SUDAN: The Conflict in Darfur Continues While Crisis Looms in the South
HUMANITARIAN ACTION

Darfur: A Disaster Unfolds

Dear Friends,

In September 2003, Doctors Without Borders/Médecins Sans Frontières (MSF) saw the first visible signs of the unfolding conflict in Sudan’s western Darfur region. An MSF emergency team was dispatched to assess the conditions of Sudanese refugees flooding into eastern Chad. The refugees were fleeing the fighting in Darfur. Around the Chadian border towns of Tine and Birak, MSF started treating refugees, vaccinating children, and feeding malnourished children.

It wouldn’t be until late December that four international MSF staff, including logistician Jean-Sébastien Matte and nurse Coraille Lecelle, would be allowed to have access inside Darfur. The pair headed to the town of Mornay, where they struggled to provide assistance and treat civilians wounded during attacks in and around the town. A mortality survey conducted by MSF’s epidemiological research center Epicentre in Mornay would later reveal that 1 in 20 people were killed in scorched earth attacks on 111 villages from September 2003 until February 2004.

Four years later, more than 2.4 million people have been forced from their homes in the region, according to the United Nations. MSF is still running its largest humanitarian aid operation in the world today to respond to the conflict with 2,000 MSF staff members working in the region and over the border in Chad.

What began as a war between two rebel groups—the Sudan Liberation Army and the Justice and Equality Movement—and the Sudanese government has now fragmented into a conflict involving dozens of factions. In this issue of Alert, we have an in-depth report on situation in the Darfur region and southern Sudan.

Just as the Darfur emergency was worsening, the 21-year civil war in southern Sudan was coming to a close. In 2005, the Comprehensive Peace Agreement (CPA) was signed between the Sudanese government and the Sudan People’s Liberation Movement (SPLM). In the past three years, an estimated 1.2 million internally displaced people and refugees have returned to the region.

In recent months, however, the conflict has threatened to reignite over territorial disputes that were never resolved by the CPA. MSF teams are responding to fresh outbreaks of violence, acute malnutrition, and epidemics. A tenuous peace is holding as a referendum for independence from the North is scheduled for 2011. MSF has called on governments, the UN, and other aid agencies to recognize that the people of southern Sudan still need humanitarian assistance.

It is your continued support of MSF and your belief in our principles of independent and impartial medical humanitarian action that allows us to maintain programs for people affected by conflict in Sudan and to respond to the needs of others threatened by epidemics, malnutrition, and natural disasters around the world. Thank you.

Sincerely,
Nicolas de Torrenté, PhD
Executive Director, Doctors Without Borders/Médecins Sans Frontières (MSF)
Doctors Without Borders/Médecins Sans Frontières (MSF) was among the first organizations to provide large-scale assistance to victims of Cyclone Nargis, which hit Myanmar and devastated the Irrawaddy Delta on May 3. But two months after the region was destroyed, MSF teams were still encountering villages where survivors had not received any significant aid.

“We managed to send our first team to Pathein, in the delta, on May 5, and started first aid to victims further south the next day,” says Dr. Frank Smithuis, MSF’s head of mission in Myanmar. With immediate mobilization of its Burmese staff, MSF was able to provide aid on a large scale from the start. About 250 local doctors, nurses, and logisticians were soon working in the delta. Teams traveled by boat from one village to another, bringing food, shelter, water, and sanitation material, and giving hundreds of medical consultations.

“From the moment we left the boat, the villagers would come and follow us around,” says a 27-year-old Burmese physician who worked during the first two weeks in Ngapudaw, in the western part of the delta. “They’d help us to find a house to do consultations and set up the distribution. We saw a lot of patients with stress symptoms—aching limbs and hypertension—especially in villages where the destruction is on a massive scale and many people had been killed by the flooding.”

The first relief supplies were purchased locally, and the need for a major influx of food and equipment was immediate. On May 12, the first of five MSF cargo planes was permitted to land in Yangon.
From May 5 to July 9, MSF provided:
- 5,826,156 lbs. of rice
- 1,362,320 lbs. of beans
- 202,390 liters of oil
- 151,302 packages of therapeutic ready-to-use food
- 216,679 lbs. of salt
- 64,111 packets of high-energy biscuits
- 50,159 lbs. of fish
- 186,611 rolls of plastic sheeting
- 183,196 mosquito nets
- 131,125 water containers
- 63,560 wool blankets
- 19,717 hygiene kits
- 10,865 bars of soap

Carrying a total of 500 tons of therapeutic food, plastic sheeting to build shelters, mosquito nets, pumps, and water treatment units.

Eventually, MSF teams were able to reach the southern central part of the delta. These remote areas and islands are accessible only by small boats or on foot. Villages there have been nearly erased from the map, and survivors are living in unimaginably harsh conditions. Emmanuel Goué, MSF field coordinator, returned in early June from Setsan, a five-hour boat trip south of Bogale, and described total devastation. “A giant wave during the cyclone simply flattened the area; 90 percent of the houses have been destroyed. We have there an estimated 21,000 people, including numerous children and elderly, who live in the middle of nowhere, in an ocean of mud. Everything has been broken and they have not seen any aid for one month.”

In relief operations such as this one, for a disaster comparable in scale to the 2004 tsunami, MSF would usually send to the field a large number of experienced international staff doctors, emergency coordinators, and water and sanitation experts. However, initial restrictions imposed by Myanmar authorities officially prevented foreign experts from working in the delta. MSF eventually received permission for eight international staff to carry out activities, but more experts were needed. In June, more travel authorizations for MSF staff were received.

As of June 4, MSF had provided support to 300,000 victims of the cyclone. At first, more than half the patients were treated for injuries, but very soon other pathologies linked to the dire living conditions dominated the consultations. MSF teams have seen a high number of respiratory infections and diarrhea cases, which could be linked to a lack of access to clean water, absence of shelter, and exposure to heavy rains.

“In many areas, especially where death rates have been high, we are seeing more and more people suffering from mental health problems,” says Alena Kosclova, MSF medical coordinator in Yangon. “Some can not talk anymore; others are highly depressed after they lost their loved ones. We will try to address this problem by giving trauma counseling and psycho-social support with mental health specialists.”

Food, shelter, and access to clean water remain the biggest needs in the delta. Food supplies have been largely insufficient, and people barely receive enough to survive, if anything at all. Displaced families have been moved into overcrowded camps set up by the government outside of urban centers, or in their villages where there is little assistance. Much remains to be done, and the emergency is far from over.

MSF staff treats a cyclone survivor in Bogale.
Myanmar 2008 © MSF

In the hard-hit Bogale area, MSF distributed food and provided medical assistance.
Myanmar 2008 © MSF
**EMERGENCY DESK – SICHUAN PROVINCE, CHINA**

**MSF Provides Post-Earthquake Assistance**

An 8.0-magnitude earthquake devastated parts of southwestern China's Sichuan province on May 12, affecting a densely populated area nearly as large as France.

An MSF team working in an HIV project in Nanning, Guangxi province, left that night for the provincial capital, Chengdu, and another emergency team was dispatched. While areas at the epicenter of the earthquake were inaccessible, MSF was able to start assessments of the immediate health needs in districts north of Chengdu. The teams found urgent needs for shelter, drinking water, and medical materials.

"In the assessed areas, a lot of houses have been destroyed and many people have lost their basic living conditions," Philip Tavernier, the MSF head of mission in China, said on May 16. "We will, therefore, send blankets, plastic sheeting, and hygiene kits from Hong Kong to the affected area. These materials are meant to restore basic living conditions for about 20,000 people."

The quake damaged many of Sichuan's hospital facilities, and services were overwhelmed by the numbers of injured people. MSF donated surgical material, perfusions, and dressing material to several Chengdu area hospitals and clinics.

An MSF team provided surgical and post-operative care at a temporary triage referral center in Guanhan city, treating some 70 wounded patients who were transported, many by helicopter, from some of the hardest-hit areas in the region.

MSF's medical activities also included treating and providing expertise in "crush syndrome" a potentially fatal condition in which muscle tissue damaged by severe internal injury may release massive quantities of toxins into the bloodstream and lead to kidney failure.

The local, regional, and national response to the disaster was rapid and enormous, and by June, MSF was focused on filling the gaps. With millions still homeless, the need for shelter remained dire. Within two weeks of the disaster, MSF distributed 4,570 family tents to earthquake victims.

Teams of MSF psychologists experienced in post-disaster trauma management also provided expertise and training to medical staff and started mental health programs in Pengzhou and Mianzhu cities. In Sichuan province, MSF continues to provide support and training for mental health, including community outreach.

Within two weeks of the disaster, MSF distributed 4,570 family tents to earthquake victims.

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An MSF doctor treats an earthquake survivor at a triage referral center in Guanhan, Sichuan Province. China 2008 © Joanne Wong/MSF

MSF-donated tents are loaded onto a truck at Chengdu airport for distribution. China 2008 © Kris Torgeson/MSF

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**EMERGENCY DESK – SICHUAN PROVINCE, CHINA**
SITUATION REPORT - DARFUR, SUDAN

Five Years of Fighting with No End in Sight

The conflict that began five years ago as a battle between Sudan’s government and two Darfuri rebel groups has developed into a far more complex disaster. While the large-scale, destructive attacks that marked the first few years of fighting are no longer frequent, Doctors Without Borders/Médecins Sans Frontières (MSF) sees a different kind of emergency developing.

Darfur remains the largest humanitarian aid operation in the world, with more than 80 organizations and 15,000 aid workers—2,000 of whom are from MSF. But some parts of the region are blocked from assistance due to insecurity or isolation. And in the current context of rapidly changing alliances among armed groups and increasing violence, still more people are at risk of being cut off from aid.

“The media attention and political involvement in Darfur means that everyone knows about the conflict here,” says Banu Altunbas, MSF head of mission in South Darfur, “but in the last four years, the situation has not improved. In fact, for most people, things have gotten worse. Conditions in many of the internally displaced person (IDP) camps and in rural areas have deteriorated, and the insecurity is a major concern for ordinary people. People are living in fear. Every day is a question mark for survival.”

DARFUR IN THE BEGINNING

The majority of the UN-estimated 200,000 violence-related deaths occurred during 2003 and 2004, after the Sudan Liberation Army (SLA) and the Justice and Equality Movement (JEM) rebel groups began fighting the Sudanese government and its militias, including nomadic fighters. This is also when most of the now 2.2 million displaced people fled their homes amid scorched-earth attacks.

“We are worried that the humanitarian effort will unravel because of insecurity.”
The first evidence of the violence came from Sudanese refugees pouring into eastern Chad. MSF teams were able to reach tens of thousands of these refugees in September 2003 and established clinics, carried out vaccination campaigns, and ran feeding centers for malnourished children.

It wasn't until late December 2003 when MSF was allowed to enter Darfur. A team began working around the West Darfur towns of Nyala and Zalingei, and later, Mornay. A survey by MSF's epidemiological research organization, Epicentre, found that most of the 80,000 IDPs who fled to Mornay between September 2003 and February 2004 came from villages where one in every 20 persons had been killed during attacks. People were fleeing burning villages and pouring into more secure areas, some of which would become IDP camps.

MSF logistician Jean-Sébastien Matte saw violence and human tragedy unfold along the side of the road leading to Mornay that would have been similar to many scenes in Darfur throughout that 2003-2004 period: "We drove through the villages of Tulu, Salulu, and Mara: all three were aflame. Fires were burning on both sides of the road. A group of 20 or so Janjaweed was firing into the air. We just hit the gas."

When Matte and an MSF nurse arrived at Mornay camp, "We received 80 wounded people, including children. People arrived with bullet wounds or beaten. Some had been whipped by the Janjaweed. At least 17 women had been raped." Matte and other aid workers on the ground in Darfur immediately found themselves surrounded by the most desperate kind of need.

A DIFFERENT DYNAMIC

The Darfur Peace Agreement, which laid out a plan for power- and wealth-sharing between Darfur and the government in Khartoum and made provisions for IDPs, failed when only one of the then three rebel groups signed it in May 2006; armed groups—rebels, nomadic tribes, government—
supported militias—proceeded to splinter and proliferate into about 30. Since 2005, neighboring Chad has been involved in a war by proxy with Sudan, with each country employing militias that fight one another. The result of all of this is that now dozens of armed groups are constantly fighting, creating alliances and enemies that change quickly and frequently.

Another element to this conflict is territorial disputes among different nomadic groups—not a new development, but a more dangerous one now that many of them have acquired a large number of deadly weapons. Nomadic groups who lose a dispute often must seek safety, like the millions who have lost their homes, in IDP camps.

Although large-scale attacks, like those that drove 80,000 people into Mornay, have subsided, there are exceptions. On February 8, 2008, a brutal raid in West Darfur’s northern corridor area was a cruel reminder of the early days of the conflict, with bombings, attack helicopters, and ground troops belonging to the government and government-supported militia, according to refugees who fled to Chad. Villages were burned and emptied, affecting about 50,000 people. MSF confirmed that at least 7,000 fled over the border to Birak, Chad, where the UN High Commissioner for Refugees (UNHCR) estimates there are now 200,000 Darfur refugees. Approximately 15,000 people disappeared.

“We saw the soldiers surrounding our town before they started looting our houses and setting them afire,” says an inhabitant of Selela, where MSF has run a health center since 2000. The MSF team’s compound in Selela, where some civilians had taken refuge, was attacked and looted; and people reported being attacked, threatened, and robbed while they fled the area to seek safety.

The arrival of international forces in January 2008 did not prevent that attack, nor has it had much of an effect otherwise. The United Nations African Union Mission in Darfur (UNAMID) has so far established a presence of only 9,000 troops, most of them existing African Union soldiers. The UN plan to protect Darfur civilians is projected to eventually include 20,000 troops and 6,000 police.

About one-third of the population of Darfur is displaced. More than 600,000 fled their homes to escape violence in 2006 and 2007, and 80,000 became displaced in the first quarter of 2008, according to the UN Office for the Coordination of
Humanitarian Affairs (OCHA). But the nature of IDP movements has changed since the start of the conflict; instead of sporadic mass influxes of people fleeing their villages, smaller groups of IDPs are arriving consistently.

“New families have been coming in regularly for a long time,” says MSF’s Saïd Ebrahim, who works in Zalingei camp in West Sudan. “They are continuous, less visible arrivals—a stream of varying intensity. Since December 2007 there has been another large increase; as many as one or two thousand additional displaced persons per month.” These arrivals say that they are coming to the camp because government troops are abandoning their villages, leaving them open to attack, reports Ebrahim.

Some also leave less secure, smaller IDP camps for larger ones. As insecurity grows on the roads and inside some villages and camps, people are migrating for safety and access to medical care.

MSF is assisting hundreds of thousands of IDPs in West, South, and North Darfur states, as well as refugees in Chad, providing primary health care, surgery, obstetric care, nutrition, mental health care, treatment for sexual violence, vaccinations, water, and sanitation and distributing necessary items such as blankets and jerry cans for water.

The numbers for recently displaced people do not include secondary displacements—when already-displaced people have to move yet again due to insecurity, threats, or orders. Some IDPs have had to move three, four, five times, or more.

Fatima, a woman living in Motorwat camp in the area of Muhajariya town with her husband and four children, told MSF that she and her family have had to move eight times so far, from town, to forest, to camp, and back again.

“Every time we moved, we lost our property. Even when Muhajariya was attacked and we moved outside into the bush and came back to Muhajariya two days later,” she says. “Sometimes, I get very tired of this, but if you do not move quickly, you will get killed, or you and your kids will get killed. I can’t get angry; even if I get angry, I can’t do anything.”

Large IDP camps are relatively secure—the safety in numbers, which does not exist in vulnerable rural villages or small camps—but tense ethnic and political divisions in some camps have developed into violence.

In October 2007, about 35,000 people were forced from Kalma camp, which shelters more than 100,000 people of 27 ethnic groups in South Darfur. Tensions among rival groups led to thousands of IDPs being evicted by other residents. A subsequent armed attack within Kalma led to the large-scale, violent expulsion.
MSF followed some of those who fled Kalma, many with nothing but the clothes on their backs; about 550 families were transported by the government to Sakali, an area near a garbage dump with no water or sanitation system, no food or shelter. MSF conducted mobile clinics and established clean water access there.

**INSECURITY THREATENS HUMANITARIAN AID**

"With increased violence, the number of areas people are being crowded into is getting smaller and smaller," says Vanessa Van Schorr, MSF operational manager for Sudan. "And we are worried that the humanitarian effort will unravel because of insecurity."

Civilians and humanitarian aid workers on the roads are targets for banditry in parts of Darfur; they are routinely robbed of cars, money, equipment, donkeys, wood, or other belongings. For aid organizations, carjacking has had a severe impact on their ability to provide aid. In the first three months of 2008 alone, OCHA reported the following actions against humanitarian aid workers: 3 deaths, 9 sexual or physical aggressions, 84 kidnappings, 75 cars robbed, 4 convoys attacked, and 3 arrests.

"Banditry has become hyper-endemic all over Darfur," says Fabrino Weissman, an MSF head of mission in Darfur. "As a result, in some areas, you cannot travel by road anymore because, sooner or later, you will be carjacked."

In some places, personnel must be moved by helicopter. But transport of most food aid, drugs, and equipment requires travel by road convoy, which leaves teams vulnerable to attack. The worst impact has been on the delivery of food distributions.

In April 2008, the UN World Food Program (WFP) reported delivery of only 50 percent of needed food aid to Darfur. Due to banditry, two food truck drivers were killed in the first half of 2008, 66 vehicles were hijacked, and more than 700 metric tons of food aid stolen.

For these and other reasons, including the steadily rising cost of food, distributions have not been keeping up with the increase in IDPs: in some cases, the aid system considers new IDPs fleeing insecurity to be economic migrants who do not qualify for food aid; and no newborns have been recognized to receive rations since 2004. Thus, food is becoming seriously
stretched. Families with ration cards for five might have three times that many mouths to feed.

About 10 new families arrive each month at Hamedia camp in Zalingei, South Darfur, where about 40,000 IDPs live. Raddia, an IDP, came to Hamedia five years ago, as did all the inhabitants of her village. She and her family numbered six people when they arrived, but the family has grown to 13 people, including two new babies and a cousin who joined them, bringing four of his family members. The WFP still considers Raddia’s family to be six, however, and they have not been able to receive more rations. In addition, food distributions to Hamedia have been infrequent, and rations have been cut.

“Since we arrived, we had regularly received all we needed: food, blankets, plastic sheeting... But this year, we have lacked water and food, and we have had no blankets, nor sheeting to remake the shelter. For 40 days, there was no food distribution and we just received a reduced ration... no oil, nor lentils, and less sugar and millet,” she says.

Cutbacks and blockages in food and medical aid could not come at a worse time. In 2007, MSF treated twice as many children for malnutrition as the previous year; between September and December 2007, 1 child in 10 was treated in MSF’s nutritional program. In Zalingei hospital, the number of severely malnourished children—those in immediate danger of dying—rose from 419 to 700, and global malnutrition in Darfur has exceeded the emergency level of 15 percent.

**AFFFECTED POPULATION AND HUMANITARIAN ACCESS**
(AS OF MARCH, 2008)

**MSF IN DARFUR TODAY**

There are 2,000 national and international MSF staff currently working in Darfur. MSF is present in all three Darfur states and over the border in Birak, Chad, where 200,000 Darfuri refugees have sought safety. At IDP camps throughout the Darfur region, MSF provides assistance to thousands of people every month, treating malnourished children, holding mass vaccinations, providing pre- and antenatal care and help for obstetric emergencies, treating victims of sexual violence, and performing surgery for trauma patients. MSF also carries out water and sanitation activities, distributes items such as plastic sheeting and blankets, conducts mobile medical clinics to reach isolated populations, and offers mental health care.
TIMELINE

MSF Response to Darfur Emergency

2003
February: The Sudanese Liberation Army (SLM/A) and Justice and Equality movement (JEM)—rebel groups in western Darfur—rise up claiming that the region is being neglected by Khartoum.

April: First refugees begin arriving in Chad.

May: Sudanese government forces and government-backed paramilitary forces carry out widespread attacks against civilians, accusing them of supporting the rebellion in Darfur.

September: MSF sends an exploratory team to assess the condition of Sudanese refugees flooding into eastern Chad. Refugees have little or no access to food, potable water, or shelter.

MSF opens therapeutic feeding centers for severely malnourished children and health centers in eastern Chad for refugees.

December: Among one group of 10,000 internally displaced persons (IDPs) gathered in and around Nyala, South Darfur, MSF estimates that children under 5 are dying at a rate of 10 per day—six times the death rate used to designate an emergency. MSF team provides basic food assistance and health care services to the population.

2004
January: Repression of the rebel uprising in western Darfur leads to hundreds of thousands of refugees fleeing to Chad. UN estimates more than 700,000 IDPs and an additional 140,000 refugees in Chad.

February: On the 16th, bombing stops around Mornay. MSF team treats 300 severely malnourished children, provides supplementary food to 1,200 more, and a water and sanitation team is able to provide 10 liters per person per day to the population.

July: In third week of July alone, MSF treats 92 victims of violence—many sexually assaulted, abducted, or held hostage—at clinics throughout Darfur. Across Darfur, MSF treats some 10,000 malnourished children and performs almost 12,000 medical consultations a week.

October: MSF measles vaccination campaign launched in eastern Chad. Nearly 27,000 children vaccinated in Kebkabiya, North Darfur, alone.

2005
March: Faced with hundreds of women and girls seeking medical care as a result of sexual violence, MSF publishes a report: "Crushing Burden of Rape: Sexual Violence in Darfur, Sudan."

May: Following the release, two senior MSF international staff arrested by Sudanese authorities and charged with "publishing false information, undermining Sudanese society and spying."

June: The Sudanese government drops the charges and releases two MSF staff.

2006
January: With a reported 2.1 million people dependent on outside aid, MSF maintains 170 international and more than 2,600 Sudanese staff working in 18 locations in Darfur.
April: The World Food Program (WFP) announces a halving of its food allocations for IDPs because of funding shortfalls. WFP receives increased funds after this announcement but is still unable to provide full food distributions.

May: The Sudanese government and one faction of the SLM/A sign the Darfur Peace Agreement. Other rebel groups reject the deal. Fighting continues.

An attack in Labado, South Darfur, brings 46 injured in a truck to MSF's clinic in Muhajariya on May 8. Many require surgery; some describe family members shot down before their eyes.

June: On June 16, 10,000 people, Chadians and Sudanese refugees, flee attacks on villages in southeastern Chad for camps around Um Dukhun, South Darfur. MSF provides medical care, vaccinations, and plastic sheeting.

December: An armed attack on Goroila camp in South Darfur includes brutal raids on NGO compounds; a worsening trend of violence against aid workers continues.

2007

January: Sharp increase in severe malnutrition cases admitted to Zalingei hospital's nutrition center—700 children, compared to 419 in 2006.

August: MSF starts work in Tawila, where close to 35,000 IDPs have gathered in three camps and have been without health services since April. Project is halted because of robbery of MSF's office.

September: Heavy flooding—the worst in decades—leaves more than 250,000 people homeless.

Twelve members of the African Union force are killed in Haskanita, North Darfur, in one of the deadliest attacks to date.

MSF opens two outpatient nutritional centers in Zalingei, one in Hamedia camp and one in Hassa Issa camp, responding to an increase in severe malnutrition.

October: Heavy fighting in Kalma camp forces 25 percent of population to flee. MSF medical teams follow refugees and provide medical care and relief supplies.

November: The UNAMID force takes the reins from the African Union.

2008

January: Government planes bomb rebel positions in West Darfur.

February: Fresh aerial bombings in western Darfur, affecting at least 50,000 people and disrupting all MSF medical activities in Selea.

May: Darfuri rebel group JEM leads an attack on Khartoum, but are defeated. Sudan cuts diplomatic ties with Chad.

June: MSF holds the first distribution of supplementary ready-to-use food for malnourished children at Zalingei IDP camp, West Darfur, for 11,500 children.
Dying in Peace

For 21 years, the south of Sudan was the country's hotbed of conflict. A civil war with the North resulted in an estimated two million people dead and four million driven from their homes. In 2005, the Comprehensive Peace Agreement (CPA) was signed, formally ending the war. But today, southern Sudan, where Doctors Without Borders/Médecins Sans Frontières (MSF) is present in more than a dozen villages and towns with about 130 international and 1,300 national staff, is facing an increasingly dire situation.

While the conflict has subsided enough for an estimated 1.2 million internally displaced people (IDPs) and refugees to return to the region, violence has flared up again, its roots in territorial disputes that were never resolved by the CPA. With elections slated for 2009, and a referendum for independence from the North scheduled for 2011, the future is increasingly uncertain.

And while vast numbers of people are coming home to an environment that is decidedly less violent than the one they fled, these returnees and those who did not leave are facing severely strained health care resources. Public services, including health care, education, roads, and water and sanitation, were barely developed in southern Sudan before the civil war began in 1986, and the region has not made great progress since then.

“I have been to other war zones, but at least after the war there was something to go back to,” says Martin Braaksma, MSF head of mission in southern Sudan. “And I think...”
that’s a very big difference in southern Sudan. Because it’s not just rebuilding a country; it’s building a country. There is nothing in place.”

Malnutrition is especially worrying; maternal mortality rates are among the highest in the world; tuberculosis and kala azar are ongoing problems; and large-scale outbreaks of meningitis, measles, cholera, and malaria are common. Another major concern is food insecurity: the World Food Program (WFP) has made cutbacks in food aid and delivery trucks often cannot enter unstable areas; the price of food is rising; and major floods in 2007 destroyed much of the crops in some areas.

In the midst of all this, humanitarian aid is conspicuously lacking. Some major donors have redirected their funds to development after the signing of the CPA because, supposedly, the emergency in southern Sudan is over.

**SPORADIC VIOLENCE AND DISPLACEMENT**

An issue the CPA did not resolve is whether certain oil-rich areas are part of northern or southern Sudan. The region to which these areas rightfully belong will reap the economic benefits.

At the end of 2007, fighting broke out between the armed forces for southern Sudan and northern-backed militia in an oil-rich area near the town of Abyei, where MSF supports a hospital and a therapeutic feeding center for malnourished children.

In February 2008, after an extremely violent attack in this area, thousands of new IDPs gathered in three sites: Mathiang Dot Akot, Leith, and Rumerol in Northern Bahr-el Ghazal State, and an estimated 10,000, possibly more, dispersed into the bush.
On May 14, fighting broke out in Abyei between the North's armed forces and the southern rebel group Sudan People's Liberation Army (SPLA), virtually destroying the town and driving nearly the entire population north and south to seek safety.

An estimated 60,000 people are now displaced. By late May, only some of the 700 malnourished children MSF had been treating in Abyei had been relocated; in early June, an MSF team, including a surgeon, were treating wounded in accessible towns near Abyei and providing water and shelter for those refugees who had to flee their homes with absolutely nothing.

"They showed me their only resources: leaves and small nuts gleaned from the bush."

**RISING MALNUTRITION AND MATERNAL MORTALITY**

When MSF was able to arrive at one of the IDP camps, people had been there for a month without receiving aid, and 20 percent of the children were malnourished.

"When I met these families... I was struck by their despair, which bordered on aggression," says Gabriel Trujillo, an MSF program manager in Sudan. "In the Mathiang Dot Abot site, we were surrounded by men, women, and children who were slapping their stomachs and holding their fingers up to their mouths to express their hunger in a universal language. They showed me their only resources: leaves and small nuts gleaned from the bush."

MSF opened therapeutic feeding centers in the state capital, Aweil. By the end of July, MSF teams were treating nearly 5,000 children, almost half of whom were displaced or recently returned.

There is a fledgling health system developing in southern Sudan with oil revenues and donor funding, but it has a long way to go before it can serve the region's eight million people. While funding and attention are decidedly on development instead of meeting the current health needs, populations will remain dependent upon aid organizations, including MSF.

Meanwhile, the health needs are many. Pregnant women die at a rate of 2,053 for every 100,000 live births, according to the World Health Organization, about 200 times the number of maternal deaths in the US. "A girl is more likely to die in childbirth than she is to finish primary school in southern Sudan today," says Vanessa Von Schoor, MSF operational manager for Sudan.

Women tend to deliver at home and, if the birth becomes complicated, there is often no medical facility nearby; too frequently, by the time a woman arrives at a facility, it's too late. There is also the problem of medical staff not having the training to perform a C-section, which can mean the difference between life and death during complicated deliveries.

In 2007 MSF saw 6,800 women for antenatal care, compared to 2,500 in 2006. In Aweil, MSF has set up a referral system throughout the state that could avert 250 maternal deaths this year.

**RESPONDING TO EPIDEMICS**

With its harsh environment, southern Sudan is subject to frequent epidemics. In 2007 MSF treated 2,113 people and vaccinated more than 630,000 for meningitis, while also responding to several outbreaks of cholera. MSF also ran measles vaccination campaigns and treated populations for outbreaks of malaria, pneumonia, and diarrhea.

One of the region's biggest killers is TB, and MSF has set up "TB villages" where infected women can receive treatment for the required six to nine months while their children are put on prophylaxis so they do not become infected. However, there is not nearly enough coverage for TB treatment. Similarly, MSF estimates that only half of the people suffering from kala azar, a potentially deadly parasitic disease, receive treatment for it. Though the toll from HIV is not known, MSF offers testing and treatment at several projects, and there is concern that populations returning from other areas could bring it back with them.

**HOPES AND FEARS**

The instability of southern Sudan's future has not affected the stream of returnees. They continue to come back after many years, perhaps hoping for a better future.

"I think there's hope that, since the civil war has stopped for three years and the country is starting to establish itself, they're going home and they have a skill set that they can come with to help and rebuild," says Von Schoor. "There is hope that they can live safely back home again."

**OPERATIONAL OUTLOOK - SOUTHERN SUDAN**
However, she says, “Sudan is where we’ve seen some of the worst famines in the past. Our experience has been that when you are looking at famines, it’s never just one cause, usually. It’s this combination of factors with high prices and insecure distribution routes, and we’re seeing a couple of these key elements starting to come up, and it’s a concern.”

As day to day life continues precarious and needs continue to multiply, MSF finds itself increasingly alone in providing emergency medical aid. In 2007 the number of MSF patients increased by 40 percent, and many projects are operating at maximum capacity in the face of more and more need. At the same time, insecurity further compromises the ability of aid groups to stay in the region.

“Our concern,” says Von Schoor, “is that we’ve been working hard treating all these people, and now we’re looking at the numbers, going, ‘No wonder we’re exhausted and overwhelmed.’ We can’t do it on our own.”

OPERATIONAL OUTLOOK – SOUTHERN SUDAN
FIELD JOURNAL – PIBOR, SOUTHERN SUDAN

"Human love in the face of great challenges"

Deborah Van Dyke, a nurse practitioner from Vermont, was in the village of Pibor in southern Sudan’s eastern Jonglei State from January to April 2008, overseeing all of MSF’s medical programs there. She also trained locally hired staff to take on increasing responsibilities, responded to medical emergencies, and prepared a mass trauma triage system for an area where, three years after the official end of the North-South civil war, health structures other than MSF’s do not exist and peace cannot be taken for granted. Here, she describes her experience.

In addition to running the main medical facility in the village of Pibor, we also ran two clinics that were located in opposite directions from the village. To support the staff working at these outposts in Gumuruk and Lekonge, a nurse and a logistician would leave Pibor to visit them weekly, driving an hour and a half over a rut-filled road that was difficult to navigate in the dry season and impassable in the rainy months, when MSF used a boat instead. Some patients always traveled with them, so in the morning, I got everyone ready and made sure they were boarded, along with the necessary drugs and vaccines, to be on their way by 7 a.m.

People wait for consultations at MSF’s Pibor medical facility. Sudan 2008 © Gloria Chan/MSF
The people of Pibor didn't seem to mind the horrible state of the roads. They walked where they needed to go, but the lack of infrastructure made supply transport difficult, and basic health care was beyond people's reach, except where MSF offered it.

I spent the mornings on medical rounds at the main compound's inpatient department. Then I would survey the tuberculosis program and the outpatient department, which included a therapeutic feeding program for malnourished children. We saw twice as many cases of malnutrition this year, compared to last, because it had been a particularly bad harvest. At any given time, about 100 patients were in the program.

It's hard to describe my work in Pibor because telling it day to day doesn't give the sense of all the details involved and everything that's happening at once. We were constantly training staff; we were reorganizing the pharmacy; and then there were the medical emergencies.

MEMORABLE PATIENT STORIES

We had many ordinary success stories of malnourished babies gaining weight, good pregnancy outcomes due to timely referrals, and patients treated for malaria, tetanus, or snake bites. To me, though, the most memorable patient stories are not always those with ideal outcomes, but those that demonstrate human love in the face of great challenges.

I think of an eight-year-old girl brought to us too late, already with brain damage possibly caused by meningitis. During her month at our facility, we treated her with antibiotics and taught her father how to exercise her limbs to prevent contractures. He never showed discouragement or loss of hope. He spent the days putting her limbs through the motions, holding her all the time, carrying her to the latrine, and tube-feeding and washing her. Eventually we took them back to their village near our outreach clinic, with her feeding tube still in place. They will need to continue the same care at home for the rest of her life.

We admitted a boy, about the same age, to our inpatient department with an enlarged liver, wasting, and a bacterial disease called brucellosis. He required a blood transfusion, and his mother was the only relative nearby. The others lived an eight hours' walk away. To make sure that he had two possible blood donors, someone left in the late afternoon to notify the family, and another relative arrived by morning. He had walked through the night to help save this little boy's life.

PREPARING FOR THE WORST SCENARIO

During my time in Pibor, we received patients wounded from violence no more than a few times a month, but we can't take this measure of stability for granted. When I left, Pibor was surrounded by armed Sudan People's Liberation Army (SPLA) troops, and a disarmament process was looming.* In other towns, disarmament has led to heavy fighting, so we could receive hundreds of wounded if it happens there.

For that reason, we set up a mass trauma system, so that staff will know what to do if that happens. We did a run-through so that the person following me as the next medical focal point could see it in action. I divided the medical staff into color-coded teams; and the cooks, cleaners, and logisticians played the role of patients and patients' families. I told them, "I'm going to assign you a problem, and you need to be very realistic, acting like it's your problem, and all the family members need to be unruly."

Everyone really acted his part and it went great. The new medical team leader and I did triage, giving colored cards to all the so-called patients. Stretcher-bearers brought them to different places in the hospital, and medical staff laid the supplies on the bed of each patient, to see if they had everything they would need. In the following days we filled small gaps in the plan. For example, there were many fractures in the practice and the local staff didn't know how to do casting, so we trained them.

The future of the project just depends on what happens in southern Sudan in the lead-up to the referendum between the North and South, now set for 2011. In the meantime, we can continue to train staff and prepare for what we can.

* Disarmament began on June 4, and at the time this story was published, there was no resultant violence.
The Sudanese Conflict

Doctors Without Borders/Médecins Sans Frontières (MSF) recently published From Ethiopia to Chechnya: Reflections on Humanitarian Action, 1988-1999, a collection of essays by François Jean (1956-1999) translated by Richard Swanson. Jean contributed enormously to the field and at headquarters to the evolution and direction of MSF for nearly two decades. 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.

Throughout his time with MSF, Jean wrote prolifically about the difficulties and challenges faced by humanitarian aid workers in a shifting political landscape. Over the course of this year, excerpts of Jean’s collected works are appearing in Alert. This second excerpt is a portion of “The Sudanese Conflict,” which was originally published as an interview in Catholica, a French journal, in February 1993. His description here of Sudan’s violent history sheds some light on the region’s current, deeply rooted problems.

Displaced people seek safety from the violence between northern government-supported forces and southern rebels in south Sudan. Sudan 1993 © MSF

Learn more about François Jean; read From Ethiopia to Chechnya: Reflections on Humanitarian Action, 1988-1999 online; and order the book at doctorswithoutborders.org/alert
Catholicia: For brief periods, Somalia and Bosnia made the ratings jump. Not so with Sudan. Is there nothing special at all going on there?

François Jean: Since 1983 the country has been devastated, once again, by war. Sudan has actually been through a series of wars, each rooted in the deep ethnic, religious, and historical cleavage between the Arab-Muslim north and the black-African south, which is mainly Christian and animist. The south has always been in a sense disadvantaged economically—not to mention being robbed, in a sense, by people in the north with no desire to share the nation’s resources.

The first war broke out even before the country’s independence in 1955 and lasted until 1972, the year the Addis Ababa accords were signed. Then there was a period of respite, but this was relatively brief. Fighting set in again as early as 1983; just recently it has reached such a level of intensity that it is now reasonable to speculate if it is not tantamount to genocide. The number of victims is estimated at about 10 percent of the south’s population—or roughly six hundred thousand people out of six million.

There have been three overall phases in this exceptionally bitter war. In the first, the conflict was “normal,” although it did bring about major population displacements. The second, so-called “democratic,” phase coincided with the coming to power of Sadek al-Mahdi. The new regime formulated a strategy based on exploiting ethnic antagonisms, and their first step was to arm tribal militias. There has always been friction between the shepherds of the north and those of the south, taking the form of raids and cattle theft. The regime deliberately stoked these antagonisms, arming a group of Islamized nomads known as the Baggara to do battle with those in the south who allegedly—and this is not entirely untrue—provide the base of support for the Sudanese People’s Liberation Army (SPLA) created in 1983 by John Garang, then an officer in the Sudanese Army. This was a period of large-scale massacres, of which little was really known because they occurred in a remote, hard to reach region. Also, it must be added, there was a very serious famine following the 1988 drought that, unlike the famine in Ethiopia, has never been discussed.

A new phase began in 1989 when, to everyone’s surprise, the National Islamic Front came to power. The Egyptians, in any case, greeted the change with clear satisfaction, believing the new regime would be ready to negotiate an end to the conflict. But the reality was entirely different—it turned out to be no more than an Islamist takeover of power led by Hassan al-Turabi. Instead of being abandoned, the previous regime’s use of tribal militias instead became more widespread.

At this time, a policy of mass deportation was implemented, as well, with the aim of transforming the nation’s ethnic and religious balance. Over a million and a half people fleeing war in the south gravitated to the outskirts of Khartoum, seeking a measure of security and some means of subsistence. Under the pretext of urban planning and environmental conservation, the government targeted shantytowns, clearing them with bulldozers. The now-homeless inhabitants were forcibly transferred to the desert.

—Interview by Stéphane de Pétiville in 1993
MSF RESPONDS TO THE EARTHQUAKE IN CHINA

MSF field coordinator assistant Liang Jiaxiong was in Guangxi province when an 8.0 magnitude earthquake shook Sichuan province to the north. In this audio slideshow, Liang describes arriving in the destroyed area and how MSF provided assistance to the population.

DARFUR: FIVE YEARS OF FIGHTING

This interactive Darfur timeline provides links to MSF Field Reports, press releases, multimedia and more.

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

Yangon, Myanmar: “People tell stories of spending the night of the cyclone hanging onto trees all night long,” Souhei Reutiche, MSF’s head of mission in Yangon, talks about what he saw and heard in cyclone-stricken Irrawaddy Delta.

Abyei, Sudan: “They only have the clothes they were wearing when the fighting started.” Nearly the entire population of Abyei fled north after fighting in May. Andreas Popp, MSF field coordinator, describes the population’s dire situation.

ON THE MEDICAL FRONT

“Second-line antiretroviral therapy in resource-limited settings: the experience of Médecins Sans Frontières,” published in the journal AIDS, presents new MSF medical research on the outcomes and survival factors for patients switched from first- to second-line antiretroviral treatments. The collected data comes from more than 60 MSF HIV/AIDS projects in 26 countries between 2001 and 2006.

PODCASTS

June: Hear why pharmaceutical R&D is failing millions of people; how MSF is assisting Myanmar’s Rohingya refugees in Bangladesh; and MSF’s response to the nutritional emergency in southern Ethiopia.

May: MSF’s emergency updates on the humanitarian situation in Myanmar following Cyclone Nargis.

April: MSF conducted a study on measles outbreaks in Niger; hear how a South African mother and her baby fought a deadly form of TB; and how thousands are waiting for peace in southern Sudan.

March: Listen to an MSF report on the situation in Darfur, including an MSF nurse’s personal account of assisting victims of unexploded ordnance.

SLIDESHOW

South Africa: MSF Aids Migrant Population Displaced by Violence

When violence aimed at foreign nationals broke out in Johannesburg and Cape Town, MSF provided medical assistance to people who sought refuge in police stations, community halls, and churches.
MSF LAUNCHES 2008 NORTH AMERICAN TOUR OF "A REFUGEE CAMP IN THE HEART OF THE CITY"
This fall, MSF will take its outdoor educational exhibit, A Refugee Camp in the Heart of the City, to eight cities in western Canada and California. A list of cities and dates are below. At each location, MSF will host panel discussions, recruitment events, and other public activities. Visit doctorswithoutborders.org/refugeecamp for details.

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

US CITIES
- San Francisco, Little Marina Green Park: October 15-19
- Los Angeles, Crystal Springs Picnic Area at Griffith Park: October 22-27
- Santa Monica, Parking Lot 1 North, Santa Monica Pier: October 31-November 2
- San Diego, Presidents Way Lawn, Balboa Park: November 6-9

PUT YOUR IDEALS INTO PRACTICE: ATTEND AN MSF RECRUITMENT INFORMATION SESSION
Every day, MSF field staff from around the world work alongside locally hired staff to assist people struggling to survive amid armed conflicts, nutritional crises, natural disasters, and epidemics—regardless of political, religious, or economic interest. Prospective medical and non-medical aid workers are invited to join us for a presentation, film, and question and answer session to learn more about how you can become part of MSF's field work. For more information, and to register, visit doctorswithoutborders.org/volunteer/recruitment.cfm

RECRUITMENT INFO SESSIONS
- Anchorage, AK: Thursday, August 14
- Seattle, WA: Tuesday, August 19
- New York, NY: Thursday, August 28
- Boulder, CO: Tuesday, September 9

PANEL DISCUSSION
"Starved for Attention: The Neglected Crisis of Childhood Malnutrition" will be held in New York, September 10.

HAVE YOU CONSIDERED INCLUDING MSF IN YOUR ESTATE PLANS?
With the support of loyal friends like you, MSF is able to provide urgent medical care for people in great need. Please 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:
Beth Golden, Planned Giving Officer, at (212) 655-3771 or plannedgiving@newyork.msf.org.
Violence aimed at foreign nationals broke out in Johannesburg, South Africa, on May 11 and spread into Cape Town days later, displacing an estimated 100,000 people and wounding thousands. Patients affected by the violence suffered gunshot wounds, head traumas, wounds resulting from beatings, lacerations, burns, and other injuries. MSF treated the displaced where they gathered for safety—in police stations, churches, and community halls. The MSF physician in this photograph spent the evening consulting with people living in and around a police station. These shelters quickly became overcrowded and unsanitary; people slept inside crowded masses or outside the buildings, vulnerable to attack, as well as the elements.

MSF worked to provide immediate emergency medical assistance and established a regular presence with mobile medical teams in 15 sites. As of late June, MSF had treated more than 4,000 patients and distributed 10,700 blankets, 8,600 hygiene kits, and 1,300 square meters of plastic sheeting. "Our patients have already been traumatized by the violence they have suffered and the abhorrent conditions of displacement," said MSF nurse Bianca Tolboom.