RESPONDING TO KENYA’S POST-ELECTION VIOLENCE
Humanitarian Action

HUMANITARIAN ACTION

The Dangers of our Work

Dear Friends,

On January 28, in what was an organized attack, a Doctors Without Borders/Médecins Sans Frontières (MSF) vehicle was struck by a roadside bomb while traveling through the port city of Kismayo in southern Somalia. The blast killed Victor Okumu, a 51-year-old Kenyan surgeon; Damien Lehalle, a 27-year-old French logistician; and Mohamed Abdi Ali, a 28-year-old Somali driver. Another member of the team was wounded in the explosion.

On the next page you can learn a little about their lives. It was their impulse to take action—to save lives—and bring a measure of hope to people in a war-ravaged country, such as Somalia, that brought them together from different corners of the world. We will greatly miss Victor, Damien, and Mohamed, and extend our heartfelt sympathies to their families and friends for their loss.

In the midst of the grief and shock that such an attack provokes, the question immediately arises: What is the purpose of intentionally killing a medical team providing surgical care in a chaotic city where people are deprived of essential services? While we are currently investigating to understand what happened, there is no acceptable answer. The killing of our colleagues and the targeting of humanitarian aid workers must be firmly condemned.

Attacks such as the one in Kismayo vividly remind us that gaining acceptance for our presence and work can never be taken for granted, and may, in some places, be nearly impossible to achieve. In this issue of Alert, we republish an essay by François Jean (1956-1999) that touches on the very real dangers of practicing humanitarian aid in conflict zones. Though written a decade ago, this essay remains hauntingly relevant today.

The immediate consequence of the attack was the withdrawal of our 87 international staff from 14 projects across Somalia. Although hundreds of Somali staff continue lifesaving medical activities, the suspension of MSF’s international presence hampers our medical work. We are currently analyzing the security conditions to determine whether we can continue working in the country.

Weighing heavily in the balance is the consideration that Somalia has been experiencing heightened fighting and instability since the removal of the Islamic Courts Union administration in southern Somalia by Ethiopian forces backing the Transitional Federal Government in December 2006. Hundreds of thousands of forcibly displaced Somalis are in urgent need of immediate assistance, particularly in and around Mogadishu.

Thank you for your continued support of MSF’s work.

Sincerely,
Nicolas de Torrenté, PhD
Executive Director

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

Victor Okumu
Age: 52
Born: Busia, Kenya
Nationality: Kenyan

Victor was a committed surgeon with more than 14 years of experience. He worked with MSF from 2002 to 2008 in South Sudan, Sierra Leone, Nigeria, Darfur, and Somalia, and had joined the MSF Kismayo project at the beginning of this year. Victor was married with five children—three sons and two daughters.

Damien Lehalle
Age: 27
Born: Pont-a-Mousson, France
Nationality: French

Damien had worked with MSF as a logistician since 2006. Before he arrived in Somalia in early January of this year, he had worked with MSF in Katanga, the Democratic Republic of Congo, where he made a strong impression.

Mohamed Abdi Ali (Bidhaan)
Age: 28
Born: Abudwaq, Galgudud, Somalia
Nationality: Somali

Mohamed Abdi Ali, called Bidhaan, was working for MSF as a driver for the international team in Kismayo. He was married with three children, and his wife is expecting their fourth child in a few months. Bidhaan’s mother and father still live in Galgudud region, which is where he was originally from.

“Humanitarianism is about valuing life. Paying with your life while doing this work is unimaginable. Humanitarian action is an act of kindness. That this should happen is utterly cruel and utterly unjust.”
– Marilyn McHarg, General Director of MSF-Canada, speaking at the memorial service for Damien, Victor, and Mohamed.
EMERGENCY DESK – CHAD

Coup Attempt in Chad Leaves Hundreds Dead and Wounded, Thousands Flee to Cameroon

During the week of January 27, reports surfaced of rebel forces advancing on the Chadian capital, N’Djamena, to oust President Idriss Déby. In preparation to support local health workers in treating any wounded, Doctors Without Borders/Médecins Sans Frontières (MSF) quickly transferred its surgical team from Goré, in southern Chad, where it had been assisting residents and refugees from the Central Africa Republic, to N’Djamena.

By Saturday, February 2, intense combat had erupted in N’Djamena, as rebel and government forces clashed. Lasting for two days, the fighting in N’Djamena took a heavy toll: more than 270 deaths and nearly 1,000 war-wounded. In the Bon Samaritan Hospital in the Walia District, the MSF surgical team treated more than 120 wounded over the course of one week.

“I was heading for my mother-in-law’s home when a mortar hit the building,” said Ahmed K., the father of a 6-year-old girl who was hit by shrapnel. “When
I went in, I saw three bodies. There were three wounded: my daughter and two other children. One of them had lost an arm. The nearest clinic was shut and the General Hospital was completely overloaded. In the end, we stopped a motorcyclist and while I buried the dead, he took the wounded to Walia, because we knew the hospital there was still running.

The rest of the family took refuge in a village further to the south. It’s the fourth time that Ahmed and his family have fled N’Djamena. “This time was the worst,” he said. “It’s the first time there’s been fighting in the capital. Everyone wants to rule, but if there are no people left, who are they going to rule?”

The General Hospital found itself in the middle of the fighting. The few doctors and nurses who remained had to cope with an influx of more than 250 wounded. The MSF teams could only reach it on Monday, February 4.

“The hospital was too close to the fighting, it even had to shut for a few hours,” said Dr. Meinhard Kritzinger, an MSF anesthetist who came with a surgeon to reinforce the emergency room. “They had to deal with the most urgent cases. They were often unable to operate, just stopping the hemorrhages, applying bandages, and sending the patients home.” MSF donated medicine and surgical supplies for dealing with the most urgent needs.

**REFUGEES FLEE INTO CAMEROON**

According to UN High Commissioner for Refugees (UNHCR), some 30,000 people fled N’Djamena, crossing into northern Cameroon and settling in Kousseri, a small border town. A surgical team was dispatched to the area as well as other medical teams to provide assistance. MSF set up an emergency surgical facility inside Kousseri hospital to tend to people with injuries stemming from the fighting in N’Djamena. Many of whom could not reach hospitals for treatment during the worst of the fighting or who were only given first aid and developed serious infections.

Within a week of the cessation of fighting, refugees began to return to Chad. However, those remaining had little in the way of supplies to cope with their hostile living conditions. “Children and adults were found to be suffering from dehydration, diarrhea, and respiratory infections. Nights in northern Cameroon are cold at this time of year and the refugees lacked any protection,” said Dr. Véronique Urbaniale, the MSF emergency coordinator in Kousseri, just days after the refugees had fled their homes.

By February 13, MSF had vaccinated 5,600 children against measles. More than 3,600 families received relief supplies, such as blankets, plastic sheeting, jerry cans, soap, and mosquito nets. Medical teams were providing assistance in three clinics in town and in the outpatient department of Kousseri’s central hospital, performing an average of 400 consultations per day in these structures.

"THERE WERE BODIES EVERYWHERE, EVEN AT OUR DOORSTEP"

Two weeks after the heavy fighting in N’Djamena, thousands of refugees were being forced to make a difficult choice: return to Chad or be transferred to a refugee camp 20 miles away from Kousseri. By March 4, UNHCR had transferred 10,000 people to the newly established Maltam camp in Cameroon.

Insecurity is the main reason given by refugees hesitant to go back to Chad. Some are still too frightened after the extremely violent clashes that shook the capital. “The rebels entered and broke down the city,” remembered Fatima, a widow who sought refuge in Kousseri with two of her grandchildren. “There were bodies everywhere, even at our doorstep.”

Safety is an important factor but not the only one for a Chadian refugee to consider when deciding whether or not to return home. For the poorest, there is also a question of finding the basics that will keep them going. “I don’t know yet if I will go to Maltam,” said Narcisse, a man in his 50s living in Kousseri with the five members of his family. Their food reserves have run out and they sleep in the open. “I am a carpenter and all economic activities have been stopped. If I go back and everything is still stopped, what will I do? In Maltam, at least, I will get food. I could stay there and see what happens in N’Djamena.”

Even if many refugees want to reach Maltam, most only see the camp as part of a transition phase. Most of the refugees who were interviewed said they want to return to N’Djamena in the coming months, after the dust settles. “I can’t go back now. If I go, I’ll remember what happened. I’ll stay until I feel rested. Once the dust has settled in N’Djamena, I’ll go back,” said Fatima.
Long a bastion of stability in East Africa, Kenya rapidly disintegrated into violence following the country’s disputed presidential election. Two months of violence, largely along tribal and ethnic lines, left more than 1,000 dead and as many as 300,000 people homeless, according to the Kenyan Red Cross, before the opposing political parties reached a tenuous power-sharing agreement on February 28.

Doctors Without Borders/Médecins Sans Frontières (MSF), which has been working in the country since 1987, had, for the most part, been focusing on providing treatment to thousands of people living with HIV/AIDS and tuberculosis in both the capital, Nairobi, and western Kenya. In the wake of the violence, MSF teams were forced to switch gears from overseeing specialized care for chronic diseases to treating machete and other trauma wounds and running mobile clinics for Kenyans fleeing the violence in their communities. MSF quickly reinforced its teams on the ground by dispatching surgeons, emergency physicians, nurses, and logistical specialists to the country in the tense, violent weeks that followed the election results.

ASSISTING WOUNDED AND DISPLACED IN WESTERN KENYA

MSF teams conducted assessments by helicopter in different areas in the west of Kenya where large numbers of displaced people were reported to have fled. Eldoret, a busy transit town in Western Province, was one of the first places where MSF teams assisted people fleeing violence. An MSF staff began assisting the estimated 30,000 people who arrived in Eldoret in early January. A team distributed relief supplies, such as plastic sheeting, blankets, and jerry cans, to people living in camps around the city.

Many displaced people settled just temporarily in churches, police stations, or any place that offered even a modest sense of safety. They often headed in the direction of areas of the country they considered ancestral or tribal homelands. The rapid movement...
of people forced MSF teams to be highly reactive and mobile.

“The population was very mobile,” said Dr. Marcela Allheimen, medical coordinator for MSF’s teams in western Kenya. “At the beginning they didn’t stay in one place for more than three days. You had to have everything with you to assess the situation in half an hour and to respond immediately because maybe the population wouldn’t be there the next day.”

The violence has torn people out of their normal lives and many—used to Kenya’s stability—have been unable to cope with the effects. “For these people who have always lived in houses, coping mechanisms are difficult, people are still learning how to live as a displaced person,” said Alexis Moens, MSF emergency coordinator in Kitale.

SUPPORTING THE KENYAN HEALTH SYSTEM

Much of MSF’s work has been to provide temporary support to Kenyan health facilities where staff had either fled or were too afraid to show up for work. Over a single weekend in late January, MSF supported the Kenyan Ministry of Health to treat nearly 200 wounded in Naivasha and Nakuru. An MSF surgical team, for example, also worked in Eldoret hospital in early January to help with a backlog of wounded and burn patients. “What’s been really dramatic to me was the intensity of some of the violence,” said Dr. Gary Myers, an MSF surgeon. “On at least three of the patients I’ve seen, the machete wounds that they’ve had have caused near amputations. In my experience working with MSF it’s been unusual to see fractures caused by knife wounds, but at least half of the patients I saw here were injured in this way. If they didn’t have surgery they would most likely lose their limbs.”

Between February 8 and February 21, another surgical team working in Kericho hospital performed 22 operations. As of late February, only 50 percent of the hospital’s regular staff had returned to work and the MSF team was prepared to continue supporting the hospital over the coming weeks.

“OUR TEAMS HAVE WITNESSED SEVERELY WOUNDED PEOPLE”

With sporadic protests breaking out in Nairobi, MSF opened first-aid posts and turned its primarily HIV/AIDS clinics into basic trauma care centers. After some disruption, Kibera South Health Center—one of MSF’s
three health clinics in the Kibera slum of Nairobi—was able to reopen on December 31. In the first two days of reopening, MSF staff treated 62 patients, over half of whom had been wounded during the violence. In Mathare, a slum on the eastern outskirts of Nairobi, MSF staff were able to go back to work on the first of January. Initially, the teams treated 19 emergency cases, some of whom had been wounded during the violence.

“In Masaba hospital, which we support to take care of the wounded, people were lying on the floor all over the waiting room. Trucks were bringing more people—some wounded, others already dead,” said Remi Carrier, coordinator of MSF’s emergency team in Kibera, of the tensions in mid-January.

Between January 16 and February 4, the MSF team in Mathare treated 150 wounded. “People have been victims of armed civilians increasingly organized in groups that perpetrate indiscriminate violence—with knives, machetes, and sometimes axes—against the population as a whole,” said Filipe Ribero, MSF emergency coordinator for Mathare. “Our teams have witnessed severely wounded people, with lacerated bodies and mutilated limbs or heads.” Many of the victims had to be evacuated to hospitals.

MSF sent three ambulances around the slums and responded to calls for assisting the injured. For the most seriously injured, a system of referral was set up with the public referral hospital and a private hospital. Then again on February 21 and February 22, the team in Mathare treated 25 wounded people following fresh violence.

AIDS AND TB PATIENTS UNABLE TO RECEIVE TREATMENT

The insecurity has also had serious consequences for the thousands of Kenyans receiving treatment for diseases such as AIDS and tuberculosis. Some MSF patients were unable to reach clinics in Kibera and Mathare to receive their medicine early on in the crisis. “With AIDS and TB, the discontinuation of treatment is very bad because it can foster drug resistance in patients,” said Dr. Allheimen. MSF set up a free telephone hotline, created advertisements, and distributed posters and flyers to find lost patients.

CONCERNS FOR THE FUTURE

Even with the power-sharing agreement signed by Kenya’s ruling political party and the main opposition group, MSF teams are continuing to work throughout western Kenya in multiple locations and will monitor health and humanitarian needs as people continue to move to their ancestral lands. The violence has disrupted many people’s ability to plant their crops and left hundreds of thousands homeless.

“The food security in the country is at stake,” said Dr. Allheimen. “February and March is the planting season, and many people will not have been able to reach their lands or obtain seeds for their crops. The food security is one of the concerns that we will be following in the coming months.”

See a video about Western Kenya’s Endebess IDP camp, where MSF staff constructed tents for 6,500 people, at doctorswithoutborders.org/alert
Situation Report – North Kivu, DRC

Since 1998, civilians in the Democratic Republic of Congo’s (DRC) North Kivu province, along the Rwandan border, have been caught in the middle of a battle for control between local and foreign militias, and the Congolese army. A United Nations peacekeeping force has also, at times, stepped into the fighting on the side of government forces.

The government of President Joseph Kabila has been engaged in a new wave of heavy combat with rebel leader Laurent Nkunda’s forces since August 2007. A number of different groups such as the Mai Mai militia and the Rwandan Hutu rebels of the Democratic Forces for the Liberation of Rwanda (FDLR) are also involved in the fighting. Doctors Without Borders/Médecins Sans Frontières (MSF) teams have been on the forefront of trying to assist people trapped by the conflict.

“I remember one woman who was caught in the crossfire at the beginning of October,” said Anne Khoudiacoff, an MSF nurse working in the Masisi district hospital. “She was carrying her child on her back; miraculously neither she nor the child was badly hurt. The bullet passed between her spine and her baby’s head. It caused a deep burn on her back but the medical team was able to treat her. I’ve also seen several civilians who had been shot in the leg and were taken to the surgical ward.”

Fighting of the kind this woman narrowly escaped has driven hundreds of thousands of people from their homes over the past year. Many have sought safety in the forest near their villages, only to have to flee again. They have little access to food or basic health care and live under near-constant threat of attack and rape from the various armed groups.

“We are now seeing more people living in camps than we’ve seen in North Kivu in the last 10 or 15 years,” said Jane Coyne, MSF head of mission in North Kivu. MSF is running emergency medical programs on both sides of the front line in the districts of Goma, the provincial capital; Rutshuru; Nyanzale; Masisi; Kitchanga; Mweso; and Kilolirwe.

“It is shocking to see these displaced people carrying what little they have, just moving constantly, and it happens every other week,” said Dr. Maria Guevara, MSF medical coordinator for North Kivu.

Photos from Democratic Republic of Congo 2007: © Cedric Gerbehaye; © Marcus Bleasdale/VII
Even though MSF is running one of its largest medical programs in North Kivu, tens of thousands of people remain out of reach. “The conflict in North Kivu involves multiple armed groups,” said Coyne. “So every time you cross into one of the frontiers controlled by an armed group, it’s more complicated to access the population. There are places in North Kivu where no international organization has been in a long time and we don’t really know what the state of the population is.”

NO RESPIE FROM WAR

A ceasefire agreement reached on January 21 has done little to ease the violence. Armed groups broke the agreement within hours. “Despite the glimmer of hope kindled by the Goma conference on peace, I saw how desperate the people are,” said Philippe Havet, MSF emergency coordinator for Masisi district. “All their property is lost. People are tired of the situation. Violence, disease, and running have been their daily life for years. In the last six months, I have witnessed great distress, a lack of food and health care.”

The grinding pace of the conflict has taken its toll on people. Malnutrition and disease remain the greatest killers. In late-January, MSF had more than 900 children under treatment for severe acute malnutrition in Masisi district. “The little kids may look cute and plump, but they actually have kwashiorkor, a dangerous form of malnutrition in which a protein deficiency causes edemas (or swellings) that makes them look plump,” said Dr. Guevara.

In these conditions, a simple cold can become life-threatening. “People are not dying from complicated things; they’re dying from completely preventable problems,” said Coyne. “They are living in terrible conditions, children are getting respiratory infections, the infections aren’t treated, they come into the hospital with pneumonia and it’s too late. The long-term impact of violence in Congo is that people can’t get access to basic health care and that’s what we’re fighting for every day.”

Epidemic diseases have taken their toll as well. In late 2007, MSF faced a cholera epidemic of unusual proportions for the region. More than 2,000 cases were recorded in less than two months in Rutshuru district. The explanation lies in the precarious living conditions of the displaced population. The villages where they are concentrated are growing and becoming virtual cities, but lack the necessary water and sanitation infrastructure. In response to the outbreak, MSF set up a cholera treatment center in the Rutshuru hospital and treatment units on the city outskirts.

INCREASING LEVELS OF RAPE

One particularly disturbing aspect of DRC’s conflict is the alarmingly high rate of sexual violence. In North Kivu, MSF treated more than 2,500 victims of sexual violence in 2007. In January 2008 alone, 550 rape cases were admitted to MSF facilities in the province.

MSF offers to pay for transportation in order to encourage women who have been raped to seek immediate treatment. Victims must be treated within 72 hours after the attack if prophylactic treatment for HIV/AIDS is to be effective. A network of women distributes information and the message is broadcast on the radio, emphasizing the need to obtain medical treatment within 72 hours.
Pediatrician Leo Ho worked in the intensive care unit (ICU) of the MSF-run Gondama Hospital in the Bo region of Sierra Leone from February to August 2007. Set in a region constantly plagued by malaria, even in the dry season, Gondama village has a high death rate due to this disease, especially among children. During his assignment, Dr. Ho was continually treating the most severe malaria cases: children brought to the hospital who had already fallen into a coma, were severely malnourished, or suffering from tuberculosis or HIV/AIDS. “We were just trying to keep them alive,” he says.

Malaria can be prevented by sleeping under a bed net treated with insecticide, but many families in poor regions cannot afford this small luxury. The most effective treatment for malaria is ACT—artemisinin-based combination therapy—fast-working drugs with few side effects that combine multiple medicines into one, making them simple for patients and medical staff to manage. “Many patients start showing improvement in the first 24 hours of taking ACTs,” says Dr. Ho. The World Health Organization named ACTs the preferred method of treating malaria in 2001, but, in spite of 41 of 54 African countries having changed their treatment protocols accordingly, too many patients are still receiving older, less effective drugs.

Here, Dr. Ho reflects on his assignment through images captured by photojournalist Francesco Zizola.

“In Bo, I mainly worked in the intensive care unit; most of the time, I was taking care of the severely ill patients, most of whom were young children under five. Those are the most susceptible to malaria.”

See an audio slideshow at doctorswithoutborders.org/alert
“Quite frequently, little children would come in comatose, just incredibly sick. This usually happened in one of two ways. Sometimes, the infection is so severe, it can progress over a day or over a few hours where a child can be sitting up, alert, and then, hours later, in a coma. Or, a lot of parents would wait before they brought their children in, so, often, they would wait until the child became non-responsive before coming to the hospital. We saw a lot of this and it’s just really unfortunate because, obviously, the later they came in, the less we could do. So, we did have a lot of mortality. But many of our patients got better, also.”

“This baby is being tested in one of our clinics for malaria, with a little finger prick. We take a few drops of blood and it’s placed in this little plastic testing device, which is a rapid test for *falciparum* malaria. It tests for the most severe species of malaria, the one that was really prevalent there. And then, within 15 minutes you get a test result, whether it’s a severe malaria infection or not.”

“We were using the newer malarial treatment, which is the artemisinin-based derivatives. This has been implemented in the last few years with MSF. And it’s really been a great weapon because it’s extremely effective, very well tolerated, and easy to administer. It’s basically the treatment of choice. Usually, it takes just three days of treatment. Even children in a coma—within 24 to 48 hours, many of them were starting to move a little bit, and that’s who survived. Some would die because there was just no chance.”
“This is a really sad picture, but a really effective one, in that it demonstrates the devastating impact of malaria. We would have at least two children die at our hospital every day on average, sometimes even more. And it would happen so unexpectedly. And this picture shows how, when a child would die, he or she would usually be wrapped up in a lappa, the same cloth that held them against their mothers’ backs when they were well.”

“A lot of these families came from small villages and they didn’t have a large support network, and, obviously, couldn’t afford many things. So, the majority of the children, after they died, we would actually give the caretakers cardboard boxes—the same cardboard boxes our medical supplies came in. And that’s what they were buried in.”

“Here, an MSF nurse is resuscitating a child who had stopped breathing. I’m standing next to her, there is another child lying next to that one and two more behind us, all in critical condition. For me, a lot of the reflection happened after the mission. It just seemed that so many things were going on, you just had to stay strong and keep doing what you were doing. Now, when I see these pictures and I think about it, I just can’t believe the stuff that I saw and I can’t believe the environment I was working in. We were resuscitating children every day and just trying to keep them alive.”
CMV Retinitis: Neglected Opportunistic Disease of the AIDS Pandemic Causing Blindness in Southeast Asia

TREATMENT TO PREVENT BLINDNESS AT AN “IMPOSSIBLE PRICE”

Cytomegalovirus (CMV) retinitis, a condition that causes blindness in patients with advanced HIV, has long been a neglected disease of the AIDS pandemic, leading to unnecessary cases of blindness, particularly in Southeast Asia. The full scale of the CMV retinitis problem in developing regions is still not known, but a recent paper published in *PLoS Medicine*, based on pilot studies from various MSF projects, found that CMV retinitis occurred in 23, 27, and 32 percent of patients with advanced HIV in Cambodia, Myanmar, and Thailand, respectively.

Complications from CMV retinitis—most notably blindness—are preventable with screening programs and anti-CMV treatment. However, screening is unfortunately not routinely performed in many places where CMV retinitis is prevalent. The $10,273 price for a four-month course of treatment is prohibitive. The treatment, an oral medicine named valganciclovir produced solely by Hoffman-La Roche, is far too expensive for most of the patients with this disease. A negotiated price of $1,899 for four months of valganciclovir is still too expensive. Lower middle-income countries where CMV is a major problem, such as China and Thailand, are not eligible for this discounted price.
CONFRONTING A DEBILITATING DISEASE

Dr. David Wilson, former MSF medical coordinator in Thailand, has worked on MSF HIV/AIDS projects throughout Asia. Back when MSF only provided palliative care for HIV/AIDS patients, it was common for very sick patients to go blind and die. In 2000, MSF first began using antiretrovirals (ARVs) to treat HIV/AIDS, and there was great hope that patients would go on to live normal lives, he said. But while ARVs helped restore patients’ health, CMV infection and resulting blindness continued unchecked.

Wilson recalls the very first patient MSF started on ARVs. “I remember her well for a very unfortunate reason,” he says. “Within one month of starting treatment, she became blind from CMV. But since she was on ARV treatment, her health improved. She went on to live a long time, but completely blind.”

CMV poses a threat to a patient’s sight once a person’s immune system is weakened. Irreparable destruction of the entire retina can occur within weeks.

Because CMV leads to blindness in patients with advanced HIV disease, treatment must consist of both CMV treatment for the infection and ARV therapy to restore immune function. If the CMV infection is not treated, it is not uncommon for a patient on ARVs to go blind just as they are becoming healthier.

Patients most susceptible to CMV—those with low CD4 counts who are not being treated for HIV/AIDS—often live in impoverished, rural areas where blindness can have a devastating impact.

“The particular kind of blindness caused by CMV is absolute, total blindness,” Wilson says. “The patient cannot tell the difference between light and dark. Someone who is blind from cataracts, for example, can distinguish some things; they need some help, but often they can manage. Someone with CMV, when everything is totally black, it’s very difficult for them to eat without someone actually feeding them, or to do very much of anything to help themselves.”

CMV is often asymptomatic in its earlier stages and can best be diagnosed through systematic screening of all at-risk patients. The best method to diagnose CMV—retinal examination using an indirect ophthalmoscope on fully dilated pupils—is not a fundamental part of HIV programs in the developing world.

The high cost of valganciclovir poses another major obstacle for patients in resource-poor settings. An alternative treatment using intravenous ganciclovir requires twice-daily injections for two or three weeks, and then daily injections for another two to three months. Another method—intraocular injections of ganciclovir—is invasive and involves a doctor repeatedly jabbing patients with a needle in one or both infected eyes. Although both options are effective, oral valganciclovir therapy remains the least invasive option.

TREATMENT OUT OF REACH FOR MANY

The preferred treatment, valganciclovir, comes in pill form and, unlike intraocular ganciclovir, can also treat potentially fatal forms of CMV that occur outside the eye. Roche of Basel, Switzerland, holds patents for valganciclovir in most countries around the world and is the only producer of the drug. Valganciclovir is marketed almost exclusively as a drug to prevent CMV infection in patients undergoing organ transplants in wealthy and middle income countries, a small but lucrative market.

“This is a classic case of the vicious circle,” said Dr. Tido von Schoen-Angerer, Director of MSF’s Campaign for Access to Essential Medicines. “Because the price of the drug is so high, HIV programs aren’t screening and therefore are not reporting large numbers of CMV patients. But since on paper there are so few patients, bringing down the price of this treatment and ensuring its availability has never been a priority.”

Even though Hoffman-La Roche has proposed a discounted price of $1,899 for least developed countries and sub-Saharan Africa, the offer remains expensive and excludes many countries, such as China and Thailand, where the CMV retinitis is most acute. This has forced difficult compromises. In Thailand, along with local partners, MSF has decided to use the sub-optimal intravenous formulation of ganciclovir, as well as intraocular injections. In China, MSF pays the full price for oral valganciclovir, which at $10,273, costs more than a Chinese economy car.

“We have a strategy to make the diagnosis that’s manageable” Wilson says. “But, once we have the diagnosis, we need the treatment, and the problem is that the treatment is at an impossible price.”

Go to doctorswithoutborders.org/alert for a link to the PLoS Medicine paper on CMV, and to read more on this disease.
Humanitarian Action – Necessary Independence

This spring, Doctors Without Borders/Médecins Sans Frontières (MSF) will publish, From Ethiopia to Chechnya: Reflections on Humanitarian Action, 1988-1999, a collection of essays from François Jean (1956-1999) translated by Richard Swanson. Jean contributed enormously in the field and at headquarters to the evolution and direction of MSF for nearly two decades. Born in Sainte Ménehould, France, he received a doctorate in sociology from the Institute for Political Studies, or Sciences Po, in Paris in 1979, as well as a diploma from the National Institute for Eastern Languages in 1980. After joining MSF in 1982 to establish medical and surgical projects in war-torn Lebanon, he went on to oversee emergency medical interventions in a variety of countries, including Chad, Pakistan, Sudan, and Chechnya.

“François Jean was a great figure of humanitarian action. Few have matched his depth of commitment both to action and reflection. His intelligence, his willingness to ask hard questions, and perhaps more bravely and originally still, accept, even insist upon, sometimes ambiguous and unhappy answers, shine in this invaluable collection of his writings. They are a model—and thus very much still relevant today—of how to think about humanitarianism.”
— David Rieff, author of A Bed for the Night: Humanitarianism in Crisis

Throughout his time with MSF, Jean wrote prolifically about the difficulties and challenges faced by humanitarian aid workers in a shifting political landscape. He helped create and edit the series, Populations in Danger, a collection of essays that wrestled with defining the scope and limits of humanitarian action, and contributed to many books, such as Ethiopia, A Useful Famine.

Over the course of this year, excerpts of Jean's collected works will continue to appear in Alert. The book will be made available through doctorswithoutborders.org. This first excerpt, “Necessary Independence,” was originally published in La Provence, a French journal, on December 20, 1997.

Murders in Burundi, Chechnya, Rwanda … kidnappings in Chechnya and Tajikistan. For several months such tragedies have been relentlessly on the rise; now humanitarian aid workers often pay dearly indeed for their efforts to deliver assistance to endangered populations.

There has been a very real deterioration of security conditions for international organizations intervening in crisis situations. Yet this is not due to any radical change in the nature of conflicts themselves. Contrary to a widely held notion, the end of the Cold War has not brought us a period of disorder, anarchy, or chaos and violence that is bloodier, more senseless, or more irrational than ever before. Disillusioning though this may be for those who are nostalgic for a lost golden age, immunity for humanitarian workers has never existed, and relief organizations intervening in civil wars or internal conflicts have always faced a multitude of obstacles—as well as threats—in their efforts to deliver aid to victims of conflict or repression.

Still, these troubles have increased in number in recent years, especially during that most perilous phase immediately following a cease-fire (which, in theory, should usher in a period of peace …)—a time when some armed groups begin to break down into detached, privatized, criminal gangs, reorganized on the basis of looting and racketeering. But the principal difference relates back to the aid system's remarkable evolution over the last decade. At the close of the 1980s, the preponderance of international aid for crisis situations

Photo courtesy of the family of François Jean
was distributed on the peripheries of conflicts in refugee
camps, with only a few rare humanitarian organizations
intervening directly to aid people trapped by the fighting.

Since then the number of relief operations in conflict zones
has rapidly increased; there is now a profusion of UN
programs and nongovernmental initiatives, Blue Helmets
and multinational forces. At the same time, emergency aid
budgets have grown six-fold, encouraging the blossoming
of organizations without experience in crisis situations.

A consequence of this rapid growth in the number
of organizations of all sorts now present in arenas of
conflict—private, state based, or even military—is that local
populations and armed groups now have a more muddled
perception of humanitarian actors. In some countries such
as Somalia or Bosnia, humanitarian organizations are
confused with the military. Elsewhere they are believed to
be associated with their governments. In every case they
are perceived to be rich and Western …

Under these conditions, it is more important than ever for
humanitarian organizations to keep their distance with
regard to the military, to outwardly demonstrate their
independence with respect to political authorities, to leave
established international circles in the capital cities behind
in order to be nearer to the people—in sum, to reaffirm
the core principles of humanitarian action: impartiality,
independence, and solidarity. It is also fundamentally
important in these crises, which in fact are not
“humanitarian” but very much political in their violence
and arbitrariness, to display clearheadedness, prudence,
and determination, in order to preserve ourselves and
protect the victims.

Order From Ethiopia to Chechnya: Reflections on
Humanitarian Action, 1988-1999, by François Jean,
at doctorswithoutborders.org/alert
MSF IN CENTRAL AFRICAN REPUBLIC

Photojournalist Spencer Platt spent two weeks in December 2007 with MSF in Central African Republic, documenting the humanitarian situation and MSF’s work. In the audio slideshow, “Through the Lens,” Platt’s striking images are combined with the stories behind them.

Also, see how MSF has responded to the needs of Central African Republic’s violence-affected populations in the video, “Bringing Medical Care to War-Affected Populations.”

VOICES FROM THE FIELD: REPORTS FROM MSF STAFF ON THE GROUND

**North Kivu, DRC:** “I saw how desperate the population is. . .”

Philippe Havet was MSF’s emergency coordinator in Masisi, North Kivu, during heavy clashes between armed groups from August to December 2007.

**Eldoret, Kenya:** “The machete wounds have caused near amputations”

MSF surgeon Gary Myers was dispatched to Kenya to help those injured in the post-election violence.

ON THE MEDICAL FRONT

In response to MSF’s 2007 symposium on the urgent need to develop new TB medicines, three articles have been published in *PLoS Medicine*, a peer-reviewed, open-access medical journal.

PODCASTS

**February:** Hear reports on how CMV retinitis continues to cause blindness in people living HIV/AIDS, on India’s hidden war, and MSF’s response to the crisis in Kenya.

**January:** Learn how civilians try to survive in Central African Republic, how MSF is responding to Sri Lanka’s civil war, and the conflict in the DRC’s North Kivu province.

SLIDESHOWS

Watch and e-mail your friends a slide-show of 2007’s Top 10 Most Underreported Humanitarian Stories.

In Bihar, India, MSF treats people living amid the world’s highest concentration of visceral leishmaniasis, also known as *kala azar*. 
MSF LAUNCHES NORTH AMERICAN TOUR OF “A REFUGEE CAMP IN THE HEART OF THE CITY”

In September and October 2007, MSF brought its outdoor educational exhibit *A Refugee Camp in the Heart of the City* to Chicago, Dallas, Houston, Milwaukee, and Minneapolis. In 2008, MSF will take the exhibit to cities in western Canada and California. A tentative list of cities and dates are below. Visit doctorswithoutborders.org/refugeecamp to check for updated information.

**CANADIAN CITIES**
- Winnipeg: September 11-14
- Edmonton: September 18-21
- Calgary: September 25-28
- Vancouver: October 2-6

**US CITIES**
- San Francisco: October 15-19
- Los Angeles: October 22-27
- Santa Monica: October 31 to November 2
- San Diego: November 6-9

CROSS-COUNTRY CYCLING EVENT TO RAISE FUNDS FOR MSF

Twenty-five riders, many of whom are fourth-year medical students, will be fundraising and participating in a 3,700-mile ride to benefit MSF.

The group represents Ride for World Health (R4WH), a national, nonprofit organization that advocates for improvements in the quality and accessibility of global health care. R4WH was founded in November of 2004 by a small group of Ohio State University medical students as a reaction to the state of domestic and global healthcare.

The riders will start on April 14 in San Diego and are expected to finish May 26 in Washington, D.C.

Please visit www.rideforworldhealth.org for more information on the tour.

JOIN OUR LEGACY SOCIETY

Your dedication to MSF is very important to us. With the support of loyal friends like you, MSF is able to provide urgent medical care for people in great need. We hope you will consider strengthening your commitment to MSF by joining our Legacy Society and designating a gift to MSF in your will. Your legacy gift will enable us to respond to the challenges we will face in the years ahead. The tax savings to your estate are an added benefit that you should discuss with your financial advisor.

If you have already included MSF in your estate plans, please tell us so we can thank you and include you in our distinguished Legacy Society.

If you would like more information about MSF planned giving opportunities, please contact:

Ronit Schlein at (212) 847-3149 or plannedgiving@newyork.msf.org.
Photojournalist Spencer Platt traveled to Central African Republic in December 2007 to photograph MSF’s activities there. He accompanied an MSF team assessing medical needs in Massabiou, a village close to the Chadian border that had been violently raided earlier that year. At least 20 people were killed during the attack, and the remaining villagers fled. When Platt and the MSF team arrived, the inhabitants were just starting to return. The woman in this photo was one of those first returnees.

“For me, it’s always difficult in these situations to capture a photo that can be seen as poignant,” says Platt. “You’re looking for an image that’s going to draw a reader thousands of miles away, into a completely different environment, and draw them into this story; kind of galvanize, maybe, their interest in Africa and Central African Republic, which they probably know very little about.”