Facing Obstacles In Afghanistan
Conflict In Darfur, Sudan
Treating Rape Survivors In Congo Republic
Malaria In Ethiopia
Aiding Iran’s Earthquake Victims
Top Ten List Of Most Underreported Stories In 2003
+ A Special Pull-out Poster
At the end of 2003, Doctors Without Borders/Médecins Sans Frontières (MSF) published the book *Civilians Under Fire*. This collection of articles describes MSF’s actions in the Congo Republic during an acute phase of the country’s recent civil war. It highlights the medical, ethical, and practical considerations that arose as the organization struggled to provide assistance to the malnourished and displaced as well as to a category of victim generally neglected by humanitarian organizations, survivors of rape.

The sexual violence program developed in the country’s capital, Brazzaville, at that time has provided the framework for subsequent MSF projects that were started to treat victims of sexual violence and to raise public awareness of the problem. In the excerpts below, contributing authors reveal why rape is often ignored as a specific health condition, discuss the results of the medical and psychological help MSF provided, and address the need for greater awareness of this crime of war.

**WAR’S HIDDEN CASUALTIES: VICTIMS OF RAPE**

Between May and December 1999, 1,190 women (including young girls and adolescents) came for treatment at Brazzaville’s Makelelele and Talangai Hospitals, saying they had been raped. Most of the rapes had occurred on the road from Kinkala to Brazzaville, which was known as the “humanitarian corridor” by protagonists of the civil war and the “corridor of death” by the survivors. Even when peace brought a sharp fall in the number of rapes, the numbers did not diminish completely. In March 2000, 22 rape victims, aged between 3 and 40, were treated at Makelele Hospital. Twenty-one of those rapes were committed by armed men and 13 were gang rapes. Between March and December 2000, 109 women were treated after having been raped. Thirty-one of those women presented less than 72 hours after the rape and were treated with anti-HIV drugs; 50 percent of the treatments were completed. Twelve babies were born as a result of rape, and 56 women received psychological counseling.

In this case, the numbers were a major factor in the creation of a specific health care service. But it is unusual to register rape cases on a systematic basis. In most conflicts, rape victims are registered as having “gynecological illnesses,” “sexually transmitted diseases,” or “miscellaneous traumas.” This is a well-known example of negligence on the part of the medical profession amid humanitarian emergencies. Trapped by their prejudices, physicians are loath to single out a specific group of patients whose visibility might lead to tensions with political, military, traditional, or religious leaders or within the medical institution itself. They therefore practice discretion, or even silence. As a result of this more or less conscious effort to avoid tension, health services designed to meet the demands of certain patients are not established.

(From the chapter “How Images of Adversity Affect the Quality of Aid” by Jean-Hervé Bradol, MD)
BREAKING NEW GROUND FOR MSF

Although MSF teams frequently encounter sexual violence, especially in the context of armed conflict, it is rare that medical treatment is given during the critical period. Humanitarian organizations tend to channel their assistance toward other population groups, which seem to them to be more vulnerable (for example children or the injured). And yet the consequences for rape victims are terrible, even though they often go unnoticed: assault on their integrity, mental and physical injury, infection with HIV, unwanted pregnancies and births, destruction of the family unit, and social exclusion.

The mission in the Congo Republic represents MSF’s first experience of setting up a specific program to assist the victims of sexual violence. Its objective was to provide comprehensive, high-quality care in three areas of activity: medical, social, and legal. Although this effort came late—after the war was over—it has brought help to numerous women in Brazzaville, in particular by restoring their capacity for choice.

Following the recent acknowledgement of rape as a “crime against humanity” and a “war crime” by the International Criminal Tribunal, discussions held with the Congolese authorities have resulted in exceptional arrangements allowing rape victims to be given pregnancy terminations if they so wish. But other issues remain unresolved: the potential for victims to give up their babies at birth, the treatment of children born to rape victims and then abandoned, aftercare for women who have been raped, and so on. The medical, social, and legal aspect must all be improved.

For MSF, launching this program has meant living with a particularly intolerable contradiction: introducing prophylactic treatment for HIV for a small population in a country where access to ARVs is virtually nonexistent, despite the fact that eight percent of the entire population is HIV-positive. This certainly explains the hesitancy of the Congolese medical authorities to allow ARVs to be included in MSF’s emergency program for victims of sexual violence in 1999. Authorization was not given until 2000. In deciding not to wait for conditions to stabilize fully before starting to treat the victims of sexual violence, we adopted a pragmatic approach.

(From the chapter “Health Services for Rape Victims” by Joanne Liu, MD, and Pierre Salignon)

RAISING PUBLIC AWARENESS TO STOP RAPE

In the Congo Republic, although the conflict has subsided, rape remains a critical problem. In early 2003, in collaboration with the Congolese Ministry of Public Health, MSF launched a nationwide awareness-raising campaign called “Tika Viol, je dis non” (No more violence, I say no) to combat the social and political apathy resulting in an ongoing failure to address the widespread phenomenon of sexual violence in the country. That campaign, along with the experiences highlighted in this booklet, make clear that actually relieving the suffering of victims of violence is a complex, difficult, and uncertain endeavor that depends heavily on both the thoughtfulness and tenacity of people who are committed not to accept what is unacceptable. And that’s what humanitarian action is all about.

(From the book’s preface by Nicolas de Torrenté)


Photo far left: A silhouette used in MSF’s rape-awareness campaign hangs above a Brazzaville highway.

Remaining photos: Scenes from MSF’s women’s health program in Brazzaville. © Alain Fredaigue 2003

Cover photos: Afghanistan © Jean-Marc Giboux 2004
A WAR BEHIND CLOSED DOORS
CONFLICT BREAKS OUT IN SUDAN’S DARFUR REGION

Civil war has raged in Sudan for 36 of its 48 years as a nation. Approximately two million people, mostly civilians, have died as a consequence. According to United Nations estimates, the conflict has also caused half a million people to flee to neighboring countries and has displaced four to five million Sudanese within the country.

In February 2003, a new civil war broke out in the Darfur region of northwest Sudan involving the government of Sudan and two new rebel movements, the Sudan Liberation Army (SLA) and the Justice and Equality Movement (JEM). So far, the conflict has caused more than 3,000 civilian deaths and has displaced 600,000 Sudanese within the country. The insecurity has also forced more than 100,000 people to seek refuge in nearby Chad. This devastating new fighting remains largely hidden from the outside world as international attention remains firmly focused on the final stages of a peace process taking place between the central government and the Sudan People’s Liberation Army (SPLA), the main rebel movement in the south.

Doctors Without Borders/Médecins Sans Frontières (MSF) has been providing medical care in Darfur since December 2003. Many of those who had been displaced are in immediate need of emergency assistance. Mortality rates and severe malnutrition continue to rise in several areas. In Mornay and Zalinge, MSF found 258 severely malnourished children, but could only treat 144. Every assessment conducted by MSF finds more people living in extremely precarious conditions, requiring a massive mobilization of aid agencies with unrestricted access to the region.

LITTLE AID OFFERED IN CHAD
Because the majority of Darfur’s refugees share the same ethnicity as the Chadian population living along the border, many found help in Chad at the start of the crisis. However, the refugees who have crossed the border have exhausted the region’s limited resources. The sheer number of refugees and the expanse—almost 400 miles of border area—over which they have scattered make it difficult for aid agencies to reach them.

“Nobody stayed in the village. We all walked here. We walked during the night. We could take our children with us. But I lost four children on the way because I could not find drinking water. They were two, four, five, and seven years old.”
—Female refugee, 24, Birak, Chad

Most of the refugees have arrived in Chad in a deplorable state, having fled with few belongings and little food. There is scant relief available once they arrive. “The conditions they face on arrival are harsh,” explains Sonia Peyrassol, MSF emergency coordinator at the Chad-Sudan border. “Having walked for up to three days to escape the violence around their homes, they are greeted by totally inadequate shelter, a dire lack of protection, and insufficient food. This is exacerbated by extreme weather conditions, with the temperature fluctuating between 30 degrees at night and 100 degrees during the day.”

LACK OF AID LEADS TO ILLNESS
“In the beginning many children died here because they did not get any healthy food or water. They got diseases and died.”
—Female refugee, 24, Tine, Chad

MSF is one of the few nongovernmental organizations working in eastern Chad to address the urgent health needs of the refugees. Since September 2003, our teams of international volunteers and Sudanese staff have given medical care, nutritional support, and vaccinations to more than 30,000 refugees living near the towns of Tine, Birak, and Adré. These teams currently perform more than 1,000 medical consultations a week.
MSF’s medical teams fear a deterioration of the refugees’ health. The extreme weather conditions combined with inadequate shelter and blankets have led to respiratory illnesses, and poor drinking water has caused diarrhea, gastritis, and urinary infections. The unhygienic and overcrowded living conditions and the lack of basic materials such as soap have also led to outbreaks of skin diseases and malaria.

Refugees are also facing malnutrition. An MSF survey conducted in Tine found that 27 percent of the 536 children surveyed showed signs of moderate malnutrition and 2 percent were severely malnourished. “A severe increase in malnutrition among the Sudanese refugees in Chad looms if security and food aid are not urgently taken care of,” emphasizes Ton Koene of MSF’s emergency team who recently returned from the area.

A major factor influencing the dire health situation is that the refugees have received so little assistance in securing food, shelter, and water. Although the first refugees began arriving in April 2003, it took nine months for the United Nations High Commissioner for Refugees (UNHCR) to begin relocating them away from the border to safer and more organized camps deeper inside Chad’s territory.

**VIOLENCE AGAINST CIVILIANS**

Numerous refugees have told MSF workers that they were forced to flee when their villages were attacked. During these raids, houses were destroyed, women were raped, crops razed, and cattle stolen. From January 19-23, 2004, alone, MSF medical staff in Tine treated 66 civilians who had been seriously injured in an aerial bombing of Darfur.

Despite these circumstances, the refugees continue to arrive in eastern Chad, where they remain in makeshift shelters near the border and the conflict. Unable to reap the harvests they left behind, victimized by looting, subjected to continuing displacement, and, for the most part, unable to bring their animals with them, their situation will only worsen.

MSF is calling on the Chad government, UN agencies, and other nongovernmental organizations to ensure that the refugees from Darfur receive sufficient protection and assistance before the situation worsens.
More than two years after US-led forces ended the Taliban’s rule in Afghanistan, life there remains harsh. Now that Iraq dominates the headlines in the United States, Afghanistan and its people have fallen from view. Yet, Doctors Without Borders/Médecins Sans Frontières (MSF) teams working in Afghanistan encounter the country’s enormous problems on a daily basis. Today they struggle to provide emergency medical care in 11 of the country’s 32 provinces despite severe obstacles.

OVERWHELMING HEALTH PROBLEMS

Years of conflict, drought, and forced migration have left the people of Afghanistan in a dire state. Infectious diseases such as malaria, meningitis, diarrhea, and acute respiratory infections are just some of the life-threatening conditions affecting Afghans, most often children. “These diseases are generally caused by living in poor conditions,” explains Brigg Reilley, an MSF epidemiologist who recently spent a month assessing MSF projects in the country. “There’s the full gamut of the illnesses you would expect in a country suffering from a chronic disaster.”

But while the needs are great, access to medical care remains difficult and often impossible. “Access to care is a huge issue due to the lack of transport, infrastructure, and medical staff in the country,” says Reilley, “but at least we can start doing something about it in areas that are considered safe. In some regions, particularly in the south, it’s too dangerous.” In 2003, several vehicles operated by nongovernmental organizations (NGOs) were shot at, or forcibly stopped, and the occupants murdered. “We can’t start looking at these problems until the security issue improves,” says Reilley. “Right now our teams have to take it very much day to day and week to week.”

The ongoing fighting and targeting of NGOs restrict MSF’s access in the south and east of the country, where few areas are considered safe enough for humanitarian aid workers to operate. This insecurity has cut off needed medical care to more than seven million Afghans—approximately one-third of the country’s population. “In the insecure areas, it seems it’s two steps forward and one step back,” says Reilley. For example, at the end of 2003, MSF was forced for some time to suspend its operations at the Zhare Dasht camp near Kandahar. MSF had been providing basic health care to a population of 40,000 displaced persons. Our teams had been caring for an average of 7,500 patients there each month and recently responded to a major diphtheria outbreak in the camp. Compounding the absence of basic medical services, MSF’s withdrawal of international staff meant that maternal and neonatal health care and vital immunization services for children and pregnant women, as well as a feeding program for malnourished children, became much more difficult for our local staff to provide.

DESPERATE FOR CARE

Afghanistan, which is roughly the size of Texas, lacks basic infrastructure. For example, to travel from the western city of Qal‘eh-ye Now to the capital, Kabul, in the east takes more than three days by road, with the ever-present risk of armed robbery en route. Most roads are dirt tracks or dry riverbeds on which four-wheel-drive vehicles can only manage about 20 miles per hour. The poor condition of the roads means that sick people reach health clinics much too late, or not at all.

For many Afghans, basic health care services are a long distance away and humanitarian aid agencies cannot get to many communities due to insecurity. This insecurity has slowed the rehabilitation of smaller health structures and has turned...
larger hospitals, such as Mir Wais hospital in Kandahar, where MSF is working, into the main hospitals for large surrounding areas. More than half the deaths at Mir Wais happen within 24 hours of admission, the largest proportion occurring among children under five. “We are seeing higher mortality rates than we would like in the hospital,” states Reilley, “generally because people are getting there so late.”

MSF started working in the infectious disease ward of this hospital in 1999 when an outbreak of cholera swept through the Kandahar area. Since then, MSF and an international medical team have continued to work there, mostly treating children. The ward’s reputation attracts patients from all parts of southern Afghanistan. Yaqub Sulliaman, an Afghan nurse who has spent most of his life as a refugee in Pakistan, now quietly and efficiently manages the MSF ward. Many of the Afghan medical staff do a rotation on this ward, since most medical graduates have received limited training and have almost no practical experience treating patients. Today it is the only fully equipped infectious-disease ward for the entire province.

MOTHERHOOD AGAINST ALL ODDS

Statistics show that Afghanistan is one of the world’s most dangerous places to become a mother. Maternal mortality is extremely high—estimated to be the second highest in the world. Breech births, retained placentas, obstructed labor, and postpartum hemorrhage are complications that happen every day in US delivery rooms, but are rarely life-threatening. In Afghanistan, these complications can be fatal for the child and sometimes for the mother as well.

“Only the strongest newborn babies survive in Afghanistan,” stresses Natalia Aguirre Zimerman, MD, an obstetrician-gynecologist who worked in Afghanistan for MSF. “In the US and in Europe, a baby weighing between 700 grams (1.5 pounds) and one kilo (2.2 pounds) has a very good chance to live. In Afghanistan, a baby weighing one to two kilos (2.2 to 4.4 pounds) will die. A baby who cannot suck is dead. A baby who cannot do everything perfectly is dead. Statistics show that one out of every five babies born in Afghanistan will die before reaching the age of five.”

“It’s very tough as a doctor when you deliver these beautiful baby girls and boys and you know they have a low chance of survival,” continues Zimerman. “There is a false sense that Afghanistan is very good right now. But it is destroyed. In Afghanistan, it’s not about living, it’s about surviving. It’s not about retirement plans, what you will do for the next 10 years. It’s about being alive tomorrow and having enough to eat.”

LOOKING TO THE FUTURE

“In some ways, Afghanistan is both better and worse than I thought it would be,” says Reilley. “I was shocked by the remoteness of some of the areas I visited and really wondered how you could ever get needed services out there.” He also found it difficult to comprehend the level of suffering and insecurity civilians now accept. “Sometimes you would hear civilians say that it was safe to travel despite the fact that they may get shot at. They’re so conditioned to the violence and you think to yourself, this is not normal.”

MSF plans to continue aiding Afghan civilians wherever it can. Site visits like those undertaken by Reilley provide crucial information about medical needs that is used to plan future interventions. “With the high turnover of MSF staff caused by evacuations and displacements, it’s sometimes hard to know exactly what happened in the course of a year, and you need a year’s information. There are seasonal issues. In winter, there are high levels of respiratory infection, in summer, it’s diarrheal disease. This kind of review lets us see how many people are benefiting from our programs and tells us how many people are recovering from the illnesses we’ve treated. It helps us see the problems that occurred and find solutions for them.”

MSF has been working in Afghanistan since 1980, throughout the Soviet occupation, the civil war, and during the Taliban regime. MSF medical teams are now running therapeutic and supplementary feeding centers, vaccination campaigns, basic health care units, mother-and-child health care programs, mobile clinics in remote areas, water and sanitation provision, and specialized programs for diseases such as tuberculosis and leishmaniasis.

Photos from left to right: An MSF pediatrician listens to the lungs of a young patient at the MSF clinic in Saragi, Bamiyan province. MSF provides free health care and medicines at the clinic and local people walk for hours through the mountains to reach it.
A child is examined by an MSF doctor at the MSF mobile clinic in the Pasroia Valley in Bamiyan province, one of the most remote parts of the country. An Afghan nurse immunizes a child at the Saragi clinic, the only health facility for miles around. © Jean-Marc Giboux 2004
TOP TEN MOST UNDERREPORTED HUMANITARIAN STORIES OF 2003

TENS OF THOUSANDS SEEK REFUGE IN CHAD FROM FIGHTING IN SUDAN AND CENTRAL AFRICAN REPUBLIC

ONGOING OPPRESSION OF CHECHEN CIVILIANS

UNRELENTING VIOLENCE IN BURUNDI

MASSIVE DISPLACEMENT AND ISOLATION IN COLOMBIA

WAR AND NEGLECT IN THE DEMOCRATIC REPUBLIC OF CONGO

MALARIA DEATH COUNT SOARS

PUNISHING CYCLES OF VIOLENCE IN SOMALIA

REPRESSION OF NORTH KOREAN REFUGEES IN CHINA

TRADING AWAY THE HEALTH OF MILLIONS

COLLAPSE OF HEALTH CARE IN WESTERN IVORY COAST

MSF-USA PUBLISHES TOP TEN LIST FOR 2003

Neglected stories of violence against civilians, the plight of refugees, and the ongoing lack of access to essential medicines were the topics highlighted in MSF-USA’s sixth annual top ten list of the year’s most underreported humanitarian crises.

Some of the events on the list include the escalating refugee crisis along the border of Sudan and Chad as well as the ongoing conflicts in Colombia, Chechnya, Burundi, and the Democratic Republic of Congo.

“Few Americans are aware that right now hundreds of thousands of people are seeking refuge from intense violence in Sudan’s Darfur region, or that tens of thousands of people have been sent back to a war zone in Chechnya,” says Nicolas de Torrenté, executive director of MSF-USA. “Yet people we speak to around the country tell us they want to know about these crises so they, too, can speak out and act against them.”

This year MSF also highlighted the lack of attention given to malaria’s high death toll, the crises in North Korea and Somalia, the new war in Ivory Coast, and the threats posed by regional trade agreements to poor people’s access to essential medicines.

“North Korea was in the media spotlight all year,” continues de Torrenté. “But the nightmarish situation for people living there, as well as the persecution of North Korean refugees, was nearly invisible. And from our experience, silence and indifference are what allow such injustices to continue.”

MSF-USA published its list in January in response to the mainstream media’s lack of interest in important humanitarian crises throughout the year. While the online, media-tracking journal, The Tyndall Report, found that the three major US television networks increased their international coverage in 2003, most of it was concentrated on the war in Iraq. In fact, the 10 crises that made MSF’s list accounted for only 30.2 minutes or 0.2 percent of the 14,635 minutes on the networks’ nightly newscasts. And 7 of the 10 crises received a combined total of just 3.2 minutes.

To learn more about the crises highlighted in this year’s top ten list, open the poster included in this issue of Alert and visit our website: www.doctorswithoutborders.org.

Photos from top left to bottom right: Chad © Simon Norfolk, Georgia © John Vink, Ethiopia © Stephan Vanfleteren, Liberia © Kate Holt, Colombia © Juan Carlos Tomasi, Burundi © Caroline Livio, Nigeria © Remco Bohle, North Korea © Peter van Quaille, Somalia © Roger Job, Sudan © Laura Brav
In 2003, Ethiopia faced its worst malaria outbreak in many years. High infection rates appeared in the regions of Amhara; Oromia; Southern Nations, Nationalities and People Regional state (SNNPR); and Tigray. MSF medical teams working in Oromia and SNNPR began to see dramatic increases in the number of patients coming to their clinics with malaria symptoms. Lab test results confirmed that the vast majority of the malaria cases were due to *Plasmodium falciparum*, a deadly form of the disease. Nationwide, 15 million of Ethiopia’s 65 million inhabitants were estimated to be at risk of contracting the disease.

Annick Hamel, a member of Doctors Without Borders/Médecins Sans Frontières (MSF)’s Campaign for Access to Essential Medicines, who recently returned from Ethiopia, says that the escalating number of cases MSF volunteers and national staff have seen in various locations points to a real epidemic. “The number of cases has sharply increased compared to last year,” says Hamel. “In Damot Gale where one of our teams is working, more than 3,000 cases were treated in 2003, a five-fold increase over the number in 2002. And in East Wollega (Gutten), the numbers have skyrocketed from 9,686 malaria cases in 2002 to 23,446 cases last year.” The number of cases began to decline in January 2004.

The duration and intensity of the epidemic has been made worse by the fact that the drugs used currently to treat the disease in Ethiopia appear to have failed in many cases. These drugs, sulfadoxine-pyrimethamine (SP) and SP with chloroquine have been the first-line treatments for a number of years and are now ineffective in many people because of drug resistance. Still, they continue to be provided by donors and are used in many African countries. “We think resistance is playing a major role in the outbreak,” emphasizes Hamel, “as many of the patients have the same symptoms after treatment.” In fact, the preliminary results of a new study suggest a very high level of resistance to SP.

Ethiopia’s latest outbreak illustrates the urgent need to increase the availability of other treatments to replace these failing drugs. The disease kills between one and two million people, mostly children, each year, and MSF experts believe implementation of new malaria protocols is a matter of life and death.

During the past few months, MSF teams in Ethiopia have requested permission to use a newer treatment, artemisinin-containing combination therapy (ACT). This centuries-old Chinese medicine is known to be highly potent, fast-acting, and well tolerated. Yet, MSF’s request to use ACT on an emergency basis in Ethiopia was denied by the government.

In 2001, the World Health Organization (WHO) began promoting the use of ACT. Today it is well established that ACT is the most rapidly and reliably effective anti-malarial treatment. Increased use of ACT has led to a fall in drug prices, so that today it costs less than $1 to save the life of a child with malaria using these drugs.

MSF has experience administering ACT and has already used the medicine to respond to emergencies in Kenya and Sudan. Following the WHO’s recommendation, MSF policy calls for ACT to be used in all of its malaria projects. To help promote its use, MSF will organize a symposium in New York in the spring of 2004 on the implementation of ACT.

At present, MSF continues to advocate for the inclusion of artemisinin in the malaria treatment protocol in epidemic areas. In the meantime, the disease continues to kill. The next high transmission season in Ethiopia is expected to follow the seasonal rains in February and March. “What will happen after the rains is the main question now,” concludes Hamel.

Photos above: Ethiopian children are at particular risk for contracting malaria. © Stephan Vanfleteren, © Gughi Fassino, © Stephan Vanfleteren, 2003
NEW MSF INTERNATIONAL PRESIDENT
Starting in January 2004, the new president of the MSF International Council is Rowan Gillies, MD, the former President of MSF-Australia. Gillies has been involved with MSF since 1998, and has worked in various medical capacities in Afghanistan, Sierra Leone, southern Sudan, and Liberia. Marine Buissonniere has been named the organization’s new Secretary General. She takes on this role after seven years of working with MSF in the Palestinian Territories and North Korea and directing operations at MSF-Japan. Both will be based in Geneva when the international office moves there from Brussels this summer.

ARJAN: MISSING FOR MORE THAN 500 DAYS
Christmas Day marked the five-hundredth day that Arjan Erkel has spent in captivity. He was abducted by armed gunmen on August 12, 2002, in Dagestan, a Russian republic neighboring Chechnya. Erkel had been working as the MSF head of mission in Dagestan when the kidnapping occurred.

“Five hundred days without knowing what will happen the next day, without being sure that he will leave his prison alive one day is an unimaginable ordeal,” says Thomas Nierle, operations director for MSF in Switzerland.

International organizations including the United Nations and the European Parliament and Commission have repeatedly expressed their concern about Erkel’s fate in the past few months. The most recent demand for his release by a political leader came from Italian President Silvio Berlusconi, who, during a European Summit under Italy’s EU presidency, held in Rome in November, urged Russian President Vladimir Putin to do more to secure Erkel’s release. In Rome, a delegation of MSF staff and Erkel’s father, Dick Erkel, publicly demanded that Erkel be freed.

Despite these efforts, Erkel remains the only foreign humanitarian worker held in captivity in the Northern Caucasus.

WORLD AIDS DAY EXHIBITION HELD
On December 1, World AIDS Day, MSF-USA hosted a reception at its New York City office to open the multimedia exhibit “AIDS Treatment for Africa: the South African Struggle,” featuring photographs by award-winning South African photographer Gideon Mendel. Nondumiso Hlwele, a patient in MSF’s antiretroviral treatment program in Khayelitsha, South Africa, introduced the “body maps,” a series of self portraits by women in MSF’s treatment program, facilitated by the University of Cape Town’s Memory Box project.

Edited transcripts from three discussion events, held during the fall of 2003 as part of MSF’s Frontline Reports series, will be available soon on the MSF-USA website. A spring series has been scheduled. For more details, visit our website.

IN THE SHADOW OF “JUST WARS”
This spring, Cornell University Press will publish In the Shadow of “Just Wars”: Violence, Politics, and Humanitarian Action. The publication is the newest volume in the MSF book series “Populations in Danger.” It focuses on current international crises and the predicament of people living in vulnerable situations.

“Just wars”—however legitimate—still result in the deliberate sacrifice of non-combatants," emphasizes the book’s editor Fabrice Weissman, a long-time MSF expert on humanitarian aid. “And above all, these interventions remain the exception. On the international level, the most common reaction to crises that engulf hundreds of thousands of people is to say and do nothing.” Rony Brauman, one of the publication’s contributors, will be highlighting some of the book’s themes later this spring at MSF events planned in New York, Washington, DC, and Boston. For more details about the upcoming book tour, visit our website.

MSF TESTIFIES ON BUSH AIDS INITIATIVE
On December 18, 2003, MSF testified on the President’s Emergency Plan for AIDS Relief (PEPFAR) at a town hall meeting organized by the Presidential Advisory Council on HIV/AIDS through the Department of Health and Human Services. MSF’s testimony, geared toward informing the Bush administration’s efforts to increase access to HIV/AIDS prevention, care, and treatment in Africa and the Caribbean, summarized the lessons learned from our antiretroviral treatment programs. Specifically, MSF stressed the importance of simplifying pill regimens, decentralizing and adapting treatment protocols, reducing drug prices, involving the community, and promoting research and development of new medicines and monitoring tools.

MSF NEWS AND EVENTS

PHOTOS THIS PAGE FROM LEFT TO RIGHT: Rachel Cohen, director of the Campaign on Access for Essential Medicines for MSF-USA, talks with Nondumiso Hlwele and Anya Subotsky of the Memory Box project. © MSF 2003
Rowan Gillies now leads MSF’s International Council. © MSF 2003

© MSF 2003

Doctors Without Borders = Médecins Sans Frontières = MSF
MORE THAN

500 DAYS IN CAPTIVITY.

SIGN THE PETITION TO SUPPORT ARJAN AT
WWW.DOCTORSWITHOUTBORDERS.ORG
To meet the enormous needs caused by the devastating earthquake that hit the southern Iranian city of Bam on December 26, 2003, Doctors Without Borders/Médecins Sans Frontières (MSF) has sent tons of emergency supplies and quickly assembled a 23-member volunteer team.

REACHING THOSE IN NEED
The first MSF medical volunteers arrived only hours after the quake. Soon after, an MSF cargo plane and trucks arrived in Bam carrying tons of emergency medical and relief supplies including medicines, emergency materials, blankets, water treatment kits, and 5,000 jerry cans for transporting water.

The supplies provided crucial assistance, yet the needs were considerable. With an official death toll of 40,000 people, the city was almost completely destroyed, as were many of its health facilities. “The number of survivors in Bam and its surroundings is estimated at 40,000 people—23,000 for the city of Bam alone,” says Jean-Francois Corty, MSF head of mission in Iran.

In the days immediately following the earthquake, MSF medical volunteers and national staff traveled to villages near Bam to provide medicine, food, and blankets to the more than 250,000 people living in the region. Azadeh Namdar Mofrad, an Iranian nurse, rushed to Bam from an MSF project in Mashad that assists Afghan refugees. After six years with the organization, she says, “This is the first time I am helping my own fellow citizens.” In the first few days after the earthquake, she and other MSF staff searched for people in need of medical care and listened to their stories. “We stopped at each tent to talk to people, treating injuries—some more and some less serious. They needed and still need our support and I am proud to provide them with a little relief.”

“MSF’s response to the disaster was not to provide emergency care that others were in a better position to handle, but to offer general primary care,” explains Eric Vanhalewyn, MD, a physician working with MSF in Bam.

CARING FOR SURVIVORS
The medical teams found civilians suffering from emergency and more chronic health problems. “We saw more than 80 patients every day,” remembers Vanhalewyn. “Many of the problems were linked directly to the earthquake like trauma, wounds, lung infections from the dust, and gastritis due to stress. We also cared for people with chronic illnesses. Many patients with asthma, diabetes, hypertension, and epilepsy no longer had access to their daily treatment.”

But treating the physical wounds left by the disaster was only part of MSF’s work. “Each tent contains many personal dramas and faces marked by grief,” says Jean Paul Delain, MD, MSF medical coordinator in Bam. Treating these emotional wounds is the next phase of MSF’s work in the devastated city. Adds Vanhalewyn: “Thousands of people have lost family members or others close to them and are suffering from post-traumatic stress disorder. We have to be there to listen and treat their psychological problems too.”

MSF has worked in Iran since 1995 and provided aid during the 1990 earthquake.

Photo above: An MSF volunteer working in Kerman, Iran, examines a child injured by the earthquake. © Tim Dirven 2003