Life and Death in Darfur
Violence, Malnutrition, and Disease Imperil Over One Million People in Darfur

"On our arrival at Abdel Shakor, we are welcomed by a cemetery. A handful of stones marking the bodies. Someone says, ‘Fresh graves, hot ashes.’ It seems the village was attacked a few days ago. A woman explains what happened. Helicopters came thundering from the sky and the Janjaweed (pro-government militias) on horses, burning and slaughtering. Her husband and two children were killed. She still has two more children but no way to leave as their donkey was also killed. She hides her fear and waits. I offer her some dates while examining a baby born yesterday, wrapped in cotton, whom a woman is showing me.”—Paula Farias, MD, a Doctors Without Borders/ Médecins Sans Frontières (MSF) volunteer, recalling from her mission in July to assess the conditions of displaced people in the Darfur region of western Sudan.

Horrific stories like this one abound in Darfur, where more than 1.2 million people have been forced to abandon their homes and livelihoods following attacks by government-backed Janjaweed militias on their villages. Most of the displaced left their homes with few or no personal belongings. They have gathered in and around cities and towns in the region, and up to 190,000 have sought refuge in neighboring Chad.

MASSIVE NEEDS, MASSIVE RESPONSE

Doctors Without Borders / Médecins Sans Frontières (MSF) has responded with one of the largest interventions in its history. Now nearly 170 international volunteers and 2,000 Sudanese staff are providing life-saving assistance in 24 locations, where 550,000 people have sought refuge.

Today, MSF teams treat more than 10,000 malnourished children, 2,000 for the most severe form of malnutrition. Doctors and nurses conduct more than 10,000 medical consultations each week. But even with some of MSF’s most experienced staff on the ground and tremendous resources being devoted to the emergency, hundreds of thousands of people remain without adequate assistance.

“What you see there is widespread suffering, inadequate relief efforts and continuing violence,” says MSF International President Rowan Gillies, MD, who spent a month working in the clinics and camps in Darfur. “Hardly anyone is getting the care civilians should get in a conflict. And there are pockets of real disaster, where people are at grave risk of dying in large numbers.”

ONGOING VIOLENCE

Eighteen months after the crisis began, and more than two months after high-profile visits from UN Secretary General Kofi Annan and US Secretary of State Colin Powell, violence against civilians continues to be a daily reality.

The camps provide little additional security for the displaced people. Men risk being killed if they venture outside the areas where the displaced have gathered, so it is women who bear the brunt of attacks as they look for wood, grass, and other extra resources beyond the camps and settlement sites.

“It happens everywhere,” says Jennifer Pahl, an MSF nurse, who visits the Riyadh camp on the outskirts of the city of El Geneina regularly to refer the sickest patients to the MSF-supported El Geneina hospital. “It’s unbelievable to see little 14- or 15-year-old girls on donkeys going over the hill with all their stuff for three days. They risk being beaten and raped, but they tell me, ‘We don’t have any choice.’”

Women report having been abducted, held hostage for several
days, and repeatedly raped. In the third week of July alone, MSF treated 92 victims of violence—many of the patients had been sexually assaulted—at clinics throughout Darfur.

“MSF uses a three-part protocol for treating rape victims: drugs to prevent sexually transmitted diseases, emergency contraception, and post-exposure prophylaxis with the anti-retrovirals lamiduvine and AZT to prevent HIV infection,” says Greg Elder, MD, MSF head of mission in Sudan.

RAMPANT MALNUTRITION
In regular surveys to assess the population’s health, MSF has found that the situation has stabilized in camps where aid has been deployed, but many displaced people have not received any assistance.

Mothers continue to bring their weak and wasted children to MSF feeding centers, which saw a 28.8 percent increase in admissions during two weeks in late July. In Mornay, one child in every five is malnourished. In Kalma camp near the city of Nyala, MSF is treating more than 675 children in its therapeutic feeding center for most severely malnourished.

Many women have told MSF that food aid saves them from having to leave the gathering areas too frequently. Unfortunately, when this assistance is insufficient, they are forced to venture out and expose themselves to attacks.

EMERGING EPIDEMICS
Most of the displaced live in makeshift shelters with poor sanitation and insufficient access to clean water. While MSF is addressing water supply needs in some locations, such as in Ardamata, the demands far outstrip its capacity. In El Geneina’s overcrowded camps, for instance, no safe drinking water is distributed and people are barely receiving half of their daily water requirements.

In August, the World Health Organization confirmed an epidemic of Hepatitis E, a disease linked to the lack of clean water and sanitation and most dangerous to pregnant women. Since the outbreak erupted in July, MSF has treated more than 1,000 cases in Mornay alone, with 19 deaths.

Diarrheal diseases and respiratory infections represent 40 to 45 percent of the total caseload in MSF clinics and have doubled in number since the beginning of the rainy season.

MSF has conducted measles-vaccination campaigns in many locations and among children in its feeding centers, but the risk of an outbreak is still high amid new arrivals that have not been immunized.

“Malaria peaks with the rainy season and will likely claim more lives because children are already weakened by malnutrition,” says Dr. Elder.

RESETTLEMENT AND RETURN
The Sudanese government has announced plans to move people back to their towns and villages or to 18 resettlement sites or “urban centers.”

“We are extremely concerned about reports of relocation of people from the camps back to their villages,” says Dr. Gillies, MSF international president. “Any relocation must be done with the clear and informed consent of the people themselves. Many are very frightened, though, and don’t want to return.”

Displaced people all over Darfur repeatedly tell MSF that the prospect of returning to their devastated homes or relocating elsewhere makes them fear for their lives. They are terrified and traumatized, preferring the safety of numbers in overcrowded gathering sites to the risk of being attacked again in their villages. Many have said that they would rather die in the camps than go back now.
IRIBA, CHAD 68,000 displaced people

“The amount of food distributed in the camp covers only the bare necessities in kilo-calories needed by people to survive: 1,800 kcal per person per day. A man lying in bed for an entire day without moving consumes 1,500. In our opinion the quantity of food that should be distributed should reach 2,200 kcal per person per day. With the current situation, the slightest sickness—fever or diarrhea—leads the children to fall into a state of severe malnutrition.”

Laurence Sailly, MSF project coordinator for the Iridimi, Touloum, and Iriba camps in eastern Chad.

EL GENEINA 68,000 displaced people

“The displaced people do not go out at night because it is too dangerous. During the day, the women have to leave in search of wood for cooking or additional food, but the violence is ongoing. Government-supported militias still control the outskirts of the camps and most of the rapes and violence occur during the day. Every week, when we see patients in Mornay, we see a dozen victims of violence, including two or three female rape victims and women with marks from whippings or blows to the ankle from a club. But we know for certain that not all the victims come to us.”

Isabelle Defourny, MD, MSF project coordinator in the city of El Geneina.

KEBKABIYA 68,000 displaced people

“With so many people living cramped together with poor sanitation and water facilities, we are very nervous about outbreaks of water-borne diseases such as cholera or shigella. It would be disastrous in these circumstances. We are also worried about the potential for measles, since we believe that many of the displaced children who continue to arrive have never been given a measles vaccination. Measles is very unlikely to be fatal for a well-fed, otherwise healthy child. But for malnourished children already suffering from other chronic diseases it can easily kill, especially the very young. Our goal in Kebkabiya is extremely simple: to get the mortality rate down as quickly as possible by treating respiratory infections, diarrhea, and malaria correctly and by urgently vaccinating newly arrived children against measles.”

Nathalie Civet, MD, MSF medical coordinator in Kebkabiya, who has been working in Darfur since January.
CHILDREN LINE UP TO RECEIVE TREATMENT FOR CHAGAS.
© OLGA RUIZ 2004

KALMA
76,000 DISPLACED PEOPLE

"The number of malnourished children in the food program is rising by the day. There are now around 485 children in the therapeutic feeding program and another 1,997 or so in the program for supplementary nourishment. During my visit I was shocked by the poor condition of some of the children. Some were definitely beyond saving—even with our intensive approach. The mothers clearly realized that there was no hope for their children. Having fled unimaginable misery, they still haven’t found the peace and quiet they are looking for. The accounts of the attacks on their villages, the loss of loved ones, and sometimes even children, are disturbing and horrific. The reports of sexual violence inflicted on women during these attacks are heartrending and beyond all comprehension."

John Heeneman, MSF project coordinator for Kalma camp.

© MSF

ZAM ZAM
15,000 DISPLACED PEOPLE

"We have opened a feeding center in Zam Zam, a camp, south of El Fasher. In just a few days the center is packed with hundreds of tiny children needing water, milk, and medicines. A battalion of Sudanese nurses diligently helps us to measure them, weigh them, and give them medication. But their number grows by the day. Crops have been lost as people have not been able to harvest due to the attacks and now their only chance is to get food through the distributions conducted by the World Food Program. A whole year waiting and depending on external aid is still ahead of them.”

Paula Farias, MD. Dr. Farias conducted exploratory missions in July in northern Darfur, resulting in the establishment of aid programs in the Zam Zam camp.

© Sebastiao Salgado

MUKJAR
13,000 DISPLACED PEOPLE

"The rain washes mud and excrement into the open wells and boreholes containing water that people drink. The wells are full of bacteria and pathogens. In these conditions, the outbreak of diarrheal diseases such as cholera is only a matter of time. We can guard against diseases and treat them if necessary, and the people are less undernourished than in other areas of Darfur. But we are powerless against the unrestrained violence. That is very depressing.”

Lucas Beck, an MSF water-and-sanitation expert in Mukjar. Beck is leading the digging of wells and latrines to guard against epidemics.

© MSF

*All quotes from July and August.*
With a deep feeling of sadness and anger, Doctors Without Borders/Médecins Sans Frontières (MSF) announced on July 28 the closure of all medical programs in Afghanistan. MSF made the decision in the aftermath of the killing of five of its aid workers in a deliberate attack on June 2, 2004, when a clearly marked MSF vehicle was ambushed in the northwestern province of Badghis.

Our colleagues were mercilessly shot in the attack. This targeted killing is unprecedented in the history of the organization. MSF has been delivering medical humanitarian assistance in some of the most violent conflicts around the world for more than 30 years.

“After having worked nearly without interruption alongside the most vulnerable Afghan people since 1980, it is with outrage and bitterness that we take the decision to abandon them,” said Marine Buissonnière, secretary general of MSF. “But we simply cannot sacrifice the security of our volunteers while warring parties seek to target and kill humanitarian workers. Ultimately it is the sick and destitute who suffer.”

For the past 24 years, MSF has worked in Afghanistan throughout difficult periods of the country’s history, regardless of the political party or military group in power.

“We simply cannot sacrifice the security of our volunteers while warring parties seek to target and kill humanitarian workers. Ultimately it is the sick and destitute who suffer.”

Until the assassinations, some 80 MSF international volunteers and 1,400 Afghan staff provided health care in 13 provinces. MSF’s projects included primary and hospital-level health care as well as tuberculosis treatment and programs to reduce maternal mortality. MSF has handed over its programs to the Afghan Ministry of Health and other organizations.

**FAILED RESPONSE TO KILLINGS**

Although Afghan government officials have presented MSF with credible evidence that local commanders conducted the attack, officials have neither detained them nor publicly called for their arrest. The government has failed to meet its obligations under international humanitarian law and shows an inadequate commitment to the safety of aid workers on Afghan soil.

“We believe in the humanitarian ideal that going unarmed into an area of conflict, trying to save lives, trying to alleviate suffering, is a reaffirmation of human dignity.”

“It is unacceptable to put people on the ground when the people responsible for security fail to follow it up, because it sends a message to those who will kill aid workers that there will be impunity,” said Kenny Gluck, director of operations for MSF, at the press conference in Kabul announcing MSF’s withdrawal from Afghanistan. “And that’s what we need to see changed before we come back.”

Following the assassinations, a Taliban spokesperson claimed responsibility for the murders and falsely accused organizations like MSF of working for American interests, further stating that MSF could be at risk of attacks. MSF took this threat as a clear refusal by the Taliban to accept independent and impartial humanitarian action.

“MSF is not willing to turn into an armed agency of medical providers,” said Gluck. “We believe in the humanitarian ideal that going unarmed into an area of conflict, trying to save lives, trying to alleviate suffering, is a reaffirmation of human dignity.”

**CO-OPTING HUMANITARIAN ACTION**

The violence directed against humanitarian aid workers occurs at a time when the United States-backed coalition has consistently sought to use humanitarian aid to build support for its military and political ambitions. MSF has denounced the coalition’s attempts to co-opt humanitarian aid and use it to “win hearts and minds.”

In May, MSF publicly condemned the distribution of leaflets by Coalition forces in southern Afghanistan that conditioned aid on providing information about the Taliban and al-Qaeda. The result of enforcing such conditions is that humanitarian aid is no longer seen as an impartial act motivated by need alone and devoid of political or military motives.

“We’ve also seen military people with weapons in civilian clothing, in white cars going about providing health care,” said Gluck of MSF. “If you ask Afghans to try to distinguish between two modes of engagement—military and humanitarian—how can you expect them to?”

MSF does not object to militaries “building village clinics” or “offering medical help.” But these are legal...
obligations under the Geneva Convention, not humanitarian assistance.

“We want a volunteer doctor who goes off to treat tuberculosis—unarmed and without any armed escort, as we work—to be able to work in an environment where everybody knows he or she is not a legitimate target, but an aid worker,” Gluck continued. “And that’s an ethic we have to restore in Afghanistan.”

Humanitarian assistance is only possible when belligerents respect the safety of humanitarian workers, more than 30 of whom have been killed in Afghanistan since the beginning of 2003.

The killing of our colleagues, the Afghan government’s failure to arrest the culprits, and the false allegations by the Taliban have regrettably made it impossible for MSF to continue providing assistance to the Afghan people.

MSF WITHDRAWS FROM AFGHANISTAN

On the evening of June 19, MSF held a vigil in Manhattan’s Union Square Park for Hélène de Beir, Egil Tynaes, Pim Kwint, Besmillah, and Fasil Ahmad, MSF aid workers who were killed in a brutal attack in Afghanistan on June 2.

More than 100 MSF field volunteers, staff, and members of the board of directors, each carrying an orchid, walked in single file up Fifth Avenue to the park. Five field volunteers carrying large bouquets of flowers, one for each of our colleagues, led the vigil. The world-renowned saxophone player Kenny Garrett was waiting for us, playing gentle music in the same park that had been an important place of mourning and remembrance immediately after September 11.

MSF created a shrine of photographs and text describing Hélène, Egil, Pim, Besmillah, and Fasil, and placed our flowers in front of it, one by one, then tied MSF armbands to the fence surrounding the shrine before we left. The shrine remained in place for more than a week, with many New Yorkers stopping as they passed by to pay their respects.

All vigil photos © Jake Price

VIGIL IN NEW YORK FOR OUR COLLEAGUES KILLED

Diderik van Halsema, MSF head of mission in Afghanistan, preparing to board the last MSF plane out of Herat, Afghanistan. © Diderik van Halsema

MSF national staff unload equipment from the MSF office in Kabul for donation to a local school. © Diderik van Halsema
Doctors Without Borders / Medecins Sans Frontieres (MSF) started working in Afghanistan in 1980, shortly after the Soviet invasion, and continued to do so through mujahadeen wars, Taliban rule, and the US-led invasion. In the beginning, small teams of doctors and nurses would travel into the country, starting from neighboring Peshawar, Pakistan, where they would spend a month organizing a mule train and negotiating security with the local mujahadeen commanders. A journey of several weeks would take them to the hospitals and dispensaries in Paktia and Nuristan, where they would stay from May until October, leaving before the heavy snowfall. By the 1990s, MSF was operating throughout much of the country, reaching many of the most vulnerable Afghans. Before the killings of our colleagues on June 2, 2004, MSF provided health care in 13 provinces with 80 international volunteers and 1,400 Afghan staff. MSF projects included the provision of basic and hospital-level health care as well as tuberculosis treatment and programs to reduce maternal mortality.
24 YEARS OF INDEPENDENT HUMANITARIAN AID IN AFGHANISTAN

An MSF doctor listens to the lungs of a patient at the MSF mobile clinic in the Pasroia Valley in Bamiyan Province.

Sudanese refugees in Chad lack adequate shelter.

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

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

Refugees have almost no access to safe drinking water.

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

A boy is measured as part of a nutritional screening in Sar-i-Pul.

An MSF doctor checks the nutritional status of a refugee child in Tine.

MSF doctors perform surgery on a wounded Afghan in the open air.

At an MSF clinic in Kandahar, a national staff member gives an Afghan boy a six-month dosage of Vitamin A to reduce the risk of measles.

MSF doctors and nurses examine patients in an Afghan village.

A child is weighed to see whether he is malnourished at an MSF clinic in Meymaneh.

MSF volunteers clandestinely transport several tons of medicine and medical equipment through the Badakshan Valley.

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A 39-year-old civil war has displaced between two and three million Colombians—the third highest rate of displacement in the world. The combination of the Colombian government’s ongoing conflict with two guerilla organizations, ELN and FARC, and violence by paramilitary forces has left millions of Colombians isolated from any medical care.

In many areas, guerrillas, paramilitaries, or the army block roads and rivers, and prevent transport of medicines and food. Civilians may raise the suspicion of armed groups if they cross roadblocks too often. Even if people are brave enough to seek out health care, the few existing health facilities in rural areas may be in “enemy” territory, only partially functioning, or, in the worst case, just abandoned. Hospitals are often afraid to organize medical teams to visit the communities because of the ongoing violence. Threats towards Colombian health workers are frequent and made by all belligerents in the conflict.

Doctors Without Borders/Médecins Sans Frontières (MSF) has been working in Colombia since 1985 and is now sending mobile medical clinics into some of the most isolated and remote regions of the country to assist Colombians in greatest need of assistance.

Traveling in vehicles—or even by boat or horseback—MSF’s mobile clinics provide medical consultations, vaccinations, psychosocial support, reproductive health services, and even dental care to approximately 50,000 Colombians each year. The mobile clinics operate in 7 of Colombia’s 32 administrative regions. (See map.)

For many Colombians, MSF mobile clinics provide the sole opportunity to receive health care. Fewer than half of the 44 million people living in Colombia have access to basic health care, and 15 percent have no safe drinking water.

“The mobile clinics are important to the local community because for many families it is their only chance to access health care,” says Paul McPhun, who runs MSF’s programs in the Costa Atlantica and Norte de Santander regions of Colombia. “Without these services, people would be forced to weigh the risks of a dangerous journey to the nearest government health centers—which often they cannot afford—against simply living with their medical condition.”

“All too often they choose the latter,” McPhun continues, “resulting in conditions becoming critical before assistance is sought.”

The MSF mobile clinics visit each community every four to six weeks, and insecurity forces them to work quickly. The teams must return to base before nightfall. MSF reaches out to community leaders before sending out the mobile clinics to explain MSF’s independence and neutrality with respect to the conflict in Colombia, and volunteers reemphasize MSF’s impartiality once in the communities. There are no guarantees, though, when working in such a volatile conflict.

“Our main protection is probably to attend to the medical needs of the people in the most independent, impartial, and neutral way we can,” says Thierry Vanvert, who is responsible for MSF’s activities in Colombia’s Tolima region.
COLOMBIANS TRAPPED IN CIVIL WAR

INTERNALLY DISPLACED PEOPLE

- Sudan 4 million
- DRC 3 million
- Colombia 2.9 million
- Uganda 1.6 million

All photos 2003 © Juan Carlos Tomasi
CHILDREN NEGLECTED IN AIDS FIGHT

In Thailand’s Petchburi Province, a Doctors Without Borders/Médecins Sans Frontières (MSF) nurse carefully measures the dose of antiretroviral (ARV) medicines needed to treat a 2-year-old boy who is HIV-positive. The MSF nurse is demonstrating the dosage for the child’s caregiver, but it is hardly an exact science. While HIV/AIDS treatment regimens for adults have been vastly improved over the past decade, with particular advances in the effectiveness of ARV therapy, the same cannot be said for children’s treatment.

According to UNAIDS, more than 2.5 million children were living with HIV/AIDS in 2003. Approximately 50 percent of these children will die before the age of two. Yet neither major pharmaceutical companies nor governments are developing and producing AIDS medicines, diagnostic tools, and treatment guidelines suited to children. Relatively few children are being born with HIV in wealthy countries, leaving little economic incentive for pharmaceutical companies to develop ARVs and diagnostic tools for children.

“Children who need treatment have to drink great amounts of foul-tasting syrup or swallow large tablets, and that’s only if they are even able to access treatment in the first place,” says David Wilson, MD, MSF medical coordinator in Thailand. “Right now we are still being forced to treat children like small adults.”

MSF began treating children with ARVs in 2000 and by March 2004 about 5 percent of MSF patients were children under 13. In Thailand, MSF has created innovative tools, such as health diaries, treatment calendars, and fairy tales about “Devimmon,” a witch who is a metaphor for HIV, to help children understand the disease and adhere to treatment.

MSF wants to do more for children but lacks the proper tools. Standard HIV tests are not reliable in infants under 18 months of age and most of the commercially available CD4 machines are not adapted for use with young children.

Once a child is diagnosed with HIV, few pediatric formulations of ARVs are available, which makes treatment complex and burdensome. Currently, doses are determined by weight or body surface and must be adjusted as the child grows.

Without standardized dosing schedules, doctors and other health workers have no simple guidelines for treatment of HIV in children. In most cases, bad-tasting, difficult-to-measure syrups are used for children under 10 kilos (22 lbs.). For older children, MSF uses a chart to calculate dose by weight. Syrups and oral solutions are not suitable for older children because of the large volumes they would require, yet low-dosage tablets are not produced for most ARVs. Caregivers must measure syrups and cut and crush adult formulations.

Pediatric formulations are expensive. While the fixed-dose combination (FDC) of ARVs—three drugs in one pill—that MSF gives most adults cost about $200 per patient per year, the same drugs in oral and syrup formulations are approximately $1,300. There are no pediatric FDCs.

“Unless there is increased pressure on drug makers and intervention from governments, it will be years before new therapies are available,” says MSF pharmacist Fernando Pascual.

Furthermore, the World Health Organization should provide clear, simplified technical guidelines on the treatment of children, and UNICEF must take on a long overdue leadership role in demanding that treatment for children be addressed as a matter of urgency.
On July 29, Doctors Without Borders/ Médecins Sans Frontières (MSF) and the Arua Regional Referral Hospital commemorated two years of providing free antiretroviral (ARV) therapy for nearly 1,100 people living with HIV/AIDS in Arua, a rural part of northwestern Uganda. An estimated 46,200 (5.5 percent) of Arua’s 840,000 residents are living with HIV/AIDS, yet ARV treatment is available only through the MSF-supported Arua Hospital AIDS Program.

“Although our program has improved the lives of more than a thousand patients and their families, we must be modest regarding our achievements, be aware of the important challenges that we face, and remind ourselves that more than one million people have died in Uganda since the epidemic first appeared,” said Dr. Charles Olaro, medical superintendent of Arua Regional Referral Hospital and the Arua Hospital AIDS Program.

The Arua Hospital AIDS Program has released a clinical monitoring report showing that patients are responding well to ARV therapy. “At first I was losing weight, down to 45 kilos (99 lbs.), but now I’m 52 kilos (114 lbs.) I couldn’t come from home into town and I couldn’t do my work at home. Now I can and my family is happy,” says Diana, who has received ARVs through the Arua program.

There is an urgent need for expansion of free ARV treatment throughout Uganda. UNAIDS estimates that 150,000 Ugandans clinically require these medicines, but only 15 percent actually receive it, and nearly 80 percent must pay for at least a portion of their care.

Factors that have enabled the Arua program to grow include the availability of free treatment, simplified treatment protocols and regimens, and close partnership with the local ministry of health, the community, and people living with HIV/AIDS. The Arua experience has also revealed challenges similar to those found in other MSF ARV programs, including the need for decentralized health services, increased human resources, and improved and cheaper diagnostic tools and medicines, especially for second-line and pediatric treatment.

“Treating people living with HIV/AIDS in poor, rural areas like Arua is possible and transforms lives and communities,” says Janthi Price, MSF’s field coordinator. “But expanding HIV/AIDS treatment and care to all people who urgently need it in Uganda is a challenge that only the government, with strong international support, can take up.”

The celebration in Arua included dramatic performances as well as visits by Jim Muhwezi, Ugandan minister of health; Stephen Lewis, UN special envoy on HIV/AIDS in Africa; and others. To read testimonies from Arua program patients visit: www.doctorswithoutborders.org/publications/voices/arua_07-2004.shtml.

Lecture Series Continues
MSF-USA is continuing its Frontline Reports series with four events in New York, beginning September 30. Topics include the unfolding emergency in Darfur, Sudan (September 30); MSF’s withdrawal from Afghanistan; mental health care for war-traumatized people; and a film screening on MSF’s AIDS treatment programs. Please visit our website for more details.
FIELD UPDATES

HALF A MILLION CHILDREN VACCINATED IN THE DRC
In August, MSF conducted a measles-vaccination campaign in the eastern Democratic Republic of Congo (DRC), bringing the total number of immunizations to nearly 500,000 since 2003. Working with the local ministry of health, MSF vaccinated about 55,000 children between the ages of six months and 15 years across the Yahuma region, one of the most remote and hard-to-reach areas in the country. “Vaccination campaigns in most of the DRC are complicated by the totally inadequate infrastructure,” explains Maureen Billiet, MSF medical coordinator for the DRC. “We have to set up an unbroken ‘cold-chain’ to keep vaccines under a certain temperature. Doing so while traveling by motorbike for hundreds of kilometers across mud tracks is a daunting task.” © Alixandra Fenton

AIDING THE NEGLECTED IN BRAZIL
Dulcinéia da Silva no longer has to wake up at 3 AM and take two buses to reach the local hospital for assistance. She can now visit an MSF doctor only three blocks from her home. Dulcinéia and 6,800 other people from Marcílio Dias, Mandacaru, and Kelson—three favelas, or slums, near the international airport in Rio de Janeiro, Brazil—have been receiving health care from MSF doctors and nurses since July 2003. “We are so happy to have MSF here,” says Dulcinéia. “The doctors who treat us are kind and make us feel like someone again.” The MSF clinic in Marcílio Dias has provided approximately 15,500 medical, psychological, and social service consultations. Teams of MSF doctors and nurses make home visits within the communities, offering information on how to prevent diseases such as dengue, an often fatal tropical fever, and hypertension, a disease that affects most of the people in these communities, particularly the elderly. “When we first got here, we found people who had hardly any access to the public health structures,” says Susana de Deus, MSF head of mission in Brazil.
Alert is a quarterly newsletter sent to friends and supporters of Doctors Without Borders/Médecins Sans Frontières. 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 ethnicity.

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Koeut C., 38, is HIV-positive and receives antiretroviral (ARV) therapy at the Doctors Without Borders/Médecins Sans Frontières (MSF) clinic in Siem Reap, Cambodia. He lost his leg in a landmine explosion while serving in the army. When he married his wife he did not know his HIV status. He and his wife were both tested for HIV, found to be positive, and sent to the MSF clinic. Thanks to having adhered faithfully to his treatment, Koeut C. is now able to work. He and his wife sell books in Siem Reap. The couple has three children. Two of them have tested negative for HIV; the youngest has yet to be tested.

MSF has been providing ARV therapy to people living with HIV/AIDS in Siem Reap since October 2002. MSF is aiming to increase the number of patients in this program to 700 by the end of 2004.