In Aceh province on the island of Sumatra, Indonesia, displaced people look over a pamphlet created by MSF as part of its mental health care programs in areas devastated by the December 26, 2004, tsunami. "For many people, the extent of the catastrophe quite simply remains unbearable," says psychiatrist Renato Souza, who oversees MSF’s mental health care programs in Aceh. "One woman, for instance, who lived in a modest house near the coast with her husband, their four children, and her mother-in-law, lost everything in a matter of minutes. She was the only one to escape alive; the house and everything around it was destroyed. As the water surrounded her, she tried to hold one of her children tightly but to no avail. Now she lives in cramped conditions in a temporary camp and has no way to earn a living: she is completely dependent on others. And the situation I have just described is far from being a tragic exception."
Doctors Without Borders/Médecins Sans Frontières (MSF) medical teams that arrived within 48 hours of the quake are finding thousands of people with severe wounds, including fractures, spinal cord injuries, lacerations, and infections. In addition, many health care structures have been destroyed, creating a critical problem of setting up temporary facilities. Tens of thousands of people are now sleeping outside with little or no shelter from the cold and rain. And now winter is fast approaching.

By October 18, 2005, MSF had dispatched 130 international staff including doctors, nurses, surgeons, kidney specialists, psychologists, social workers, logisticians, water-and-sanitation experts, and flight-transport specialists to the areas in Pakistan and India that were most devastated by the earthquake. The medical teams quickly began working in 16 hard-hit locations in Pakistan-administered Kashmir and in the country's North-West Frontier Province. As Alert went to press, MSF was extending its aid operations to remote villages that had been cut off by landslides and damaged roads. Teams have been traveling by helicopter, vehicle, and foot to reach more locations. They have treated thousands of patients, focusing on infected wounds and fractures, providing psychosocial counseling for traumatized people, and distributing thousands of blankets and shelter items.

Within two weeks of the earthquake, MSF had sent more than 400 metric tons of relief goods into Pakistan including medical supplies (emergency medical kits, drugs, surgical material, dressings, and dialysis machines), logistical materials (water tanks and pumps), and shelter materials (about 70,000 blankets, 10,000 sleeping mats, and 1,200 winterized tents).

More than a week after the disaster, the MSF project coordinator in Lamnian, Jan Peter Stellema, said, “…we are still seeing terrible, terrible injuries that still have not been taken care of.” Stellema, whose team was dropped by helicopter into the village on October 12, established three medical tents. “Many wounds are severely infected and need to be cleaned urgently to prevent patients from dying from sepsis,” he said.

AIDING THE INJURED IN INDIA

With the first snow starting to fall in Indian-administered Kashmir, 10 international MSF aid workers and 51 national staff were distributing medical and relief supplies, and providing basic health care and mental health counseling to people in Srinagar, Tangdar, and Uri.

“Immediately after the earthquake, our team in Indian-administered Kashmir set off to try and reach the most severely affected regions,” said Hans van de Weerd, MSF country coordinator in New Delhi, India, on Oct. 10. An MSF team working in Tangdar, the most remote part of Indian-administered Kashmir, treated basic injuries in the village of Balakot. MSF brought enough relief supplies to assist 20,000 people in Tangdar for a period of four weeks, and a medical team has been assisting nearly 400 families in Cherundu in Uri district. Mental health counselors are offering support to those receiving treatment in four hospitals in Srinagar and are providing food and clothing to unaccompanied children before referring them from the hospitals to orphanages. MSF is also providing medical and logistical supplies to these hospitals.
VIOLENCE STALKS CIVILIANS IN EASTERN DEMOCRATIC REPUBLIC OF CONGO

Despite the official end—nearly two years ago—of a war that involved several African nations, and the presence of UN peacekeepers, looting, murder, kidnapping, torture, and rape remain part of daily life for people living in the Ituri district of the northeastern part of the Democratic Republic of Congo (DRC). The ongoing violence, carried out by armed groups fighting for control of resources, has forced tens of thousands of people from their homes and fields, leaving them in need of outside assistance.

Doctors Without Borders/Médecins Sans Frontières (MSF) medical teams have borne witness to some of the most brutal acts of violence—machete attacks on children as young as 3 and the gang rape of women as old as 80—through its medical and surgical programs in the area. MSF provides assistance at the 300-bed Bon Marché Hospital in the district’s main town of Bunia and, until the brutal kidnapping of two MSF aid workers in May 2005, offered assistance in makeshift camps outside Bunia.

“The people are saying that their villages are not safe anymore. That they can no longer stay in their homes safely, otherwise they will be attacked, they will be raped, and they will sometimes be killed,” says Jerome Souquet, MSF head of mission in Ituri.

Many never make it out of their villages alive. Seventy percent of the deaths reported to MSF in a survey of nearly 800 families in April were due to war-related violence. More than one-third of the families said that they had been victims of at least one violent act. Thirty-five percent were subjected to physical violence including mutilation, gunshot wounds, rape, torture, kidnapping, or arbitrary detention.

“When we were held captive, we were beaten—men, women, and children,” a 22-year-old man told MSF. “A few people were killed by machete and others were shot. After beating people, they took everything from me—my money, my clothes, and even those of my family.”

CHASED INTO THE FOREST

Often attackers chase entire villages into the neighboring forest. “After seven weeks in the bush, they found us. They set the bush on fire and shot in all directions. They shot dead my uncle’s six children, three girls, and three boys,” said a 47-year-old man who was interviewed by MSF.

Survivors are in many cases forced to watch acts of torture, rape, and murder. “They killed some people with machetes, including people from our family. They were killed right in front of me. I saw them bleed,” a girl, 12 years old, told MSF.

Sexual violence against women and children is another prominent characteristic of the violence. In more than two and one-half years, MSF has treated more than 3,500 victims of sexual violence between the ages of 8 months and 80 years at Bon Marché Hospital. Nearly one-third of them had come to the health center within 72 hours of the attack and were thus able to receive effective preventative treatment for HIV and other sexually transmitted infections.

“When they attacked the village, people took refuge in another village. They followed them and took them to yet another village. After looting and burning the huts in that village, the armed men gathered up all the girls and took them to be their wives far away into the forest,” a 14-year-old girl told MSF after she escaped from fighters who had held her for more than a month as a sex slave.

The violence seems to be increasing. In Bon Marché Hospital, one-third of all surgical procedures performed by MSF surgeons are for war-related injuries.

But many of the most seriously wounded never make it to the hospital; instead they die alone in the forests or along deserted roads.

PHOTO EXHIBIT SHEDS LIGHT ON SUFFERING IN DEMOCRATIC REPUBLIC OF CONGO

Doctors Without Borders/Médecins Sans Frontières (MSF) teamed up with five world-renowned photographers from the VII Photo Agency—Ron Haviv, Gary Knight, Antonin Kratochvil, Joachim Ladefoged, and James Nachtwey—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. The five photographers traveled to the Democratic Republic of Congo with MSF medical teams from May through August 2005.

Their work is presented in Democratic Republic of the Congo: Forgotten War, an exhibition curated by Alison Morley, and a new book by the same title published by de.MO. The exhibition, which will tour the United States, Africa, Asia, Australia, and Europe in the coming year, opened in New York City's Engine 27 on September 21. A sampling of the photographs is available at www.doctorswithoutborders.org.

NO SAFETY IN NUMBERS

Even after reaching the camps in Kakwa, Gîna, Tché, and Tchomia in the Djugu region of Ituri, people are not safe. In Gîna camp, women leave early in the morning to try to gather food for their families from their abandoned fields, and some have reported being raped by armed groups during their search for water.

The displaced people also face the threat of epidemic diseases. In just seven weeks, in February and March 2005, MSF treated 1,633 cases of cholera in Kakwa and Tchomia. Fevers and diarrhea were the number one killers of children under five in these camps.

ATTACKS ON MSF AID WORKERS

In early June, MSF had to suspend its aid operations outside of Bunia following the 10-day kidnapping of a French logistician and Congolese driver. An armed group that had only days earlier assured MSF of safe passage through its area of control kidnapped the two aid workers and subjected them to death threats, mock executions, and beatings.

Says MSF Director of Operations Maryline McHarg, “Despite the fact that we have had to leave the periphery of Bunia, our priority today is to continue our assistance to the people of Ituri, within Bunia town.”

From left to right: 
I found out during Easter last year,” says Adam. “I was losing a lot of weight and I could hardly lift a finger. Because I worked at the port, I was entitled to go to the GSSI hospital. I was there for 22 days. After that they sent me away because there were no drugs in Puerto Barrios. They told my wife to take me home to die because there was nothing they could do.”

“I accepted that I was ill, but not that I had to die so soon.”

“When I left the GSSI, my CD4 count [an indicator of the strength of an immune system] was 8,” says Adam. “Later, when MSF started to treat me, I got up to 22 and just recently at a blood test they told me I’m at 178 now! [Healthy adults typically have between 800 and 1,200 CD4 cells.] The doctors give me free medication at the hospital, I don’t want to leave. My wife says I’m entitled to treatment from the GSSI but I have no intention of going to Guatemala City for them to take so much time in treating me, and I’m not going to risk being left with no medication. Now that I’m on treatment I know that I can keep the virus under control.”

But many Guatemalans living with HIV/AIDS struggle to access treatment, suffer from discrimination and loneliness, and are abandoned by their friends and relatives. Leticia Soriano, an MSF social worker at the Puerto Barrios hospital, says Adam’s case is very special because he is one of the few men she has met whose wife and family support him.

“HIV is not just about treatment,” she says. “The person needs a lot of support from the people closest to them because being HIV positive still has a huge stigma attached to it.”

BRINGING TREATMENT TO THE COUNTRYSIDE

While the Ministry of Health and GSSI provide health care and treatment for HIV/AIDS in Guatemala City, they do not offer help in obtaining treatment in the rest of the country. MSF has been running its projects in the municipalities of Puerto Barrios and Livingston since 2003 to offer needed services and to urge the Guatemalan government to expand access to AIDS care and treatment.

The World Health Organization and UNAIDS estimate that there are 78,000 people living with HIV/AIDS in Guatemala. Barely 30 percent of Guatemalans who are in clinical need of treatment are receiving ARV treatment.

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“Before I became ill, I used to sow crops and do other jobs in the fields. Although I’ve always been a port worker,” says Adam from the front steps of his home near Morales, a half-hour’s drive from Puerto Barrios. Izabal has the largest commercial port in Guatemala and is a thoroughfare for migrants. It also has the country’s second highest rate of HIV infection, after the department of Guatemala (the capital).

Adam was very weak when he got to the hospital. Photographs of him before he started receiving ARV treatment illustrate how far he has come. Adam was little more than skin and bones, and had an absent look in his eyes.

“Now that I’m on treatment I know that I can keep the virus under control.”

REFUSING TO DIE: LIVING WITH HIV/AIDS IN GUATEMALA

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Innovation in Care of Malnourished Saves Thousands

An innovative approach to treating severe acute malnutrition has allowed Doctors Without Borders/Médecins Sans Frontières (MSF) to save tens of thousands of starving children in Niger this year.

MSF medical teams have treated more than 40,000 severely malnourished children in Niger, and they expect the number to reach 60,000 by year’s end. This is more than four times the number of children admitted to MSF feeding centers during the 2002 nutritional emergency in Angola, which differed little in severity.

The stunning increase in the number of children under MSF’s care in Niger is the result of a revolutionary change in thinking about treating severe malnutrition and of a new product that enables even desperately malnourished children to be treated on an outpatient basis.

For years, MSF admitted severely malnourished children to therapeutic feeding centers—essentially field hospitals—where they received round-the-clock medical care and nutritional rehabilitation from medical staff. While the children were fed therapeutic milk at regular intervals, their mothers waited with them in the centers typically for three to four weeks until the children had gained sufficient weight to go home.

There were several disadvantages to this approach. Significant resources—in terms of staff and logistics—were needed to create these fixed therapeutic feeding centers, making it extremely difficult to open enough centers, in little enough time, to save the large numbers of children who required treatment. Hospitalizing children also puts a strain on families, since many of the mothers have other children at home—whose own health can be compromised by their absence. Furthermore, keeping large numbers of children in one place, even under ideal conditions of hygiene and water availability, increases the risk of transmission of infections.

MOVING TO OUTPATIENT CARE

Now, MSF is also treating severely acute malnourished children on an outpatient basis. The development of a relatively new, ready-to-eat therapeutic food called Plumpy’nut has been instrumental in freeing severely malnourished children and their mothers from inpatient therapeutic feeding centers. Plumpy’nut, the staple of the outpatient program, is a peanut butter–like specialized food that includes all necessary macro and micronutrients, in the right quantities and balance, to promote rapid growth in a malnourished child.

This product has allowed MSF to use therapeutic milk products only for the most serious cases of malnutrition. Medical teams need not worry about having adequate safe drinking water to liquefy the powdered therapeutic milk, or about over-diluting it, and it stays viable even in high temperatures.

As a result, MSF is now hospitalizing only those children who present with either no appetite or serious additional medical conditions, like severe malaria or anemia. The rest are being sent home with their mothers and being asked to return each week to one of MSF’s 41 outpatient feeding centers in 5 regions (Maradi, Tahoua, Zinder, Diffa, and Tillaberi) of Niger, where medical teams check them for any complications, document their weight gain, and refresh their supply of therapeutic food. At the same time, mothers are given five kilograms of enriched flour called Unimix and one liter of cooking oil.

Upon a child’s discharge from the program, the mother is given 50 kilograms of cereal, 25 kilograms of legumes, and 10 liters of cooking oil. This ration is enough to cover the food needs of an eight-person family for one month.

UNPRECEDENTED RESULTS

The outpatient approach has enabled MSF to treat tens of thousands of more children than in previous emergencies, and with comparable rates of cure to hospitalization. In Niger, cure rates have reached between 85 and 90 percent (with a 5 percent death rate and a 5 to 10 percent default rate). Most children are being rehabilitated in four weeks without ever being hospitalized. These high levels of success were once thought impossible outside of a hospital setting.

MSF has been able to achieve these results in Niger because the program was originally designed as an outpatient therapeutic feeding program back in 2001. Over the past three years, MSF personnel have carefully honed the outpatient protocols. Everything from establishing the best locations for weekly outpatient consultations to the training of the medical staff has been evaluated since the program’s inception. Through constant attention to the quality of the program, MSF was able to treat 10,000 severely acute malnourished children in 2004, and more than 40,000 so far this year.

“Without this approach, we wouldn’t have been able to treat nearly as many children,” says Dr. Milton Tectonidis, a nutritional specialist with MSF. “Before, we probably would have limited ourselves to Maradi—the area with the largest concentration of malnourished children—with maybe three or four fixed therapeutic feeding centers…. So it’s a huge difference. The experience in Niger may make the combination of outpatient and inpatient care the definitive strategy for MSF.”

MSF teams have also used the outpatient approach in Mauritania, Nigeria, and Sudan to treat thousands of severely malnourished children this past summer.

Inpatient feeding centers will always be needed to provide the more intensive treatment of severe and complicated cases of malnutrition. In Niger, roughly 30 percent of the children in MSF’s therapeutic feeding program had to be hospitalized for at least a few days during their rehabilitation. Many of the children admitted to the inpatient centers were suffering from respiratory infections, septicaemia, anemia, severe diarrhoea, or dehydration often associated with acute or recent malaria infection. This group accounted for most of the malnutrition-associated deaths that have occurred in the Niger program. Many of these children would have been difficult to save even in ideal conditions.

THERAPEUTIC FOOD AS AN ESSENTIAL MEDICINE

Endemic acute malnutrition has been viewed as part of life in many undeveloped countries. In Niger, for example, hospitals do not track acute malnutrition among children admitted to the public health services, and they do not maintain a supply of therapeutic food, which is essential to bringing severely acute malnourished children back from the brink of death. There is no record of the incidence of severe acute malnutrition—unlike malaria or measles—available from the ministry of health. In many respects, severe malnutrition is similar to the “neglected” diseases—like sleeping sickness or Chagas—that MSF teams are tackling around the world.

“What would be most effective from a medical point of view is to insist that therapeutic food for severely malnourished children—like Plumpy’nut or B100 (another ready-to-eat therapeutic food)—be integrated into the regular services offered in the health care system,” says Dr. Tectonidis. “It should be considered an essential medicine—just like antiretrovirals for HIV/AIDS or artemisinin-based combination therapy for malaria—and not just during emergencies.”

For the latest information about MSF’s response to the nutritional crisis in Mauritania, Niger, Nigeria, and Sudan visit www.doctorswithoutborders.org
They are reminded that they still have the disease, so they will continue to suffer from its effects, could potentially infect others, and may die. The decision to return is voluntary. In the past, most absentees have returned to continue their treatment.

FINDING THE ABSENTEES

The first absentee to be traced is Mohammed who is 50 years old and has pulmonary TB. When he went missing, Mohammed Ishmael visited his home and was told by neighbors that Mohammed had gone home to deal with some problems related to his cattle.

Since nomads move from place to place, it is important to keep very precise records of the patients’ home areas and tribes. Instead of a street address as we know it, the Afar have a specific social structure. An Afar belongs to a family, 11

The northeasternmost part of Ethiopia is home to the Afar people, a population that has survived for centuries as pastoralists, migrating with their livestock in search of pasture and water. Their nomadic life has not protected them from the scourge of tuberculosis (TB). The disease is endemic in the Afar region, an area roughly the size of California. In 2001, Doctors Without Borders/Medecins Sans Frontieres (MSF) established a TB treatment center in Galaha. Since the center’s doors opened, nearly 2,500 people have been treated there. MSF nurse Francois Colonval coordinates TB treatment adherence counseling at the Galaha center. The following is an account of his work.

It’s been several weeks since I started working with MSF in this small, rural village named Galaha, where temperatures hover between 104 and 122 degrees Fahrenheit. Today, Mohammed Ishmael, a health worker at MSF’s TB center here, and I get an early start because we have a three-and-one-half-hour drive to a town called Chifra. We are looking for three of our TB patients who have not come for their daily medicines during the past two weeks.

I supervise the TB center’s adherence activities. This includes the direct observation of patients taking a daily combination of TB drugs every morning for the first four months of their treatment. If they miss coming to the center, one of the health workers will trace them in the “patient village,” which MSF built within the complex to provide a home for patients during their treatment. MSF uses local materials and builders to create the Afar’s mobile homes, known as daboytas, and provides food to patients to encourage them to stay and complete their treatment. After the intensive phase of the program, patients are given a three-month supply of drugs to complete their treatment at home.

If patients go absent for three days, they will be recorded as “absentees.” If they do not return on their own within two weeks, Mohammed Ishmael, the absentee tracer, will make a plan to track them to their villages. At least two attempts will be made to trace each absentee. When they are found, we encourage them to return to continue their treatment.

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which is part of a tribe, kedo, and is ruled by a chief, makabantu. This tribe lives in a particular village, kebelé, in a certain district, woreda. When a patient is admitted, as much of this information as possible is collected.

After a jarring ride through the desert, we finally arrive in Chifra. Our first meeting is with the chief of Mohammed's village, as we need to seek his support in locating our patient. In a small office, we wait impatiently with other villagers to see the chief. I expect the meeting to go well because Mohammed Ishmael knows the chief. When we are called into the office, the chief generously thanks MSF for providing medical care for the Afar people and asks MSF to open a center in Chifra.

The chief summons one of his staff members who oversees Mohammed's village and instructs him to take us there to find him. We jump into our car and drive to the village. When we get there, we stop the first person and ask whether he knew where Mohammed lived. This person points to two young women standing a few feet away who turns out to be Mohammed's daughters. They shyly report that their father had died soon after he returned home. Apparently, their father had gone to the river to wash his lungs, which were affected, and is an extra-pulmonary TB case, because Mohammed had developed rashes in his mouth.

Mohammed Ishmael recognizes someone who might know the chief, who gives Kelle some money, and we are off to find the chief. We decide to have lunch and try our luck in the afternoon. As we emerge from the restaurant, Mohammed Ishmael recognizes someone who might know the patient, and we follow the tip but do not find Kelle. Just when we start to head back to the chief's office we see Kelle walking on the main road toward the MSF car.

Mohammed Ishmael jumps out of the car and greets Kelle in the local tradition: a handshake and a movement forward where opposite shoulders meet. In the local language, Mohammed Ishmael asks Kelle why he has left and explains the danger to his health, his family, and community if he does not finish his treatment. Kelle tells Mohammed Ishmael that he plans to return once he borrows 200 birr ($20) from the chief. After all, his wife and child are still at the center. We find the chief, who gives Kelle some money, and we are off to find the third absentee with Kelle and his four-year-old son in tow.

Mohammed Dimis has failed to find his camels, so he is ready to return to finish his treatment. 

### READMITTING ABSENTEE PATIENTS

Back at the compound, we readmit the two absentees. Their first appointment is with the TB doctor for a general physical examination. Upon return, patients may be required to have another sputum test. Then they see the adherence counselor to re-establish a dialog and be reminded of the importance of finishing their treatment. The current TB drugs dictate a long treatment program, which is very difficult for any TB patient, nomadic or not. Therefore, adherence counseling is an important part of MSF’s TB treatment program because staying on treatment and finishing the whole course is the best hope for a cure.

TB should be taken more seriously because it is a deadly infectious disease with many social implications. A third of the world's population has latent TB. We need new drugs with shorter treatment regimens so that we can handle this disease better. For the Afar nomads, we have the extra challenge of finding our patients, who may be spread out over a large area of the desert. Today, we were lucky to find our absentees in the towns, but treating TB would be easier if we had better drugs.

I'm impressed with the passion the adherence team has for our patients. They're really committed to each patient's health. Mohammed Ishmael has worked for MSF for five years, more than one and one-half years as absentee tracer. He still gets very emotional when patients abandon their treatment. He feels like the patient is killing himself. This motivates him to do his best to find absentees and convince them to return to treatment. When they do, he feels like he's helped save their lives. I feel that way too.

### STRESSES FAMILY

Kelle, a 36-year-old cattle owner, is the second absentee on our list and is also from Chifra but from a different village, Wahama. He has been missing for 10 days and is an extra-pulmonary TB case, which means internal organs other than his lungs are affected. For three and one-half months of treatment, he lived in a home with his wife and two children. His wife is now suspected of having TB. We are told that Kelle has left because he needed money so that he could afford to keep his family in Qalaha, especially now that his wife might have TB. He was going to ask his chief to loan him some money.

After a two-and-one-half-hour drive, we reach the town of Mille. Pastoralist Mohammed Dimis lives in Eilwaha village. He is 46 years old and has pulmonary TB. He stopped his treatment after two months and was missing for 12 days reportedly because his female camel had had a baby and he needed to find both of the animals. Mohammed Ishmael knows his way around this town, so Mohammed Ishmael stops several residents in unsuccessful attempts to locate the chief. We decide to have lunch and try our luck in the afternoon. As we emerge from the restaurant, Mohammed Ishmael recognizes someone who might know the patient, and we follow the tip but do not find Kelle. Just when we start to head back to the chief's office we see Kelle walking on the main road toward the MSF car.

Mohammed Ishmael jumps out of the car and greets Kelle in the local tradition: a handshake and a movement forward where opposite shoulders meet. In the local language, Mohammed Ishmael asks Kelle why he has left and explains the danger to his health, his family, and community if he does not finish his treatment. Kelle tells Mohammed Ishmael that he plans to return once he borrows 200 birr ($20) from the chief. After all, his wife and child are still at the center. We find the chief, who gives Kelle some money, and we are off to find the third absentee with Kelle and his four-year-old son in tow.

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Responding to a Measles Outbreak in Indonesia

In August, Doctors Without Borders/ Médecins Sans Frontières (MSF) sent its first team of doctors and logisticians to West Sumba in Indonesia to investigate reports of a measles outbreak that had killed five people in the sub-district of Kori. The team found that the outbreak had already spread to 6 of West Sumba's 15 sub-districts. In response to the outbreak, MSF initiated a three-month measles emergency project, integrating mobile-clinic activities and a vaccination campaign. The vaccination drive is targeting 170,000 children between six months and 15 years of age and is using more than 200,000 doses of vaccine, 22,000 high-protein biscuits to treat any children suffering from malnutrition, and 129,000 vitamin A tablets to protect against complications from measles such as blindness. From the first through the ninth of September, the mobile-clinic teams, working in the 6 affected sub-districts, provided 655 medical consultations through a group of more than 100 sub-Saharan African immigrants who have been abandoned by Moroccan authorities in a desert south of Morocco where there is no access to food or water. They were expelled from Casa and Mezita, two Spanish enclaves in Morocco. © MSF

Fighting Cholera in West Africa

A number of West African countries, including Liberia, Guinea, Mauritania, Guinea-Bissau, and Burkina Faso, are facing particularly bad cholera outbreaks this year. In response, MSF has sent additional staff and 70 tons of medical and logistical supplies to the region. “We have treated 282 patients in Burkina Faso; 2,337 severe cases and another 7,291 suspected infections in Monrovia, Liberia; and well over 1,000 people in Mauritania. We are opening cholera centers in Guinea Bissau and we have set up three new treatment centers and given support to another two in Conacry, Guinea,” explains Stephan Goethgebuer, MSF operational coordinator for the region.

Increasing Medical Care in a Haitian Slum

MSF has rehabilitated the only hospital located in Cité Soleil, one of the largest slums in Port-au-Prince, the capital of Haiti. CHOSCAL (short for St. Catherine Labouré) Hospital had been abandoned for more than a year. “When we arrived in CHOSCAL Hospital, everything was in the same condition as the day it was deserted in August 2004, when the activities were interrupted because of insecurity. In a few days we were able to start consultations and surgery,” says Louis De Filippi, who is in charge of medical programs in the hospital. MSF also operates the 56-bed trauma center at St. Joseph’s Hospital in Port-au-Prince, which it has treated more than 1,700 victims of violence-related injuries, including 1,300 gunshot victims, so far this year.

Violence Threatens Immigrants in Morocco

In October, Doctors Without Borders/ Médecins Sans Frontières (MSF) called attention to escalating violence against immigrants from countries such as Cameroon, Mali, and Senegal, who cross Morocco on their way to Spain. Up to 25 percent of MSF’s patients in Nador and Tangier areas of Morocco seek medical treatment as a result of persecution and attacks. Since early 2003, MSF has been running mobile clinics and increasing the immigrant community for disease outbreaks. Medical data and testimonies collected from migrants reveal that, of the 10,232 medical consultations conducted between April 2003 and August 2005, 2,544 were violence related. MSF’s immigrant patients who have been victims of violence say that their injuries were caused by Moroccan police forces (44 percent), Spanish police forces (18 percent), criminal gangs (17 percent), mafia groups or networks engaged in human trafficking (12 percent), other immigrants (2 percent), and accidents (7 percent). As people have tried to escape Moroccan security forces, they have sustained injuries from gunshots, beatings, and attacks by dogs. Deaths have also occurred.