CHOLERA: A DEVASTATING RESULT OF ZIMBABWE’S LARGER HUMANITARIAN CRISIS

POSTER INSIDE: ‘TOP TEN’ CRISSES OF 2008
Dear Friends,

I write to many of you for the first time as the new executive director of Doctors Without Borders/Médecins Sans Frontières (MSF) at a very frustrating moment. As this issue of Alert went to press, MSF medical teams working in Sudan’s South Darfur and West Darfur states were being expelled from the country. At least a dozen other nongovernmental organizations were expelled on March 4 following the decision of the International Criminal Court (ICC) to issue an arrest warrant for Sudan’s president on charges that include crimes against humanity.

The lifetime has been cut for more than 450,000 people completely dependent on the medical care provided by our teams. These are women with high-risk pregnancies, malnourished children, and rape victims left without any possibility for care. And now, as though a lack of response to these needs is not abysmal enough, the expulsions come as an outbreak of meningitis—a deadly disease if left untreated—has begun to rip through South Darfur. Kalma camp, home to more than 90,000 people uprooted by the conflict, and Niertiti, an isolated town in the Jebel Marra Mountains where 40,000 displaced persons and residents live, have already reached the threshold for cases requiring a mass vaccination. Without treatment, bacterial meningitis kills up to 50 percent of those infected. At the time of publication, there is no medical organization present in Kalma camp to administer treatment and vaccinations.

For the moment, MSF medical teams have still been authorized to work in some parts of West Darfur and North Darfur states. Our ability to assist the populations in these areas, though, has been severely compromised by the Sudanese government’s decisions. And there are no other organizations able to compensate for the loss of our lifesaving medical services.

The immediate impact of the government’s decision could be catastrophic. No less pernicious, though, are the dangers inherent in the confusion created between the work of the ICC and its relationship to humanitarian aid organizations. Since the ICC’s creation, MSF has adopted a policy refraining from any cooperation with this legal body. What is happening in Darfur is a clear example of why this distance between humanitarian action and the pursuit of judicial agendas is necessary.

Please visit doctorswithoutborders.org to find the latest reports on the situation in Darfur, as well as updates on the stories we bring you in this issue of Alert.

Even in these challenging days, I know we have a vast network of supporters around the United States who share the commitment to assist victims of violence and acute crises. It is the same ideals and principles that brought me to this position.

Sincerely,
Sophie Delaunay, 
Executive Director, 
Doctors Without Borders/Médecins Sans Frontières (MSF)
EMERGENCY DESK

ZIMBABWE: CHOLERA EPIDEMIC RAGES ON

Luis Maria Tello, Doctors Without Borders/Médecins Sans Frontières’ (MSF) emergency coordinator in Zimbabwe, encountered a devastating scene when he arrived in the town of Chegutu, 100 miles south of the capital Harare, on December 12, 2008. “The situation was absolute chaos. There were no beds and patients everywhere,” said Tello. “People were dying of thirst because there was no water. Dead people were lying everywhere.”

Just that morning, he had been alerted by government officials that cholera had hit Chegutu, a town of 20,000 people in the district of Mashonaland West, 100 miles south of Harare, the capital. “We had no clue that cholera had hit,” said Bachmann, MSF emergency coordinator in Harare. “For instance, there is only a little electricity so there is hardly any light. It is difficult for the doctors and nurses to even see the patients they are treating. The nurses have to work registering and rehydrating patients. Meanwhile, patients had been without food or water for days. An elderly man attempted to remove his IV drip so he could leave in search of food—unwilling to wear his IV in public for fear of stigmatization. MSF also learned that many people suffering from cholera had stayed at home, having heard of the desperate conditions at the CTC, making it likely that many more people may well have died without seeking treatment. To remedy this situation, MSF logisticians identified a local bore hole and began to supply the center with water, while also providing logistical support for food supplies being brought in by the UN World Food Program and Catholic Relief Services, a New York–based nongovernmental organization.

This scenario has been repeating itself all over Zimbabwe since cholera first broke out in Harare in August 2008. Cholera is the most visible manifestation of the collapse of Zimbabwe’s health system. Conditions for the outbreak were perfect: a health infrastructure chronically neglected, water and sanitation systems sliding into disrepair, and burst sewage pipes and erratic water supply opening channels for disease to spread. People were forced to dig unproctected wells and, with the sewage system in decline, to defecate in open spaces. As sewage made its way into water sources used for drinking and bathing, it did not take long for cholera bacteria to spread to one of its most hospitable hosts—humans.

The World Health Organization’s (WHO) worst-case prediction of 60,000 cholera cases was exceeded in the beginning of 2009. By the first week of March, 88,000 cases had been reported; MSF had treated 56,000 of them. Cholera had appeared in almost every province of Zimbabwe, which has a population of more than 13 million. And with the rainy season continuing, the prognosis remained grim, as heavy rains helped spread the bacteria by flushing standing sewage into unprotected wells.

At the root of these and many other problems is Zimbabwe’s political and economic meltdown. The country had been known as the “breadbasket” of Africa. For years, health professionals have been fleeing the country along with countless others, unable to afford the most basic things, such as transportation to work. With shortages in personnel, supplies, and services, hospitals and clinics have closed, leaving critical holes in the public health system. Zimbabwe’s average life expectancy is 34 years, due mainly to the massive spread of HIV, which affects one out of every five people. People living with HIV face major challenges in getting to the remaining health facilities and receiving treatment, and many have fled the country. Despite a critical shortage of personnel, government rules make it very difficult for international organizations to send health professionals into the country; a work permit can take three months to obtain, and foreign doctors are required to perform an additional three-month internship at a government hospital, many of which are now closed.

MSF RESPONDS TO THE CRISIS

MSF has been working in Zimbabwe since 2000, primarily treating people with HIV/AIDS; MSF currently cares for 40,000 patients, 27,000 of whom receive antiretroviral drugs. MSF has treated under the most basic conditions,” said Marcus Bachmann, MSF emergency coordinator in Harare. “For instance, there is only a little electricity so there is hardly any light. It is difficult for the doctors and nurses to even see the patients they are treating. The nurses have to perform an additional three-month internship at a government hospital, many of which are now closed.

MSF teams in Zimbabwe have had to adapt quickly as crisis followed crisis. In June, they opened programs to treat people injured in the violence, as well as those who were fleeing and had no access to health care. In August, when cholera broke out, MSF immediately flew in cholera kits from Europe and additional staff with expertise in cholera response, who got to work setting up two CTCs at medical facilities in Harare.

“Imagine a cholera ward with dozens of people being treated under the most basic conditions,” said Marcus Bachmann, MSF emergency coordinator in Harare. “For instance, there is only a little electricity so there is hardly any light. It is difficult for the doctors and nurses to even see the patients they are treating. The nurses have to...
monitor multitudes of IV bags to make sure they don’t run dry, which is also difficult to do in the dark and when there are so many patients.”

Within days, the centers were flooded with new patients, and MSF was already hiring and training new staff to chlorinate water sources, disinfect homes, and to assist as new outbreaks occurred in rural areas.

By the end of January 2009, MSF had treated approximately 45,000 patients—about 75 percent of the country’s cholera cases, but the epidemic was far from over. Later that month in Kadoma City, in Mashonaland West Province, the number of cases pushed the city’s CTC over capacity, and MSF relocated the center to a soccer field where it set up 250 cholera beds, a 30,000-liter water tank, 20 latrines, waste management facilities, and electricity generation capacity.

**BEITBRIDGE: 500 CASES IN TWO DAYS**

Nowhere has the cycle of broken infrastructure leading to an outbreak of cholera been more clearly illustrated than in the southern town of Beitbridge, on the border with South Africa. Thousands of people have gathered there in an attempt to flee the country, and MSF had opened a program to provide basic medical assistance. With this massive influx of people, no garbage collection, open sewage running through most streets, and almost daily water and power cuts, the conditions were optimal for cholera to spread.

On November 14, 2008, local health authorities contacted MSF’s team in Beitbridge with news of five cholera cases. Within two days, that number had risen to more than 500; by the end of the week, to more than 1,500. When MSF team members arrived at the local hospital, the scene was devastating. Patients were being moved to lie on the dirt outside the hospital, so that they could empty their bowels directly into the ground. The toilets were backed up and overflowing. Patients lay in the dust in the scorching heat, asking for treatment and water. But there was no water to give them, since the water supply for the hospital, as everywhere in town, was cut off on most days.

An MSF doctor, Veronica Nicola, described the scene awaiting her: “There was a man lying next to one of the trolleys under the sun. By the time I got to him, he was in shock. We tried to get a vein, like, 10 times, but then he started gasping and he died right there in front of our eyes. If I had seen him half an hour before, we might have been able to do something about it, but there were so many people lying there, calling out. It was very bad.”

Within three days, MSF had shipped in enough medicines and supplies to set up a CTC with 130 beds, sent in a team of 16 doctors, nurses, logisticians, and administrators, and hired more than 100 additional health workers, cleaners, and day workers. By the fourth day, the mortality rate had dropped from 15 percent to less than one percent.

**TRAINING COMMUNITY LEADERS TO RESPOND**

As outbreaks in rural areas have continued, MSF began implementing a new outreach strategy-training community leaders to administer oral rehydration salts and keep track of affected people. Chlorine tabs to kill bacteria in water supplies are also being distributed.

MSF teams give out health promotion posters to the CTCs they visit and carry out activities to encourage communities to talk about hygiene.

In February there were more than 500 MSF staff working to treat and prevent the further spread of cholera in Zimbabwe, but the number of cases was still rising.

**WHAT IS CHOLERA?**

Cholera is a highly contagious diarrheal disease spread mainly through water or food that has been contaminated by feces. Patients show symptoms of acute diarrhea or vomiting, and must be continuously rehydrated, orally or through an IV, until symptoms disappear. They must be treated in special isolation units called cholera treatment centers (CTCs). Everyone is disinfected before entering a CTC and as they are leaving, so as not to spread the infection.

**HOW MSF RESPONDS TO AN OUTBREAK**

Responding to cholera requires a lot of materials, and MSF purchases locally when possible, items such as buckets, beds, and blankets. In addition, MSF provides field staff with pre-assembled emergency cholera kits to use during outbreaks. Here are some examples of items in an MSF cholera kit.

**SUPPLIES & MATERIALS**

**Medical**
- Oral rehydration salts (ORS)
- Ringer’s lactate – a rehydration solution administered intravenously if a patient is too ill to drink water with ORS
- Gastric tubes, IV catheters, syringes, and other medical materials
- Gloves – always used during cleaning and examinations

**Logistical**
- Chlorine – to disinfect water supplies
- Soap
- Watertight boots - to protect from contaminated water and soil
- Graduated cups for drinking and administering ORS
- Pool tester – to monitor chlorine levels
- Buckets – every patient has two buckets, one for vomit and one under the bed for diarrhea

**Administrative**
- Cholera control guidelines
- Water treatment guidelines
- Patient follow-up cards
Jane Hannon, a 39-year-old nurse from Baltimore, was in Manicaland Province in eastern Zimbabwe during November and December 2008. Originally sent to Manicaland to conduct assessments of certain areas that cholera might be reaching, Hannon and her team of two national staff nurses and an Italian logistician were finished and on their way back to the capital Harare when their assignment was extended. Here, she talks about trying to help people with cholera in the middle of a large-scale, rapidly spreading outbreak, in a country that has fallen into extreme disrepair.

We ended up going to support several small clinics and rural hospitals, but the first one we went to was in Nyanyadzi, to the south of Mutare City, where we had been a few days earlier. There is a very basic rural hospital there. They had previously received only four cholera patients and the team was cop ing. There was a men’s ward with seven beds—all full—and a women’s ward with 12 beds; those were all full, too. They had a maternity ward that we ended up moving to another building to free up more space for cholera patients, and, importantly, to protect women in labor and their newborns from infection. And there was a treatment room where we squeezed four additional beds. At one point, the hospital was completely full, and on average there were about 30 patients being treated every day while I was there.

We worked with the humanitarian organization Action Against Hunger and together we got the hospital better equipped. We gave them buckets, which are critical to treating the disease, as cholera provokes massive quantities of diarrhea and vomit. We also provided the hospital with large water containers, chlorine for disinfection, medical supplies, and the training and support to manage patients and contain spread of the cholera. Treatment for cholera is pretty straightforward—replace the fluids the patient has lost, either through oral rehydration salts (ORS) or an intravenous solution of Ringer’s lactate. In some severe cases, we might administer antibiotics along with fluids. The challenge was treating these patients in Zimbabwe where the system is pretty well broken. Like much of the country now, the hospital did not have running water, so we brought them large water containers that a donkey cart took back and forth to a safe water source. We got them cholera beds, which are basically fold-up cots with a hole in the center where people empty their bowels into the buckets. Before we had the cholera beds in there, it was more difficult for nurses to defecate into the buckets. There weren’t enough hospital beds initially, so there were even people on the floor. It was really an awful thing for these patients.

The Ministry of Health had given the clinics cholera kits but they couldn’t treat many people with them; the kits were lacking a lot of items. I think everything was in such short supply in Zimbabwe, the kits, which had probably been on stand-by for a while, probably had supplies pilfered to treat other patients prior to the cholera outbreak, understandably so. As soon as MSF was able to get them to us, we received MSF cholera kits with everything you need to set up a cholera unit—all the liters and liters of IV fluids, ORS, and other medical and logistic supplies to treat cholera and prevent its spread. Treating cholera is very logistics-intensive. One of the things that made a big impression on me was that the workers, all of the staff in every clinic we went to, all needed food. The patients were all hungry. There were children who were obviously malnourished, and once they had recovered from cholera, I got them connected with an MSF nutrition program in the area. MSF ended up paying incentives to the nurses and other staff to ensure they could at least feed themselves and would therefore be better able to treat patients and manage the situation.

We spent Thanksgiving night in Mutare district, in eastern Manicaland Province and the next day conducted an assessment of the cholera situation in Mutare City. We were headed back towards Harare when we got the call: “There’s a project in the south that needs your help.” And then the assessment mission turned into a set-up mission.

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There’s a photo I’ve seen of an MSF cholera treatment center (CTC) in Angola and it’s so nice, just sort of the model of how a CTC should be set up. We were just not there. It was like trial by fire just trying to get the beds, get the water, get the buckets, and patients are coming while you’re trying to do it. We were trying to get the patients stabilized and doing everything at once. The electricity was on and off. And when there was electricity, there were no light bulbs. We had to improvise with candles and lanterns.

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The assignment was very challenging, and you can feel very ineffectual when you have deaths, when you’re struggling to get water, when everyone is hungry. And at the end of the day, I get to come home to my country, turn on the tap, and drink a glass of water. But for them, it’s ongoing.
SITUATION REPORT

GAZA: A DEVASTATING DISREGARD FOR CIVILIANS

Attacks on the Gaza Strip by the Israeli army during three weeks in December 2008 and January 2009 made medical action extremely difficult. The vulnerability of civilians sparked humanitarian outrage and widespread criticism.

Doctors Without Borders Médecins Sans Frontières (MSF) works in some of the most conflict-ridden areas of the world, but in most cases, civilians have the ability to flee to safer areas. Inside the locked-down borders of Gaza, one of the world’s most densely populated areas, there was no way out. From December 27 to January 19, the number of wounded people grew to 5,450 and the dead totaled 1,300, according to the UN agency for Palestinian Refugees (UNRWA). Shelling destroyed an estimated 17,000 homes and reports spread about bombing of locations considered safe zones and used for shelter by civilians.

Al Shifa hospital, the main referral facility in the Gaza Strip, received 500 wounded people in the first 24 hours of the army’s bombings—as well as 180 dead bodies. These were men, women, children, and elderly, said Dr. A, a Palestinian doctor working with MSF who requested anonymity.

On January 15, Jessica Fourraz, MSF field coordinator in Gaza, and her team were bunkered down in an MSF building a mile and half away from fighting in the Tal El-Hawa section of Gaza City. She described the situation of civilians: “An International Committee of the Red Cross (ICRC) building and a UN compound are very close to Tal El-Hawa and the families and people who escaped have gone to these buildings because they think they will be safe there. But, this morning three rockets were fired at the compound, so, as you see and as we’ve said, there is no safe place in Gaza anymore, and we are all very worried about that.”

TRYING TO BRING TREATMENT

MSF has been working in Gaza since 1999 and before the assaults ran a post-operative care clinic in Gaza City and one in Khan Younis in the south, as well as a pediatric care clinic in Beit Lahia, in the northern Gaza Strip. After the initial closure of MSF facilities due to violence, the staff tried to reopen them to take the pressure off overcrowded hospitals. But access to the wounded and security for medical personnel amid the bombing campaign were severely limited.

“Despite official statements from the Israeli government, there are serious obstacles to providing humanitarian aid and, specifically, medical aid. Bombs and bullets do not spare ambulances, hospitals, or health workers,” said Dr. Marie Pierre Allie, president, MSF France, during a January 16 press conference.

MSF attempted several times to reopen its pediatric clinic in Beit Lahia to relieve Kamel Edwan Hospital. But each time, the attempt was cut short; a January 1 bomb attack forced the MSF team to suspend its work only two hours after starting. Two MSF clinics for post-operative care, where patients from Al Shifa hospital are usually referred, were empty: patients in Gaza City could not reach the clinic, and no one could enter the south of the territory from the north after the Israeli army effectively cut the 140-square-mile Gaza Strip in two.

Palestinian MSF doctors, nurses, and physiotherapists began taking emergency medical kits into their own neighborhoods to meet the immediate needs of people living near them. By January 7 about 20 MSF staff were visiting nearly 40 people every day. But even this was extremely risky—the World Health Organization (WHO) estimated that 16 health personnel were killed and 22 injured while working in Gaza since the start of the conflict.

The safety of medical facilities, protected under humanitarian law, was not respected, according to Dr. A: “Buildings near Al Shifa hospital were hit with missiles. And when a building is bombed, the neighbors are immediately affected. The hospital windows that were broken in the explosions caused cuts and wounds, mainly to the children who were sleeping.” Over three weeks, 34 facilities were destroyed or damaged, including 8 hospitals, according to the WHO.

Meanwhile, hospitals were also dealing with electricity cuts and severe lack of medical supplies. Al Shifa hospital had to be powered entirely from generators. MSF made donations of drugs, burn kits, and other items to six hospitals in Gaza and kept in constant contact with doctors, pharmacists, and administrators. But insecurity made deliveries extremely difficult.
A LULL IN THE BOMBING

Starting January 7, the Israeli army announced a daily, three-hour pause in fighting so humanitarian aid, including food, water, and medical treatment, could be delivered. MSF, along with the ICRC and the UNRWA, were trying to provide aid and medical treatment to civilians, but this limited window of opportunity was restricted to Gaza City and it was insufficient to make any major progress.

“Don’t be deceived—the lull in bombing is not helping humanitarian aid workers to do their jobs or helping people reach the hospitals,” said Jessica Pourraz on January 9. “We are in Gaza, in the middle of everything, but we can neither reach patients nor do our work properly.”

While emergency wards in Gaza hospitals were short on surgical staff, as well as supplies, a five-person MSF surgical team was ready in Jerusalem but could not get the security guarantees needed to pass through the Erez Crossing.

Their emergency departments are overwhelmed by the influx of sick and wounded patients, especially at night,” said Cécile Barbou during a press conference on January 16. “It’s hell here. Even people carrying white flags are being shot at. It’s high time for the international community to organize, position itself, make decisions, and take the measures required to stop this conflict. This passive stance is unbearable, intolerable! This has got to stop. We are outraged.”

After ceasefires were separately agreed on January 17 and 18, MSF and other aid agencies were able to slowly bring more aid to civilians in Gaza. MSF logistics staff set up two inflatable medical tents that housed operating rooms and a 12-bed intensive care unit for the MSF surgical team in Gaza City.

The MSF team in Gaza, made up of 70 Palestinian staff and 12 international staff, resumed its full range of activities, including the post-operative clinics in Gaza City and Khan Younis and the pediatric clinic in Beit Lahia.

MSF “OUTRAGED”

MSF expressed strong criticism of the Israeli army’s assault on Gaza and of the international community for standing by while the incursion continued for 22 days.

“How far can the Israeli army go before the international community mobilizes to stop it?” asked Cécile Barbou during a press conference on January 16. “It’s hell here. Even people carrying white flags are being shot at. It’s high time for the international community to organize, position itself, make decisions, and take the measures required to stop this conflict. This passive stance is unbearable, intolerable! This has got to stop. We are outraged.”

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In addition to medical assistance, MSF tried to bring more attention to the situation of civilians in Gaza by speaking out publicly when it sees atrocities committed that have gone unreported. These atrocities were widely televised but nevertheless prompted little interference.

“Today, 1.5 million Palestinians in the Gaza Strip—almost half of them children—are the victims of incessant shooting and bombing,” said MSF head of mission Franck Joncret. “How can anyone believe that such a steamroller attack would spare civilians, who are prevented from fleeing and are crowded in a densely-populated enclave?”

EMERGENCY DESK

DRC: CIVILIANS UNPROTECTED FROM DEADLY ATTACKS

THOUSANDS IN DRC’S NORTHEASTERN HAUT UÉLÉ PROVINCE RECEIVE LITTLE ASSISTANCE AS THE LORD’S RESISTANCE ARMY SPREADS TERROR

Some 900 people have been systematically murdered in a string of brutal attacks across northeastern Democratic Republic of the Congo (DRC) since the end of 2008. The attacks were carried out in the country’s Haut Uélé Province by the Lord’s Resistance Army (LRA), a rebel group active in Uganda and Sudan for over two decades.

Doctors Without Borders/Médecins Sans Frontières (MSF) teams were able to provide emergency care to small numbers of people north of the town of Dungu, in the northeast of the province, in Faradje, Doruma, and Bangadi, by landing helicopters just long enough to treat wounded people and airlifting seriously injured patients to hospital. The attacks left few survivors and MSF was able to treat 17 people.

“When we arrived in Faradje two days after the attack, we found only four wounded people,” said Mathieu Bichet, an MSF doctor. “They were so gravely hurt that they had certainly been left for dead.” More than 140 people had been murdered. The LRA used bats, machetes, and knives to systematically murder children and elderly, women and men. They abducted hundreds of children into their group and looted and burned villages.

The series of attacks was in response to a joint military operation conducted since December 14, 2008, by the Congolese army–FARDC–the Ugandan military, and troops from southern Sudan to track down Joseph Kony, leader of the LRA. The operations and attacks have displaced tens of thousands of Congolese civilians in recent months, many of whom are cut off from assistance. Thousands have fled into southern Sudan, where MSF teams are assessing their needs.

CHRISTMAS ATTACKS

The brutality and destruction of what has been termed the “Christmas killings,” between December 24 and January 13, reached terrifying levels. On December 26 MSF received a radio call from a nurse in a small town south of Faradje reporting that thousands of people were streaming into the town, fleeing attacks. Unknown numbers of people had been killed and kidnapped; the head surgeon in Faradje had been killed and the hospital looted; the market and homes had been burned to the ground. This was reportedly in response to military targeting of LRA bases in Garamba National Park.

Clockwise: First two photos, MSF staff treats a child with a burn wound, Gaza 2009 © Frederic Sautereau/Oeil Public; MSF staff treat an injured child, Gaza 2009 © Mustafa Hassona;
As soon as security conditions permitted, an MSF team of Dr. Bichet, a nurse, and a project coordinator arrived in Faradje, bringing with them medical equipment for the hospital. A second plane from the nongovernmental organization Mission Aviation Fellowship arrived to evacuate the most seriously wounded. The team discovered only four people, barely alive.

MSF gathered rare testimonies from survivors who tell extremely disturbing stories of the Christmas attacks, including one man, called M.B., who witnessed the massacre of 60 to 70 people in a Batande village church on December 24. Six days later, he described what he saw to MSF staff at a clinic in Doruma, four and a half miles south.

According to his testimony, M.B. was working in his farm when he heard screaming and followed the sound to its source, where he witnessed his father being clubbed to death. He watched as a group of some 60 unknown men entered the village and surrounded a small church. “Although most of the men were surrounding the church, many others were taking the villagers out of the building one by one. They were quickly taken into the long grass and systematically executed, mostly by having their skulls smashed, but sometimes with an axe or a knife. This went on for what seemed like hours. Nobody was spared. Children, babies, pregnant women, old people, all of them were killed. More than 60 people.” Later, M.B. discovered that his own son and pregnant wife were among the dead. “There was nothing I could do.”

A Human Rights Watch team investigating the Christmas attacks reported more than 600 men, women, and children killed and 500 youths kidnapped.

MSF CALLS FOR PROTECTION

In February MSF called for MONUC—the UN peacekeeping mission in DRC—to uphold its role under a UN Security Council resolution mandating that its peacekeepers protect civilians. “MONUC must... take up its responsibilities and can no longer continue to be so absent among the inhabitants of Haut Uélé when they are being systematically attacked,” said Marc Poncin, MSF operations manager for DRC.

MONUC responded by saying that it needed reinforcements from peacekeeping troop-contributing countries because its resources were stretched thin in DRC’s North Kivu province and unable to protect the population in Haut Uélé, an area roughly the size of California. The majority of its troops are based in Ituri and Orientale provinces. Some 250 troops are in Dungu, Haut Uélé.

Some 533 people survived the dangerous journey from northern Somalia across the Gulf of Aden to Yemen on smugglers’ boats during one week in December 2008. At least 28 passengers did not survive the trip.

Desperate to escape the violence and hopelessness of Somalia, these passengers routinely arrive on Yemen’s southern coast after a two- to three-day journey. The risks they have taken to get there are huge: smugglers pack more than 100 people onto boats made for 30; and passengers arrive with reports of brutal treatment.

Contacts along the Yemen coast alert Doctors Without Borders/ Médecins Sans Frontières (MSF) when new arrivals appear on the beach and MSF responds with medical treatment, water, food, and basic mental health counseling. In 2008 MSF provided assistance to more than 7,000 arrivals.

The number of arrivals in January 2009 was 20 percent higher than at the same time last year.
“There were four smugglers: two treated us like humans; two treated us like goats—these two beat us,” one refugee said, adding that they used an iron bar to beat people who wouldn’t jump into deep water far from shore. He said that he and others left Mogadishu because it wasn’t safe anymore. “There were no nongovernmental organizations to help people there,” he said.

A 24-year-old Ethiopian woman is treated by MSF medical staff in Ahwar after she survived alone at sea for seven hours on December 1. She had been forced overboard from a smuggler’s boat and was separated from her one-and-a-half-year-old son and her sister. They had walked the beach looking for her among the dead bodies washed ashore.

Here a Somali man is examined by an MSF doctor in Ahwar. Before he boarded a smuggler’s boat for Yemen, he had fled to the outskirts of Mogadishu where hundreds of thousands of people have sought safety in camps, but the situation there was not much better. “We live under shelling everyday,” he said. “When I leave my house, I don’t know if I will return safely or if I will die. People are living in shelters that don’t provide protection against the rain and sand. We live a horrible life.”

Refugees rest and receive assistance from MSF staff at the roadside. Some of the arrivals said they had no idea how brutal the passage on a smuggler’s boat would be. Others said they did know the risks and were willing to take them, even bringing their children along. “They’re just waiting for a bullet or someone to rob and kill them or, for a woman, to be raped. For them, anything is better than what’s at home,” said MSF head of mission in Yemen, Andreas Koutepas. “They consider themselves dead anyway.”
MSF NAMES “TOP TEN” HUMANITARIAN CRISES OF 2008

The poster in this issue of Alert marks the 11th annual “Top Ten” list of the worst humanitarian crises of 2008. The photos featured on the poster represent two of these ongoing crises: the situations in Somalia and Zimbabwe. Read the full list, which also includes childhood malnutrition, Democratic Republic of the Congo, Ethiopia, HIV and TB co-infection, Iraq, Myanmar, Pakistan, and Sudan, and see this year’s media coverage of the list’s December 2008 release on our website at doctorswithoutborders.com/alert

ON THE MEDICAL FRONT

Ready-to-use food supplements (RUFs) can significantly reduce rates of the deadliest forms of malnutrition, according to the results of a study published in the Journal of the American Medical Association on January 21. The study took place in Niger in 2006 and 2007 during the period between harvests when children are most vulnerable to malnutrition and showed that children given RUFs in addition to their normal diet were 60 percent less likely to progress to the severe stages of malnutrition than those who were not given the supplements. MSF began using this preventative strategy in its projects in 2007. Readings of Somali refugees on the southern coast of Yemen in December 2008. During five days, 533 refugees arrived on the coast after surviving the journey across the Gulf of Aden on dangerously overcrowded smugglers’ boats.

PODCASTS

February: Hear a report from Democratic Republic of the Congo’s Haut Uélé province, where the Lord’s Resistance Army has conducted a string of brutal attacks. Also listen to a report on Zimbabwe’s larger humanitarian crisis, and hear about one day in the life of an MSF field worker helping to fight cholera in Zimbabwe.

January: Listen to a report from Gaza about MSF’s activities and the situation of civilians during the Israeli army incursion. And hear about two direly needed MSF maternal health programs: one in Port-au-Prince, Haiti, and one for Afghan refugees in Kuchlak, Pakistan.

December: Hear about three of the urgent crises MSF named in its “Top Ten” list of 2008.

SLIDESHOW

See a slideshow with photos of the landings of Somali refugees on the southern coast of Yemen in December 2008. During five days, 533 refugees arrived on the coast after surviving the journey across the Gulf of Aden on dangerously overcrowded smugglers’ boats.

ON DOCTORSWITHOUTBORDERS.ORG

RECRUITMENT INFO SESSIONS

Washington, DC: April 4, 2:30 p.m. EST
San Francisco: May 13, 7:00 p.m. PST

All prospective medical and non-medical aid workers are invited to attend a presentation, film, and question-and-answer session to learn more about how to work with Doctors Without Borders in the field. A recruiter will be on hand to discuss requirements and the application process.

For more information and to register for these events, go to doctorswithoutborders.org

JOIN OUR LEGACY SOCIETY

Doctors Without Borders’ Legacy Society is a group of special supporters who have chosen to remember MSF in their estate plans, helping to ensure our ability to deliver vital humanitarian aid for years to come. We invite you to join our Legacy Society by including MSF in your will or living trust. We also accept beneficiary designations on retirement plans, brokerage accounts, and life insurance policies.

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

To learn more about naming MSF in your will or other planned giving opportunities, please contact: Beth Golden, planned giving officer, at (212) 655-3771 or beth.golden@newyork.msf.org

STRENGTHEN YOUR COMMITMENT

MSF would like to thank all of our donors who have pledged to our Multiyear Initiative. With their annual commitments of $5,000 or more, these generous supporters provide MSF with predictable and sustainable funds, enabling us to respond effectively and rapidly to emergencies around the world and helping us to better plan for the future.

To date, we have received 80 pledges nearing $20 million towards the Multiyear Initiative. We invite you to join our Multiyear Initiative. To find out how you can participate, please contact Mary Sexton, director of major gifts, at (212) 655-3781.

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UPCOMING EVENTS & FUNDRAISING NEWS

CD TO BENEFIT PEOPLE OF DARFUR

Causes 2, a compilation CD to benefit the people of Darfur, Sudan, will be released on May 5 by Waxploitation records. The CD will include songs by Devendra Banhart, Grizzly Bear, LCD Soundsystem, and My Morning Jacket. All of the proceeds are distributed to MSF, Human Rights Watch, and Oxfam America. To order the CD or for more information, go to waxploitation.com/presorder

GRAPHIC NOVEL FOLLOWS MSF THROUGH WAR-TORN AFGHANISTAN IN 1986

The Photographer, a graphic novel that follows photographer Didier Lefèvre and an MSF team through northern Afghanistan in 1986, will be published by First Second Books in May. Illustrated by Emmanuel Guibert and designed by Frédéric Lemercier, the novel combines Guibert’s art with Lefèvre’s striking photographs. Led by French MSF nurse Juliette Fourraut, the MSF team with Lefèvre set out to assist Afghan civilians during the Soviet Union’s invasion. For more information, go to firstsecondbooks.com

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SNAPSHOT
An 8-year-old girl is examined by medical staff in an MSF isolation center in Western Kasai Province, central Democratic Republic of the Congo (DRC). She was brought there by her father who suspected she was a victim of an Ebola hemorrhagic fever outbreak in the area. The girl tested negative for Ebola. However, after confirming that she was malnourished, MSF staff sent her to a therapeutic feeding center. Due to the highly contagious and deadly nature of Ebola, staff must wear full protective gear in isolation centers.

MSF arrived in Western Kasai on December 23, 2008, after an outbreak of Ebola was declared. Some 48 people showed symptoms of Ebola and 14 people with suspected or confirmed cases died.

“Our work is structured around four main activities,” said MSF operations coordinator for the project, Luis Encinas. “First of all, we must isolate the patients, so they don’t infect anyone else, but also so they can receive palliative medical care. Meanwhile, others in the team go into communities to look for sufferers, and monitor people who have been in contact with infected patients. Then, there’s all the social mobilization work—in other words, raising people’s awareness of the disease, its symptoms, the modes of transmission and prevention methods. Finally, we must make sure that healthcare is free throughout the epidemic to remove the financial barrier to receiving care.”