100 200 300km



Newly arrived displaced people collapse from exhaustion outside of Dubie's schoolhouse.
© Per-Anders Pettersson/Getty Images



RUTSHURU: A RAGING BATTLE EMPTIES A TOWN

Since fighting broke out January 20 in and around the Kibiridzi area, tens of thousands of people have fled fighting and violence. At least 40,000 have managed to reach Kanyabayonga, Kayna, and Kirumba. Many others still remain in the bush around Kibiridzi, subject to violence and looting. Before the fighting, the MSF team in the Rutshuru Referral Hospital,

which had to be evacuated, carried out an average of 25 surgical interventions a week and saw more than 100 patients a week in the emergency room. In 2005 alone, MSF treated more than 1,200 victims of rape in Beni, Kayna, and Rutshuru.

*"The military harass people at night. They come to inspect our homes, make the children leave and then help themselves...when there are aid distributions, I'm frightened: there are always military who come to take what we've been given."
—A 40-year-old woman from Katanga*

KAYNA: TREATING WAR WOUNDED

In Kayna General Hospital, MSF teams treated 20 war-wounded civilians from the violence in Rutshuru during the period of January 20 to January 29.

KANYABAYONGA: VULNERABLE FAMILIES TAKE IN THE DISPLACED

More the 25,000 people displaced by fighting in the Rutshuru territory walked for up to two days to reach Kanyabayonga,

where two out of three homes are now hosting displaced families and there is only enough water for each person to have five liters per day. The displaced told MSF medical teams of people having been raped, tortured, and beaten up. In first week of February alone, MSF doctors provided medical care for 23 rape victims.

BENI: DRIVEN FROM THEIR FIELDS

In December 2005, military operations by the FARDC and MONUC (the UN peace-keeping mission) to flush out Ugandan rebel fighters (NALU) provoked forced displacement of 36,000 people along the Beni-Erengetti road. Though most are receiving medical and basic relief aid, they are living in overcrowded conditions and have been unable to harvest their fields.

*"My daughter went with the Mai-Mai. She was 16 years old when one of them saw her and asked to marry her. What could we say? If we refused, we would die. She went for the family honor. Her dowry was a bead, but you can't do anything with a bead."
—A 36-year-old woman from Katanga*



Top to Bottom:

This pregnant woman and her sister traveled 54 miles to reach an MSF Health Center. © Francesco Zizola

Fleeing rape, torture, and looting in Kibiridzi, approximately 25,000 people traveled for up to two days to reach Kanyabayonga. © Jean-Sébastien Matte/MSF

Few, if any, roads are paved in Katanga province, and many that have been damaged by heavy rains require repair. MSF physician Megan Craven and an MSF driver use tools to reconstruct a road on their way to a rural clinic in Lukonzolwa, a few hours' drive from Dubie. © Per-Anders Pettersson/Getty Images



MANSEHRA, PAKISTAN

“The world is made of glass,
people are made of stone”

Courtland Lewis, MD, an orthopedic surgeon from the University of Connecticut, spent three weeks in Mansehra, Pakistan, where he worked in the Doctors Without Borders/Médecins Sans Frontières (MSF) field hospital. The hospital, composed of nine inflatable tents, serves as the main orthopedic referral center for the wounded in Mansehra district in Pakistan's North-West Frontier Province. More than 500 surgical interventions have been carried out since the hospital opened on November 24, and another 750 patients are currently receiving physical therapy. Dr. Lewis talks about his experience working with MSF.

I left for Pakistan on December 8, 2005, joined by Salahuddin, an anesthesiologist from Las Vegas. It took three days to get to Mansehra where we found the MSF team taking its first day off in six weeks. So five of us decided to visit Balakot, one of the hardest hit towns. It created an unforgettable impression.

We drove into the mountains north of Mansehra, where occasional small tent villages caught our attention. As we drove into Balakot, we were shocked by the complete devastation of the town. Then, as one of the colorful Pakistani trucks passed us, Salahuddin (who speaks Urdu), turned to me and said, “That truck had a saying on it: ‘The world is made of glass; people are made of stone’”

Upon entering Balakot, there was a tremendous cloud of dust generated largely by workers breaking concrete with sledgehammers to retrieve steel rebar reinforcement rods.

It was almost surreal to simultaneously see people dealing with the devastation while getting on with their lives. Their resilience was remarkable, doing what they needed to do to survive and rebuild their lives. Truly, I had the sense that the world is made of glass and people are made of stone.

BEGINNING TO WORK

I started working in the hospital the next day. From an orthopedic perspective, this was phase two of the emergency—phase one being the initial triage and treatment of thousands of injuries. Two months after the earthquake, a certain percentage of these fractures had become infected or were not healing properly, and virtually all injured patients required rehabilitation—just as one would expect from high-energy trauma injuries in New York or Paris.

“It is difficult to imagine the stress level for a person who is trying to recover from a serious injury while at the same time coping with the fact that half the people in his or her town died instantly, a number of them likely family members.” —Orthopedic surgeon Courtland Lewis, MD

There were 88 beds in the field hospital. On any given day, between 55 and 75 beds were filled with orthopedic patients (and their designated family members), most of whom were earthquake victims. The orthopedic operating rooms were where the action was. I operated with the MSF team, which included international and Pakistani staff, for 6 or 7 hours a day, performing between 8 and 18 procedures. These included cleaning up infected wounds, taking cultures, doing skin grafts, and occasionally performing amputations. We created long-term treatment plans for 25 to 30 patients who had really complex problems and needed some continuity in their care. It will take six months to a year or more, in some of these instances, for the patients to heal their fractures.

In the afternoon, I spent an hour examining patients whom the assessment team had brought back to the hospital: these were patients who may have needed casts removed, further surgery, or, most often, required physical therapy. It would then take four hours to round in the hospital with Cathy Pappin, the MSF hospital nurse, and her translator, Waqar.



Page 8, left:
Dr. Courtland Lewis, center, takes a break from the operating room. © Courtland Lewis/MSF

Page 8, right:
In Mansehra, an MSF logistician examines one of the colorfully decorated trucks used by MSF to transport relief supplies. © Remi Vallet/MSF

Clockwise:
This young child is one of many who received orthopedic care from MSF in Mansehra in the aftermath of the earthquake. © Jake Price

Recovering patients sit with their family members in the MSF hospital. © Claire Reynaud/MSF

An MSF logistical team installs the division between the surgical wards in the Mansehra field hospital. © Remi Vallet/MSF

The Mansehra field hospital is composed of nine inflatable tents. © Remi Vallet/MSF



OVERWHELMING THE HEALTH SYSTEM

The sheer number of people injured was amazing. You could have half a dozen orthopedic surgeons working their entire careers in the Mansehra district hospital to care for the long-term problems related to earthquake injuries—fractures that hadn't healed right, arthritis because of fractures into joints, contractures of the affected joints. The level of resources available in Mansehra and the care provided by the ministry of health will just not be adequate to do that. But to be honest, if that many thousands of people were all hurt at the same time in the United States, it would overwhelm us too. The long-term needs are difficult to fathom, just as those for immediate shelter and health care seem right now.

The patients with the most acute orthopedic needs today are those who require physical therapy. By 6, 8, or 10 weeks after major orthopedic injury, most bones are healed, but the joints on either side of the bones and the muscles going across the joints need rehabilitation. Physical therapists and trained therapy aides are available in very limited numbers and one can see that they will be overwhelmed in the next several, all-important months.

HIGH NUMBERS OF RARE INJURIES

There were very interesting patterns of injuries. For example, if you're driving in a car and somebody hits you from the side, it compresses your pelvis, creating a characteristic injury called a lateral compression fracture. One might see one or two of those a year in most American orthopedic practices. I

probably saw 25 or 30 during my short stay in Mansehra. These were people who were lying down, taking a rest, when the ceiling or wall fell on them and crushed their pelvises. Elbow injuries in young children were typical, potentially affecting their growth plates and causing permanent damage.

PSYCHOLOGICAL WOUNDS

The biggest problem for many of the injured people—and this is true anywhere and at any time with orthopedic conditions—was the manifestation of psychological stress as physical pain. Anxiety and depression only make an orthopedic problem worse. I see this every day in my practice at home. It is difficult to imagine the stress level for a person who is trying to recover from a serious injury while at the same time coping with the fact that half the people in his or her town died instantly, a number of them likely family members. Both counseling and physical therapy will be required for many to regain the functional use of their limbs.

Beyond the tent hospital, beyond the exceptional efforts by international and Pakistani health teams working together, beyond the logistical support for shelter, food, and health care is the long-term challenge of making rehabilitation available to vast numbers of people who sustained physical and psychological injuries in the earthquake.

To learn more about the hospital where Courtland worked, visit: www.doctorswithoutborders.org/news/video/index.cfm

INSIDE THE NEGLECTED-DISEASE RESEARCH & DEVELOPMENT CRISIS

Today, an estimated 35,000 people will die from infectious diseases such as malaria, tuberculosis, HIV/AIDS, sleeping sickness, and visceral leishmaniasis (kala azar)—97 percent of them in developing countries, according to the World Health Organization (WHO).

Political will can ensure international cooperation and the marshalling of tremendous resources for research and development (R&D). The sense of urgency accorded to the SARS outbreak, the anthrax scare in the United States, and the more recent avian flu situation are striking examples. Yet the coffers are nearly bankrupt when it comes to R&D for diseases that predominantly affect people in developing countries.

Although global spending on health research has increased from \$30 billion in 1986 to \$105.9 billion today, 90 percent of this money is still spent on the health problems affecting less than 10 percent of the world's population. One recent development in response to this inaction has been the creation of not-for-profit

partnerships to develop new drugs, diagnostic tests, and vaccines for neglected diseases such as sleeping sickness, kala azar, and Chagas disease. The Drugs for Neglected Diseases initiative (DNDi), founded by Doctors Without Borders/ Médecins Sans Frontières (MSF) and six partners, is one of these partnerships.

“Most of the drugs used to treat ‘neglected diseases’ were developed in colonial times. These are often expensive, difficult to administer, and hard to tolerate.”
—Dr. Bernard Pecoul, Executive Director, Drugs for Neglected Diseases Initiative

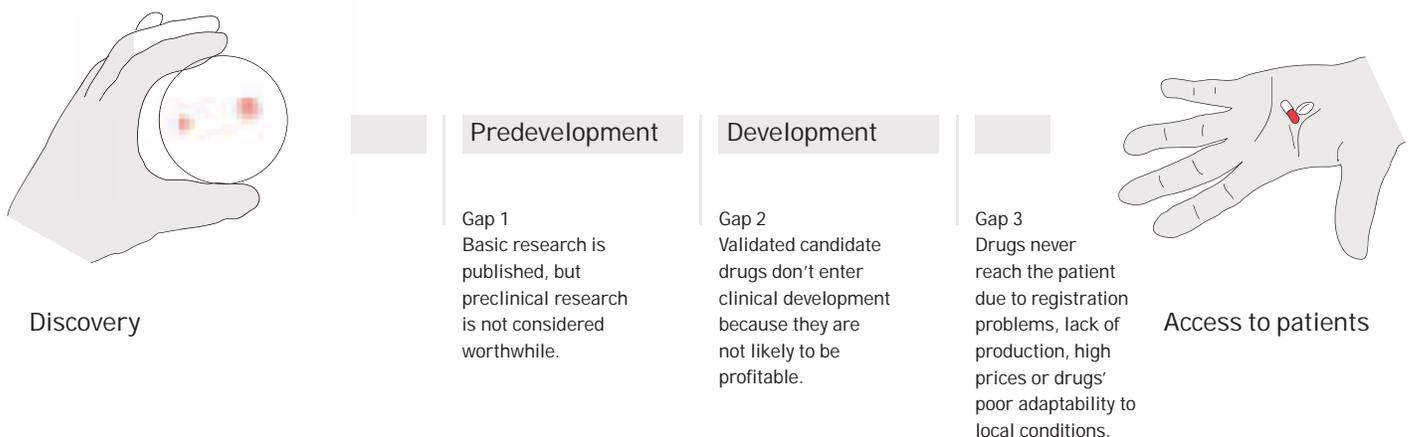
A recent report by the London School of Economics shows that, at the end of 2004, 63 drug-development projects for neglected diseases were in progress, 47 of which were being conducted by non-profit partnerships. It is estimated that these partnerships will bring eight to nine new drugs to market in the next five years. This new model for drug development potentially separates funding of R&D from drug prices so that medicines

can be sold at affordable prices. While the work of these partnerships is important as a first step in addressing health R&D for the poor, it is far from sufficient.

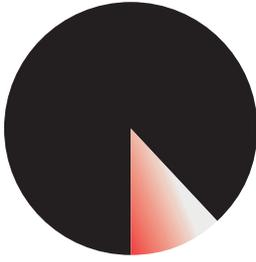
Too often, a solitary research initiative is all that exists for a neglected-disease drug or diagnostic test. Would we consider a one-drug research initiative a sufficient response to cancer, for example, as we do for TB?

The wealthiest countries of the world made clear commitments to increase R&D for malaria, tuberculosis, HIV/AIDS, and even more neglected diseases at the Group of Eight Summit in Scotland last year and at the UN Millennium Summit in 2000. Countless lives depend on these promises being fulfilled.

BREAKS IN THE DRUG-DEVELOPMENT PIPELINE



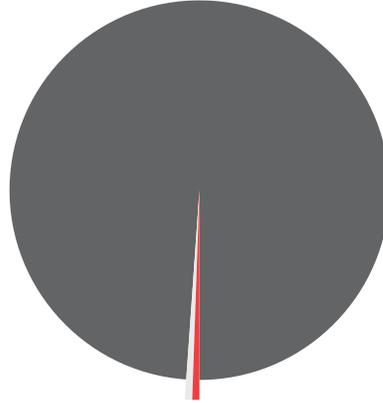
GLOBAL DISEASE BURDEN



Tropical diseases and tuberculosis account for 12 percent of the global disease burden.

Source: World Health Organization

NEW DRUG DEVELOPMENT

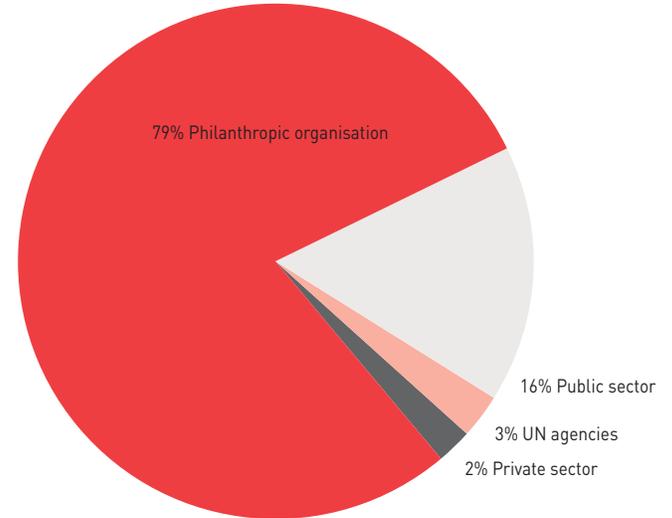


1.3% Tropical diseases and TB

From 1975-2004, of the 1,556 new chemical entities marketed, only 1.3 percent (20 new drugs) were related to treatment of tropical diseases and TB.

Source: Drugs for Neglected Diseases initiative

FUNDING FOR NEGLECTED DISEASE INITIATIVES



Today, 79 percent of funding for nonprofit drug-development partnerships comes from philanthropic donations while governments contribute a paltry 16 percent. MSF currently contributes more to nonprofit drug-development partnerships than the US government does. Source: Wellcome Trust



In a rural clinic near Homa Bay, Kenya, an MSF lab technician examines a lung fluid sample to diagnose TB. This diagnostic test is more than 100 years old and fails to detect the disease in more than half of the cases. © Lori Waselchuk

DRUGS FOR NEGLECTED DISEASES: TOXIC, EXPENSIVE, INEFFECTIVE

Communicable diseases in resource-limited settings continue to tear apart people's lives, but research into new drugs remains inadequate. Patients are often forced to endure toxic, expensive, and increasingly ineffective treatments.

60 million people are at risk of contracting sleeping sickness, but treatment options are few.

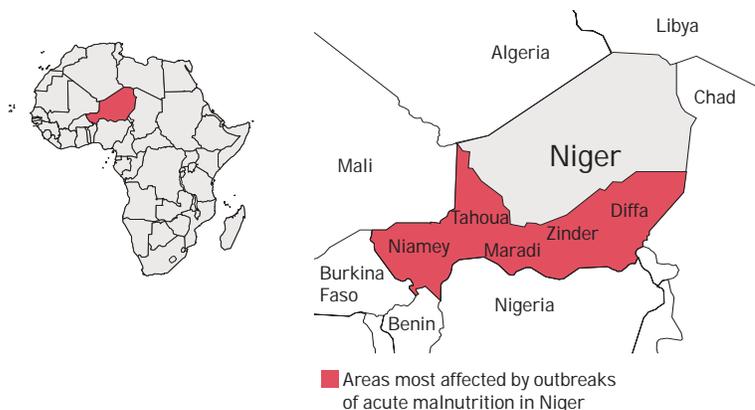
Kala azar kills 60,000 people each year, but the most frequently used treatment was developed in the 1930s.

1,400 children die every day of AIDS-related complications, but existing methods to diagnose HIV in infants are ill-adapted for poor countries, and few pediatric formulations of antiretrovirals exist.

TB is responsible for nearly two million deaths each year, yet treatment still depends on increasingly ineffective drugs dating from the 1950s to 1960s.

The most commonly available TB diagnostic test, developed in 1882, detects the disease only in 45 to 60 percent of cases.

ACUTE MALNUTRITION IN NIGER – A CHRONIC EMERGENCY



In 2005, Doctors Without Borders/Médecins Sans Frontières (MSF) teams admitted more than 63,000 children suffering from severe acute malnutrition to its therapeutic feeding programs in five regions of Niger. This was MSF's largest operation ever to treat severe malnutrition. MSF sees the potential for a repeat of last year's crisis, and is expanding its operations in the Maradi and Zinder regions to treat both severely and moderately acute malnourished children.

Based on four years of medical data from its nutritional programs in Niger's Maradi region, MSF has concluded that acute malnutrition, particularly among children younger than three years old, is a chronic emergency in Niger that has not been adequately addressed in the past. MSF believes that poor assessments of the situation and choices by governments, donor governments, and UN agencies exacerbated the crisis in 2005.

Early last year, many families were already experiencing food shortages, and their access to millet, a staple food, was extremely limited. Until June, aid providers (donor governments like the European Union, France, and the United States, along with UN agencies) backed

the Niger government's decision to charge for food aid, claiming that free aid causes market instability, creates dependent populations, and undermines development planning.

Long-term market stability took precedent over people's lives despite the availability of new treatments for malnutrition that have proven effective in curing large numbers of acutely malnourished children.

EXTENT OF THE NUTRITIONAL EMERGENCY

It remains impossible to know how many children are suffering from acute malnutrition throughout Niger because the health system does not track or monitor this medical condition. But year after year, the number of severely malnourished children—having a weight-for-height ratio under 70 percent of the average—admitted to the MSF feeding program in the Maradi region has continued to rise regardless of the quality of the national harvest.

Admissions to the Maradi feeding program were 5,200 in 2002; 6,700 in 2003; 9,700 in 2004; and an all-time high of more than 39,000 in 2005. There are undoubtedly larger numbers of cases of

so-called moderate acute malnutrition—a weight-for-height ratio under 80 percent of the average—a condition that also requires immediate medical care.

LOOKING BEYOND THE HARVEST

Ironically, the quality of the harvest has little correlation with the levels of acute malnutrition in Niger. The real problem is the ability of the poorest families to access food in sufficient quantity and quality. Although the millet harvest of 2004 was one of the most abundant in Niger's history, it still failed to feed the population sufficiently.

MSF's experience in Niger also shows that malnutrition does not decrease following years of bountiful harvests (such as those in 2001 and 2003) and that it is in the Maradi region—nicknamed the granary of Niger—that acute malnutrition is most prevalent.

Most admissions to MSF nutritional centers were recorded in the southern regions of Maradi and Zinder. Last year in the Guidam Roumjudi department of Maradi, for example, 10,223 severely acute malnourished children under five—nearly 11 percent of the children living in this

department—were admitted to the MSF therapeutic program. Aid agencies need to focus their efforts on areas with the highest incidence of acute malnutrition and not on areas with the lowest crop yields, as some did during the 2005 emergency.

A SIMPLE CURE FOR MALNUTRITION

For years, MSF admitted severely malnourished children to inpatient therapeutic feeding centers—essentially field hospitals—where they received round-the-clock medical care and nutritional rehabilitation. These centers, while very effective, had a limited capacity and required a caregiver, usually the mother, to be admitted



Page 12: An MSF aid worker measures the middle-upper-arm circumference to assess the severity of malnutrition of each child admitted to MSF's feeding program. © Christophe Calais

Clockwise:

This girl is being cared for in the intensive care unit of MSF's therapeutic feeding program in Zinder, Niger. © Christophe Calais

A severely malnourished child eats a packet of ready-to-use therapeutic food called Plumpy'nut, which is the staple of MSF's outpatient therapeutic nutrition program in Niger. © Christiane Roth/MSF

With no other options for food, a child collects plants alongside the road for his family to eat. © Michael Kamber



alongside the patient for several weeks. In 2001, MSF began providing care for severely malnourished children who did not have complicating illnesses in Maradi, Niger, on an outpatient basis.

In 2005, only 10 to 15 percent of the children registered in the Niger program were hospitalized. Those with no appetite or who also suffered from diseases with complications (anorexia, measles, pneumonia) remained under close medical supervision in an intensive care facility.

The rest of the children were given a supply of a ready-to-eat therapeutic food, which is a specially formulated and packaged peanut-based paste enriched with vitamins and micro-nutrients, and sent

home with their mothers. This therapeutic food does not require preparation and can be eaten by children at home. The mothers then brought their children back each week to an outpatient therapeutic feeding center, where MSF medical teams checked them for any complications, documented their weight gain, and refreshed their supply of therapeutic food.

Using this protocol in 2005, 91.3 percent of 39,000 children admitted to the Maradi program for severe acute malnutrition were cured when discharged. While just 3.3 percent died and 4.7 percent ceased treatment before being cured. Only 0.8 percent relapsed after treatment. In comparison, in 2001, when all children were hospitalized, the recovery rate

was 58.3 percent, the death rate 6.8 percent, and those who gave up treatment accounted for 34.8 percent.

The vast majority of children suffering from acute malnutrition who have no medical complications can be cured without hospitalization, with a therapeutic product that provides them with all necessary nutrients, minerals, and vitamins. This strategy is inexpensive and should be implemented on a large scale in Niger.

For more information on acute malnutrition in Niger, visit www.doctorswithoutborders.org



CHOLERA BREAKS OUT IN ZAMBIA AND ZIMBABWE

Doctors Without Borders/Médecins Sans Frontières (MSF) is helping to fight a cholera outbreak in Zimbabwe's eastern provinces of Manicaland and Mashonaland-East. The first cases of cholera were recorded in early December, and the disease started spreading to the east, moving downstream along the Ruwenje and Murove Rivers. At the same time, MSF established a 300-bed cholera-treatment center in northern Lusaka, Zambia's capital, to respond to an outbreak that had affected more than 3,000 people—killing 62—by the end of December.



Top left to right:

In an MSF cholera clinic in Lusaka, Zambia, patients are treated using oral rehydration solution, a mixture of glucose and electrolytes. © Juan Carlos Tomasi

An MSF physician examines a cholera patient receiving an intravenous infusion in Lusaka.

© Juan Carlos Tomasi

Middle left to right:

With only a few blankets to try to ward off the freezing cold, a boy living on the streets of Moscow prepares his bed for the night. © Ramil Gudov

Tropical Storm Stan destroyed hundreds of homes in Guatemala. © Olga Ruiz/MSF

COLD SNAP THREATENS MOSCOW STREET CHILDREN

In January, a record-breaking cold snap hit Moscow, Russia's capital, with temperatures falling to negative 72 to 87 degrees Fahrenheit (the lowest since 1978-9) for seven days. MSF has provided medical care and warm clothing to street children and teenagers in Moscow since 2003. "We find that the street kids we work with are very resourceful," says Justine Simons, MSF project coordinator in Moscow. "When their usual sleeping area in a small hollow underneath a train platform gets too cold, they use the meager money they have to find shelter inside—like one of our beneficiaries Sasha, who gives 75 roubles [US\$2] to the owner of a computer club to allow him to spend the whole night there."

RESPONDING TO TROPICAL STORM STAN IN GUATEMALA

In October 2005, tens of thousands of people throughout Central America lost their homes, livelihoods, and access to clean water when Tropical Storm Stan struck the region. In Chiquimulila, Santa Rosa department, MSF distributed relief items like hygiene kits and mosquito nets to 5,000 families, dug 33 new water wells, cleaned nearly 50 preexisting wells, and built 47 houses for families who had lost everything. In Solola, Santiago de Atitlan municipality, MSF provided 74,000 liters of water per day to 6,000 people living in shelters during the first few weeks after the storm. MSF also provided assistance to 13,500 people in Coatepeque and until the end of January 2006 to 4,800 people in Ocós.

CONTROLLING A YELLOW FEVER EPIDEMIC IN SUDAN

To halt a yellow fever epidemic in central Sudan's Kordofan province, medical teams from MSF, working with Sudanese health officials, vaccinated 200,000 children and adults over nine months old against the virus in two weeks in December. Even with treatment, 25 percent of the people infected die. The vaccine must be kept between 35 to 46 degrees Fahrenheit at all times in order to maintain its effectiveness. "In the desert, that means 1,300 pounds of ice," says MSF logistician Fleury Girard. "Ice that has to be produced, packaged, and transported every day."



DEMOCRATIC REPUBLIC OF CONGO: **FORGOTTEN WAR**

*Photo Exhibition Tour Continues
in Los Angeles*

Five world-renowned photographers from the VII Photo Agency –Ron Haviv, Gary Knight, Antonin Kratochvil, Joachim Ladefoged, and James Nachtwey–traveled to the Democratic Republic of Congo (DRC) from May through August 2005 with Doctors Without Borders/Médecins Sans Frontières (MSF) in order to shed light on the suffering of the Congolese people as they struggle to survive a war that remains virtually invisible to the outside world. Their work is presented in *Democratic Republic of the Congo: Forgotten War* an exhibition and a new book published by de.MO.

The exhibition, which is touring in the United States, Africa, Asia, Australia, and Europe over the next year, opened at the Stephen Cohen Gallery in Los Angeles on March 16.

Stephen Cohen Gallery
7358 Beverly Boulevard,
Los Angeles, CA 90036
Tel: 323 937 5525 Fax: 323 937 5523

Show dates: March 16 – May 6, 2006
Viewing Hours: Tuesday through
Saturday, 11am – 5pm
For a preview of the show:
www.doctorswithoutborders.org
www.viipphoto.com/congo



From top to bottom:
In the northeast district of Ituri, a vulture flies over
Tche internally displaced persons camp.
© Ron Haviv/VII

Inside a compound shared by nine commercial sex
workers in Kinshasa, a girl hides her face behind a
mosquito net. © Joachim Ladefoged/VII

IN MEMORIAM

MSF Loses Two Colleagues in Plane Crash in Nigeria



It was with great sadness that Doctors Without Borders/Médecins Sans Frontières (MSF) learned of the death of two of its aid workers in an airplane crash in Nigeria on December 10, 2005. Hawah Kamara, 49, and Thomas Lamy, 30, were en route to Port Harcourt in southern Nigeria, where MSF runs a surgical trauma center.

A native of Liberia, Hawah Kamara dedicated her life to humanitarian work. After spending more than three months living as a refugee in Sierra Leone with her then five-year-old daughter, Hawah returned to Liberia's war-torn capital of Monrovia in 1990 and joined MSF as an administrator there.

Hawah later emigrated to the US and began working in the New York office of MSF in 1999 as a recruiter of US-based aid workers for MSF programs around the world. She was chosen to represent MSF-USA in Oslo, Norway, when the organization received the 1999 Nobel Peace Prize. With her boundless wit, warmth, and wisdom, Hawah contributed enormously to MSF and will be greatly missed.

Thomas was born in 1975 in Annecy, France. He joined MSF in 2003. After two months with general services in MSF office in Paris, he very quickly became passionate about MSF. Thomas left on his first field assignment in August 2003 to Ivory Coast, as a supply logistician in MSF's logistical base in Abidjan for the emergency program in Liberia during the country's civil war. It was his first assignment, but his capacities, commitment and determination to overcome challenges were already impressive.

He quickly became a key-person in MSF's Liberia programs, where he was responsible for supplies as well as negotiating with the local authorities. Thomas returned to Ivory Coast in 2004, this time to Toulepleu and Guiglo, where he once again proved his capacity to take on new responsibilities and to adapt to a very different and complex situation. Beyond his role as logistician, he was the liaison with the Ivorian and French military as well as the militias in the region. In December 2004, Thomas worked in Darfur, Sudan: first in Nyala, then in El Geneina, where he stayed up until June 2005.

In August 2005, Thomas left for Nigeria, to work in the emergency nutrition program in Katsina. Less than a month after arriving, he was appointed the logistical coordinator of all of MSF's projects in the country.

The brutal loss of Hawah and Thomas has left all of MSF deeply saddened. Our profoundest thoughts and condolences go to the families and friends of our two beloved colleagues.

Photos © MSF

