

Fall 2003
Vol.7 No.3

ALERT

Sri Lanka After Years of Civil War

Aiding Congo's Civilians

Proposed Trade Pact Threatens
Public Health in the Americas

Crisis Continues in Liberia



VOICE FROM THE FIELD

WORKING AS NATIONAL STAFF IN SRI LANKA



Roshan Kumarasamy, 37, worked as a member of Doctors Without Borders/Médecins Sans Frontières (MSF) s national staff from 1994 to 1999 in Sri Lanka. A native of Colombo, of both Tamil and Sinhalese descent, he was originally recruited as a radio operator to help coordinate MSF s field work. Over time, his job description expanded to include all of the logistical tasks involved in supporting a medical team. In 1999 he moved to California where he is pursuing a degree in child psychology. In June 2003, Roshan became a member of the MSF-USA Board of Directors.

I got my job with Doctors Without Borders/Médecins Sans Frontières (MSF) while working in a bar in Colombo, Sri Lanka's capital! I was disillusioned and felt it moronic to invest time and energy in long-term goals when our society was being shredded both physically and emotionally by suicide bombers during the nightmarish ethnic civil war. Politicians? I held them in contempt. Quite apart from the real risk to one's life from showing up to vote at elections, I did not vote.

In 1989 the horror was compounded with the southern Marxist insurrection. Tens of thousands were tortured and killed. We Sri Lankans had all lost our dignity and hope. Even today those two years are painful to dwell on.

Then two MSF international volunteers told me there was a vacancy for a radio operator at the Colombo MSF office. I knew the bar was going to be shut down, and I needed a job.

I knew vaguely of MSF. I was in for a surprise. For months I searched for the catch. All these resources, both human and material, given to the most marginalized and invisible populations? And what about the low profile—all these expats flying in, then quietly spirited away to the bush to face who knew what miseries? What was in it for them? And then there were the criticisms from my mates, hinting that MSF was contributing to the Western conspiracy of creating a new world order by destabilizing the developing world for power and profit. Surely there must be a catch.

After my arrival, the logistics department was able to ease some of the administrator's workload. Using an old typewriter, I was able to bang out a little of the routine paperwork such as preparing route passes so that the military would know where we were working and not attack us, or drafting requests to transport goods to the teams in the field. I communicated directly with the military bosses at joint-operations command to ensure our teams' safety. I read letters written in German, Dutch, what have you, to volunteers in the field, hunched over my little VHS I-com radio, in radio alphabet! And after months of scrounging and negotiating, it was a special relief and thrill to pack up a medical convoy.

I stopped looking for the catch. The desperation of the internally displaced people was clear. They were entirely dependent on MSF to meet all of their medical needs. MSF was helping to resuscitate not only a failing population but an entire infrastructure, salvaged from the ruined health care system in the north



Cover:
Poonthoddam, originally built as a transit camp, has been home for years to thousands of displaced Sri Lankans. Drama is used within MSF s psychosocial care program there to educate people about health and social issues.
' MSF 1999

Photos above:
1 Roshan Kumarasamy
' MSF 2003.
2 Children in Jaffna.
' Tristy Shaw 1999



3



4

and east. MSF renovated hospital wards and put water and sanitation systems in place. Teams managed mobile clinics in remote jungle areas. One such project was Puthukkudiyiruppu, an MSF clinic located in the heartland of the rebel group Liberation Tigers of Tamil Eelam (LTTE). A local MSF driver was injured when a Sri Lankan air force helicopter opened fire on a mobile clinic—a military mistake, it turned out. Vigil was kept at his bedside by fellow drivers and MSF volunteers who feared that he might “disappear” as embarrassing evidence of miscommunication. No, I did not think MSF bore some secret agenda.

My years with MSF were intense. There was the gut-wrenching panic during the Kilinochchi evacuation: A lightning strike by the armed forces had left the ground team with no time to do anything but grab their belongings and run. And how about the personalities! To be driven by Kennedy, a Murphy’s Law magnet, was risky business, as one MSF volunteer found out when an elephant being transported in a truck threw up on our vehicle. Then there was the country coordinator who, while sea-bathing among the coral reefs, was dashed against a wall of sea urchins. His self-imposed treatment? A bottle of the local firewater and a Swiss army knife.

I was overjoyed when MSF addressed the mental health problems in Sri Lanka. A whole generation in the north and east had never known a world without war. What did they have to look forward to? Is it any wonder they were easily recruited as LTTE suicide cadres? The assurance of glory in the next life beckoned more enticingly than the assurance of an ongoing hell in this one. Adults suffered too. Having known a semblance of a dignified existence, it was harder for them to cope with the abyss of humiliating dependency, uncertainty, and horror.

MSF has had its work cut out. We started mental health programs in Vavuniya, training local staff to continue the program after MSF departed. Since the Norwegian-brokered peace agreement, the country is slowly recovering. Reconstruction discussions abound, while the internally displaced are returning slowly to their little plots, once their homes. Landmines lurk. Much needs to happen before the scars in the hearts and minds of the people can begin to heal, but an uncertain peace has broken out.

Many MSF projects on the island have been closed, others will soon be handed over to the local authorities. MSF’s presence in the heart of the worst storm we have known will fade. Those of us who were international or national staff working together will not forget the struggle to keep Sri Lanka breathing.

Roshan Kumarasamy



5



6

Photos this page:
During Sri Lanka’s long civil war, MSF provided urgently needed health care at hospitals and in mobile clinics.

- Credits:**
3 ' Eric Bouvet 1999
4 ' Karsten Bidstrup 2002
5 ' Eric Bouvet 1999
6 ' Tristy Shaw 1999

MSF IN SRI LANKA: MEETING NEEDS IN A COUNTRY HAUNTED BY CIVIL WAR

After almost two decades of civil war, hope has returned to Sri Lanka. The calm that now stretches across the island nation makes it hard to believe that ethnic tensions once erupted into a major rebellion by the minority Tamil ethnic group. From the war's start in 1979 until its end, more than 64,000 people were killed, hundreds of thousands were displaced, and the entire health infrastructure in the north of the country was destroyed.

Doctors Without Borders/Médecins Sans Frontières (MSF) teams arrived in 1987 to help those either directly affected by the conflict or isolated from health care because of it. Now, with a cease-fire agreement in place, the health system is being restored in the north and east of the country, and medical personnel are returning to take up long-vacant positions. Civilians are also returning to their villages. For the most part, the needs that initially brought MSF to Sri Lanka no longer exist. As a result, MSF has been able to close many projects in Sri Lanka and has handed others to local health agencies. Yet where needs remain, MSF is committed to stay and provide help.

GIVING EMERGENCY CARE

What started as a single surgical program in the eastern town of Trincomalee in 1987 grew to involve more than 800 international volunteers and thousands of national staff. MSF operated projects in both government-controlled towns and zones held by the main rebel group, the Liberation Tigers of Tamil Eelam (LTTE). MSF provided surgeons, anesthesiologists, midwives, nurses, pediatricians, and obstetrician/gynecologists as well as administrators and technicians. In LTTE-controlled areas, MSF tried to reach and

care for vulnerable populations, many of them internally displaced persons. This vital medical assistance was under constant strain as the authorities severely restricted the movement of essential medical supplies into rebel-held areas.

The Jaffna Peninsula, once home to the LTTE, was the site of heavy fighting. Its former population of one million inhabitants was halved to 500,000 as people fled the conflict. The peninsula, off the north of Sri Lanka, is connected to the rest of the country by two roads that were effectively closed for 15 years, cutting it off from the rest of the island. MSF teams took boats from Trincomalee to get there.

In Point Pedro, an isolated area on the peninsula where MSF set up a surgical program in 1987, there was constant tension. In the summer of 1995, when the army launched an initiative to re-take the peninsula from the LTTE, the town of Jaffna was the first to fall. Within a few weeks, hundreds of people had died, many of them civilians. Most of the casualties came to the hospital in Point Pedro where MSF teams were working.

TRAPPED IN THE EAST: BATTICALOA

In Batticaloa, in eastern Sri Lanka, MSF began in 1987 to provide health care in the town's hospital. Batticaloa was a government-controlled town in the midst of an LTTE-controlled region. Frequent fighting made travel and transport of goods extremely difficult. Almost all of the local surgeons had fled, and those who remained were unable to cope with the influx of wounded. As a result, thousands of people had no access to health care. MSF teams delivered emergency care and spoke out about the violations

of humanitarian law they witnessed.

In 1990 MSF launched mobile medical teams to reach the isolated communities around the town, eventually treating approximately 400,000 people.

"We were constantly traveling in dangerous zones," said Sureash Kirubakaran, a Sri Lankan translator and driver for one of the mobile teams. "The military prevented most civilians from crossing the checkpoints. As people couldn't come to us to get medical care, we had to go to them."

THE WORK THAT REMAINS

Despite improvements in conditions in the north, the situation remains desperate for some groups whom MSF is now trying to help, such as the 15,000 Tamils still living in camps in Vavuniya. "These people are very vulnerable," says Jan van 't Land, an MSF volunteer in Sri Lanka. "The government wants to shut the camps, but many people have nothing left. In addition, they have no work. They cannot leave, and yet they live under terrible conditions. The number of suicides is very high." A study done by MSF in the camps found that one out of four people surveyed had lost a family member to suicide.

MSF has called on the government to improve living conditions in the camps and to avoid forced resettlement. An MSF-run mental health project to treat war-related trauma will soon be transferred to local groups. MSF will continue to monitor the food supply for children in the camps because food deliveries are insufficient and unreliable. A second project in Puthukkudiyiruppu, on the northeast



1



2



3

coast, provides medical support in the town's maternity ward and trains midwives and volunteers.

"We do not know how the peace process will develop," says MSF's Cathy Howard, an MSF operational advisor on Sri Lanka. "We will remain in the areas where there is the least medical

care, and are particularly concerned for the internally displaced who may return to places with inadequate health care. The war's end has greatly improved the lives of Sri Lankans," she concludes, "and we hope that process will continue. But until peace is a fact, MSF will need to stay."

Top photo:

1 An MSF volunteer physician examines a child brought to one of MSF's mobile clinics. ' Eric Bouvet 1999

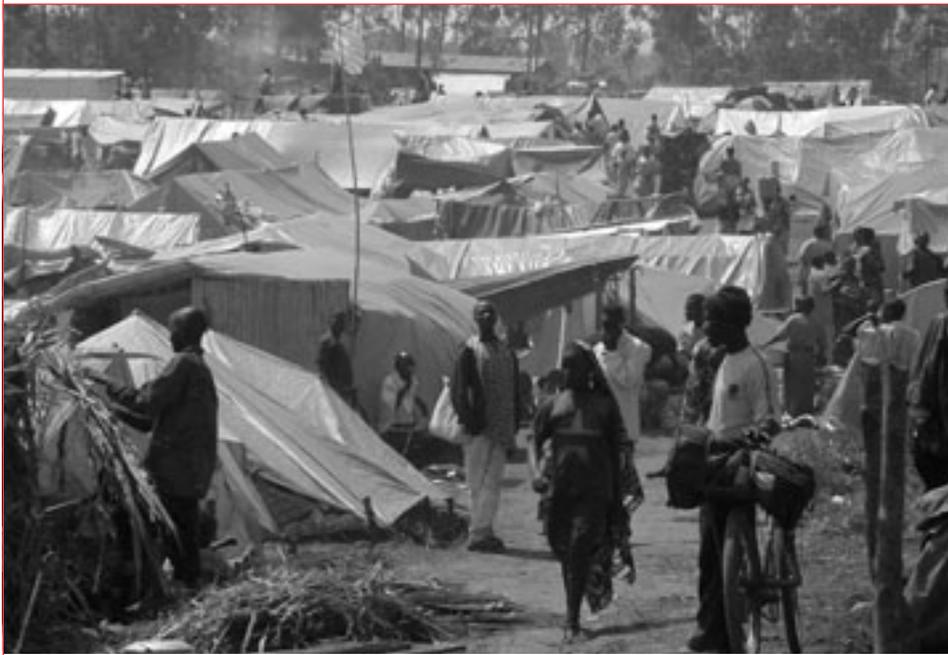
Bottom photos:

Scenes from Poonthoddam transit camp which has housed internally displaced Sri Lankans for years.

Credits:

2 ' MSF 1999

3 ' Marco van Hal 2002



WHERE THE VIOLENCE NEVER ENDS

THE DEMOCRATIC REPUBLIC OF CONGO

When MSF volunteers Tine Dusauchoit and her husband arrived in Bolomba, a small village in the northern Democratic Republic of Congo (DRC), in 1986, they were the only doctors in an area the size of New Jersey. People in this remote riverside town had not seen a doctor for five years, and there was significant malnutrition and intermittent cholera. Few, if any, children had been vaccinated against diseases like measles or polio. Health care was nonexistent in many parts of Equateur province.

“Back then,” says Dusauchoit, now the executive director of Doctors Without Borders/Médecins Sans Frontières (MSF) in Belgium, “we were saying to each other, ‘How much worse can it get?’”

Twenty years of neglect and close to a decade of war have provided the horrific answer, and the extreme social upheaval continues. Recent massacres in the eastern city of Bunia have punctuated the seemingly endless spiral of violence that has trapped people in the north-eastern Kivu provinces and Ituri region.

In the last five years alone, an estimated three million people have died—mostly from disease and famine indirectly caused by the fighting. Whole communities have been uprooted multiple times, and assaults, rapes and mutilations are common.

“This is suffering of a different type,” explains Kenny Gluck, director of operations for MSF in Holland, who recently returned from the DRC. “It is long-term, chronic suffering, where living in crisis becomes a way of life. It is the only life many have known.”

THE CONSEQUENCES OF CHRONIC FIGHTING

Acute instability descended on the eastern DRC in 1994 when the perpetrators of the Rwandan genocide streamed into the DRC among more than one million refugees. In late 1996 and early 1997, a Rwandan-supported rebel army headed by Laurent Kabila attacked and emptied the refugee camps and went on to overthrow long-time despot Mobutu Sese Seko. In 1999, a second civil war started involving armies from several neighbor-

ing countries. Now, whenever the rhetoric turns to peace, people know to expect a spike in the violence as armies and militias jockey for position before any boundary-setting accords are signed.

In the chaos, some factions have degenerated into gangs of free-ranging bandits, while others have attacked neighboring villages as a means of survival. Rather than a war between armies or soldiers, the conflict in the DRC is mostly a war of violence against civilians—with rape and looting used as a weapon and tactic.

“In reality, this is also a war between different countries,” emphasizes Karim Laouabdia, MD, executive director of MSF-France. “They are using local armed groups and manipulating the population to get their hands on the resources of the country.”

MSF IN THE DRC

Together, the programs in the DRC represent one of MSF’s largest interventions in the world today, with more than 100



3



4



5

international volunteers and thousands of locally hired staff working throughout the country. Surgical teams in Bunia performed nearly 1,300 consultations a week at a 70-bed temporary hospital set up in a former supermarket when violence erupted there this past spring. During the worst violence, in mid-May, MSF doctors and nurses treated scores of people for machete and gunshot wounds. Even though the European Union's Interim Emergency Multinational Force has reduced tensions within the city boundaries of Bunia, the insecurity continues, and no one knows what has happened to the tens of thousands of people who have fled into the surrounding forests.

Medical teams from MSF also have assisted more than 55,000 displaced people outside Beni, a city 90 miles to the south, with medical care, food, measles vaccinations, and water and sanitation facilities. MSF volunteers have performed nearly 150 consultations a day at the health center in the nearby town of Oysha and have started a mobile clinic for the displaced people in Beni itself.

Farther south in Kitchanga and Shabunda, MSF supports hospitals and clinics, runs emergency feeding centers for severely malnourished children, treats tuberculosis patients, and cares for survivors of rape. According to Gluck, there are areas where people have absolutely no access to health care. "You could go an hour and open a feeding center, then go another hour and open another one," he says. "You have to choose between bad, worse, even worse, and unimaginable."

MSF's interventions in the DRC, while huge for the organization, are small relative to the overwhelming needs. Dusauchoit feels strongly, though, that such vast problems should not paralyze MSF and keep it from continuing to act. "The level of hopelessness and despair is so incomprehensible, people have no reference point left," she says. "But it's important for people to see they are not abandoned."

"Each time we return," Gluck says in agreement, "people say to us, 'We were

so afraid you wouldn't come back.' We should be willing to have small impacts. It's one of the most worthwhile things we can do."

In a recently released report, MSF condemned the recent upsurge of violence against civilians in the DRC's Ituri region and urged the UN Security Council and the international community to take more concrete steps to protect the civilian population. You can find the report "Ituri: Unkept promises? A pretense of protection and inadequate assistance" at www.doctorswithoutborders.org.

Photos opposite page:

1 Thousands have fled to camps in Bunia in an effort to escape the violence.

' Juan Carlos Tomasi 2003

2 Women receive food at the North Kivu food distribution center set up by MSF.

' Petterik Wiggers 2002

Photos above:

3 A wounded girl at Kinshasa's general hospital.

' Layla Aerts 2003

4 A clinic in the center of Bunia.

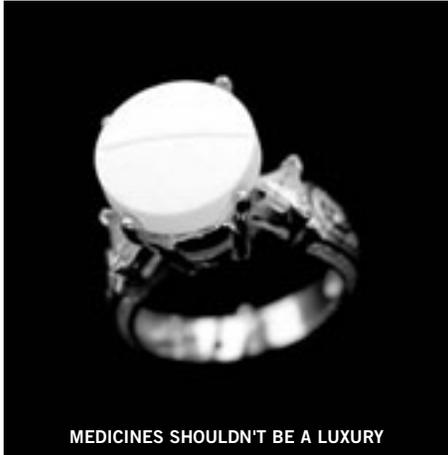
' Evan Van Beek 2003

5 A woman waits for medical help at MSF's ambulatory treatment center in Kinshasa.

' Layla Aerts 2003

TRADING AWAY HEALTH IN THE AMERICAS?

THE IMPACT OF THE FTAA ON PUBLIC HEALTH



MEDICINES SHOULDN'T BE A LUXURY

Medicines are a luxury that too many people in Latin America and the Caribbean simply do not have. In the case of AIDS drugs, however, the situation has started to change in some countries of the region because generic competition has brought prices down dramatically. Now, this positive trend is threatened by intellectual property (IP) provisions that have been drafted into the Free Trade Area of the Americas (FTAA) Agreement, a US-proposed regional trade pact that covers all of the Americas except Cuba. If implemented, the FTAA would be the largest “free trade zone” in the world, a \$13 trillion market encompassing more than 800 million people.

IP protections, especially patents, can limit the ability of governments and the private sector to produce or import more affordable medicines, resulting in higher prices and limited access to medicines. Currently, governments in Latin America can offset the negative effects of patents by including safeguards to protect public health in their national laws. This right is protected by the World Trade Organization (WTO) Agreement on the Trade Related

Aspects of Intellectual Property Rights (TRIPS) and was reinforced at the 4th WTO ministerial meeting in Doha, Qatar, in November 2001. The “Doha Declaration,” supported by all of the WTO member states affirmed the primacy of public health above the protection of private commercial interests. In particular, it affirmed the right of countries to override patents when necessary to protect public health and promote access to medicines.

In contrast, the proposed FTAA Agreement contains a far-reaching set of proposals, including provisions on IP rights, which, as they have been drafted, could restrict generic competition and put essential medicines out of the reach of those who need them most. The US, in particular, is trying to impose standards on pharmaceuticals that go far beyond what is required by the WTO TRIPS Agreement. Because Doctors Without Borders/ Médecins Sans Frontières (MSF) has seen firsthand the detrimental effects of strong IP protection in developing countries, and because it believes that tougher IP rules will jeopardize efforts to improve health conditions for people in the Americas, MSF is calling on countries in the region to exclude these IP provisions from the FTAA Agreement.

NEW DRUG RESEARCH ORGANIZATION CREATED

The Drugs for Neglected Diseases initiative (DNDi), a new nonprofit drug research center that will harness cutting-edge science to develop medicines for diseases affecting the world's poorest people, was launched in Geneva this past July. Founding members include

MSF and health and research institutes in Brazil, France, India, Kenya, and Malaysia. A body coordinated by the World Health Organization that conducts drug research on tropical diseases is a permanent observer.

The DNDi will be the first nonprofit organization to focus exclusively on the world's most neglected diseases including Chagas, sleeping sickness, and kala azar. The initiative was created in response to the current crisis in drug research and development (R&D) in which merely 10 percent of the world's R&D efforts are directed toward diseases that account for 90 percent of the global disease burden.

The new initiative moves away from the public-private partnership model that has been promoted to stimulate R&D for some diseases. It will take drug development out of the marketplace by encouraging the public sector to take more responsibility for health, and will build local capacity for R&D in countries where neglected diseases are endemic.

The scientific community has already signaled its eagerness to take part in the DNDi's goals. “The overwhelming response—71 project ideas submitted so far—shows that the science for these neglected diseases is out there waiting to be tapped,” emphasizes Dr. Yves Champey, interim director of the DNDi. “What's missing is the structure to take the most promising project ideas through the full drug-development pipeline. DNDi will provide this structure by capitalizing on existing drug-development capacity and expertise in the affected countries.”



Photo opposite page:

1 ' MSF 2003

Photo at left:

2 This woman is a candidate to receive antiretroviral (ARV) therapy in an MSF program in Guatemala. Her name has been on the waiting list for 11 months.

' Juan Carlos Tomasi 2002

FTAA: WHAT IS AT STAKE? THE IMPACT ON HIV/AIDS CARE IN GUATEMALA

The HIV/AIDS crisis and the significant disparities in access to AIDS treatment between rich and poor countries provides a striking example of what is at stake in FTAA negotiations for people in the Americas. The example of HIV/AIDS helps illustrate the potential outlook, beginning in 2005, for new medicines to treat a whole host of diseases prevalent in the region, including Chagas, malaria, and leishmaniasis. At that time, all new innovative products could be patent protected because of TRIPS Agreement rules, except in extremely poor countries.

According to the WHO, there are currently 1.9 million people living with HIV/AIDS in Latin America and the Caribbean. The AIDS epidemic is also exacerbating other infectious diseases, such as tuberculosis. In countries such as the US and Canada, antiretroviral (ARV) drugs have dramatically extended and improved the lives of people living with HIV/AIDS, and have reduced AIDS-related deaths by more than 70 percent. But in developing countries in the Americas, hundreds of thousands of people living with HIV/AIDS do not have access to these

life-saving drugs, because the drugs are not affordable.

Recently, greater access to generic medicines has started to bring down prices in Latin America. Generic competition has caused a drop in the cost of first-line ARV treatment from starting prices of \$1,000-\$5,000 to \$350-\$690 per person per year. Generic competition has been one of the most important, reliable, and powerful forces to reduce drug prices systematically. If the FTAA strengthens patent protection, it will destroy the dynamic of competition that has caused ARV prices to plummet in some low- and middle-income countries in the region. An FTAA Agreement with strong IP provisions threatens to have a catastrophic impact on the lives of millions of people living with HIV/AIDS and other diseases.

In Guatemala, 67,000 people, including almost 5,000 children, are living with HIV/AIDS. ARVs are available, but unaffordable. Treatment from originator companies (sometimes known as brand-name companies) costs between \$320 and \$800 per month, whereas the average income is approximately \$160 a month.

MSF provides ARV therapy to nearly 400 patients in hospitals in Guatemala City and Caotepeque and plans to double this number by 2004. Since ARVs are not protected by patents in Guatemala, MSF uses generic ARVs in its programs. Just one year ago, MSF was able to buy generics for prices that were 75 to 99 percent lower than the prices paid by the government for originator drugs. Although the originator drug prices have fallen significantly during the past year, they remain two to five times higher than quality generic alternatives.

“People in Guatemala already have frighteningly little access to essential medicines,” says Luis Villa, head of mission for MSF in Guatemala. “Some 67,000 people are living with HIV/AIDS in Guatemala, but only 1,500 receive antiretroviral treatment. MSF is treating almost one-third of them with quality generic drugs. If the ability to buy generics is restricted, it will become almost impossible to treat people with HIV/AIDS. Many will die as a result.”

NEWS & EVENTS



PRESIDENT PUTIN: ARJAN'S RELEASE IS IN YOUR HANDS



PRESIDENT BUSH: PRESS FOR ARJAN'S FREEDOM

Doctors Without Borders/Médecins Sans Frontières (MSF) volunteer Arjan Erkel was kidnapped on August 12, 2002 while providing medical assistance to war-affected people in Dagestan and Chechnya in the Russian Federation. He has been held captive ever since.

**HE WENT TO HELP.
NOW IT'S YOUR RESPONSIBILITY
TO HELP HIM.**

FREE ARJAN ERKEL NOW!



MSF URGES UN TO HELP SECURE ARJAN ERKEL'S RELEASE

On August 12, 2002, three unknown gunmen abducted Doctors Without Borders/Médecins Sans Frontières (MSF) volunteer Arjan Erkel in the Russian Republic of Dagestan. One year later, scores of people from MSF-USA and other organizations joined for a Day of Solidarity outside of the United Nations headquarters in New York, demanding action from Russian authorities to secure his immediate and safe release. Nearly 100 people gathered on First Avenue to hear MSF volunteers, staff, and Board members read letters written to Arjan from former hostages and from his family. Parallel events were

carried out in other cities including Moscow, Geneva, and Amsterdam.

Given the growing danger to aid workers internationally, on August 26 the UN Security Council unanimously adopted a resolution on the protection of humanitarian aid workers. MSF has urged Russia to implement the resolution by securing Arjan's release. "While it is important that the Security Council has sent a strong political signal that attacks against humanitarian aid workers will not be tolerated," said Dr. Morten Rostrup, president of MSF's International Council, "all member states must hold President Putin accountable for allowing Arjan's intolerable captivity to go on for more than a year."

MSF is also calling on Presidents Putin and Bush to discuss Arjan's kidnapping when they meet in Washington at the end of September and to do everything in their power to secure his immediate and safe release.

If you have not done so already, please sign the petition urging Arjan's release by visiting www.doctorswithoutborders.org.

**SIGN UP TO RECEIVE OUR MONTHLY
EMAIL NEWSLETTER AT
www.doctorswithoutborders.org**

PART OF A LARGER PROBLEM

The abduction of Arjan Erkel is an extension of the violence carried out against civilians in the Chechnya conflict. Such acts are devastating for civilians in need of assistance because the ability to deliver aid is dramatically curtailed. Arjan's continued captivity has caused MSF to scale back its programs in the region at a time when people's needs are most acute. Not a single independent aid organization is based in Chechnya because of the threats to aid workers.

Thousands of displaced civilians in Ingushetia have been forced to return to war-torn Chechnya. Many others live in deplorable conditions and face constant pressure from Russian authorities to go back to the war-ravaged republic even though they fear for their lives. Since the resumption of the war in Chechnya in 1999, MSF has provided direct medical assistance to war-affected people in Chechnya, Ingushetia and Dagestan.

Photos on this page:

1, 2 Scenes from the Day of Solidarity in New York City

' MSF 2003

3 MSF advertisement published this September in the *Washington Post*

' MSF 2003

Photo opposite page:

4 ' Gervasio Sanchez 2001.



4

2002 ANNUAL REPORT PUBLISHED ONLINE

MSF supporters can now download the full text of MSF-USA's latest annual report from our website. Readers will find articles on MSF's priorities during the past year, a profile of a US medical volunteer working in an HIV/AIDS program in Uganda, a list of the volunteers dispatched through the US office, and a summary of MSF's work in more than 80 countries. To read these articles and more, download the document at www.doctorswithoutborders.org.

UPCOMING WEST COAST EVENTS

On November 1 and 2, MSF-USA's program director, Catrin Schulte-Hillen, will join panels at Amnesty International's regional conference in California on human rights implications of the "War on Terrorism" and human rights in West Africa. To find out more, visit www.amnestyusa.org/events.

MSF-USA Executive Director Nicolas de Torrenté will talk on November 10 about humanitarian action in a post-9/11 world at the Commonwealth Club in San Francisco. This event is free of charge and open to the public. For more details, go to www.commonwealthclub.org.

FRONTLINE REPORTS

FRONTLINE REPORTS SERIES STARTS

On September 18, MSF-USA opened a winter discussion series with a panel discussion on humanitarian action in a post-9/11 world. Due to popular demand, the event had to be moved to a larger location in the nearby Fashion Institute of Technology at 27th Street and Seventh Avenue. To reserve a seat for one of the discussions, call 212-847-3151. For more information about the series, visit our website.

EMPIRE STATE AIDS RIDE UPDATE

Two MSF-USA volunteers, Max Morel and Tom Commerci, completed the Empire State AIDS Ride, a six-day, 500-mile bicycle fundraiser, on Saturday, August 23, 2003. Their trip began in Niagara Falls and ended in New York City's Battery Park. Sixty-one riders participated in the first-time event and raised funds on behalf of MSF and three other organizations working in the area of HIV/AIDS. The riders raised approximately \$139,000 for MSF. Additional donations for this year's ride will be accepted through September. For more information, please visit www.empirestateaidsride.org.

DOCTORS WITHOUT BORDERS/ MEDECINS SANS FRONTIERES USA

Board of Directors

Carol Etherington, MSN, RN
President
Darin Portnoy, MD
Vice President
David A. Shevlin, Esq.
Secretary
Jennifer White
Treasurer
Jean-Hervé Bradol, MD
Martha Carey
William Conk
Roshan Kumarasamy
Bruce Mahin
Bart Meijman, MD
Christine Nadori, RN

Board of Advisors

Richard Rockefeller, MD
Chairman
Robert Bookman
Chairman, West Coast Council
Creative Artists Agency
Victoria B. Bjorklund, Esq, PhD
Partner, Simpson Thacher & Bartlett LLP
A. Bruce Brackenridge
J.P. Morgan & Co., Inc. (Ret.)
Peter Grose
Foreign Affairs
Jean Karoubi
The LongChamp Group
Susan Liautaud
James Ottaway, Jr.
Dow Jones & Co.
Ottaway Newspapers, Inc.
Kevin Patrick Ryan
DoubleClick, Inc.
Garrick Utley
Marsha Williams
Blue Wolf Productions
Robert W. van Zwielen
Lehman Brothers Inc.

Doctors Without Borders (MSF-USA)

Nicolas de Torrenté
Executive Director

New York Office

333 Seventh Avenue, 2nd Floor
New York, NY 10001-5004

Tel: 212-679-6800

Fax: 212-679-7016

Email: doctors@newyork.msf.org

Web: www.doctorswithoutborders.org

West Coast Office

2525 Main Street, Suite 110

Santa Monica, CA 90405

Tel: 310-399-0049

Fax: 310-399-8177

Alert is a quarterly newsletter sent to friends and supporters of Doctors Without Borders. As a private, international, nonprofit organization, Doctors Without Borders delivers emergency medical relief to victims of war and disaster, regardless of politics, race, religion or national boundaries.

Editor: Lisa Hayes

Design: CoDe, Jenny 8 del Corte Hirschfeld

Doctors Without Borders is recognized as a nonprofit, charitable organization under Section 501(c)(3) of the Internal Revenue Code.

All contributions are tax-deductible to the fullest extent allowed by law.

CRISIS IN LIBERIA CONTINUES MSF ADDRESSES UN SECURITY COUNCIL ON URGENT NEEDS



1



2

Active fighting in Bong County northeast of the Liberian capital, Monrovia, is threatening tens of thousands of people and forcing them to flee their homes and camps. On September 9, 2003, Doctors Without Borders/Médecins Sans Frontières (MSF) briefed the UN Security Council on the current situation in Liberia and emphasized the extreme crisis still faced by hundreds of thousands of civilians.

“Fighting may have ceased momentarily in Monrovia, said Morten Rostrup, MD, president of MSF’s International Council, in his address to the UN Security Council, “but Liberia is not a country at peace.”

In September, nearby fighting forced more than 50,000 displaced people, including sick patients, to flee from MSF feeding centers and cholera treatment facilities at camps in Maimu and Totota. MSF has stressed that it is not just the fighting among different armed groups that these civilians fear. Looting, in-

discriminate violence, rape, and forced conscription committed by all the warring parties have sent thousands in search of safe havens throughout the war. The massive displacement currently taking place is symptomatic of the vicious cycle of violence against civilians that has been continuing since 1999.

“Tens of thousands of people are cut off from assistance as they are forced to flee the fighting,” stated Rostrup. “It’s impossible to even begin discussions about moving into a peace and reconstruction phase when hundreds of thousands of Liberians are still being threatened by fighting and are in desperate need of protection and assistance.”

Today MSF has more than 40 volunteers and 300 locally hired staff running two hospitals, 11 clinics, two therapeutic feeding centers, and three cholera treatment centers in Monrovia. We are also running three health clinics in camps

for displaced people in Montserrado County, and a mobile clinic in Bomi County. MSF also provides health and water/ sanitation assistance in three camps located in Bong County.

MSF medical teams continue to assess conditions wherever possible in the country. They have discovered horrendous conditions in camps, villages and cities throughout Liberia.

There is a severe lack of water and food, and access to primary medical care is practically nonexistent.

“Despite claims that the nightmare is now over,” stressed Rostrup, “Liberia remains a humanitarian emergency that deserves an emergency response.”

Photos:

1 ' Chris Hondros 2003

2 ' MSF 2003

