SRI LANKA - WORKING TO BRING AID AMID OVERWHELMING NEED
Dear Friends,

This edition of Alert comes to you in the aftermath of major violence and upheaval for civilians in northern Sri Lanka. Many were killed and injured during the first months of this year in a war between the Liberation Tigers of Tamil Eelam and the Sri Lankan army.

A narrow strip of jungle and beach in the northeastern Vanni area was transformed into a devastating conflict zone where hundreds of thousands of civilians were trapped under heavy fire. Doctors Without Borders/Médecins Sans Frontières (MSF) and other aid agencies had been forced to leave the Vanni in September 2008 by Sri Lankan authorities. That left people with little or no access to medical care.

Many of those who escaped and needed urgent treatment reached the region’s main hospital in the Vavuniya district, 50 miles south of the conflict zone, with injuries caused by bullets, landmines, and other explosives. MSF teams worked around the clock alongside Ministry of Health medical staff to save as many lives as they could. In May, the 450-bed Vavuniya hospital saw its patient load rise to 1,900 patients.

In recent years, we have witnessed a worrying trend of gross disregard for the protection of civilians during armed conflicts, and a lack of access for humanitarian organizations to provide lifesaving assistance. You will find more details about the challenges of delivering impartial and independent assistance in Sri Lanka in this issue of Alert. You will also find an article about MSF’s activities more than 20 years ago in Afghanistan, another war zone where civilians were trapped with little access to humanitarian assistance. The Photographer is a critically acclaimed graphic novel about photographer Didier Lefèvre’s time with MSF’s medical teams in Afghanistan during the Soviet invasion. A primary figure in his story is Dr. Juliette Fournot, a founding board member of MSF-USA. We invite you to take this opportunity to learn about Lefèvre, who sadly passed away in 2007, and about the courageous MSF medical teams who crossed the mountains of eastern Afghanistan to bring urgent medical assistance to civilians injured in the Soviet bombings.

While it is frustrating that in many ways things have not changed for so many people, we know that our presence, our medical action, and our commitment—all possible due to your support—have offered millions of people a lifeline, and very often a reason for hope.

Sincerely,

Sophie Delaunay
Executive Director,
Doctors Without Borders/Médecins Sans Frontières (MSF)
More than 77,000 traumatized and exhausted civilians poured out of Sri Lanka’s conflict zone in May after being trapped for months on a narrow strip of jungle and beach under nearly constant artillery fire and bombardment. Thousands leaving the Vanni had shrapnel, gunshot, or landmine injuries, while others were malnourished and dehydrated. At Omanthai, the main crossing point for about 10,000 people every day for five days, Doctors Without Borders/Médecins Sans Frontières (MSF) medical teams performed triage. MSF staff identified and immediately treated hundreds of the most seriously injured—still only a fraction of those who needed medical attention—and transferred many of them to Vavuniya hospital, 50 miles to the south.

“We treat as many people as we can directly on site because the hospital is more than full,” said MSF’s Dr. Alexa ter Horst. “It is always a difficult decision to make: treat on site, or let them go to the displaced persons camps with the follow-up that can be provided there, or send them to the hospital, where there are already four patients to a bed.”

OVERWHELMED WITH SEVERELY WOUNDED PEOPLE

In mid-May 2009, the 26-year civil war in Sri Lanka came to an end after the Sri Lankan military cornered the Liberation Tigers of Tamil Eelam in the northeastern Vanni area. By May 20, Vavuniya hospital, a Ministry of Health facility where MSF medical staff worked side by side with government health staff, became overwhelmed with admissions. The 450-bed hospital was holding 1,900 patients.

“I’ve been doing around 30 surgical procedures per day over the last few days. Normally, I would do five,” said Dr. Matthew Deeter, one of four MSF surgeons working at the hospital. “We sometimes work together on the same patient; one is amputating the leg and the other is amputating the arm.”

SITUATION REPORT

SRI LANKA: CIVIL WAR ENDS, BUT NEEDS REMAIN

Some 7,000 civilians were killed and 300,000 displaced between January and the end of the war in mid-May, according to United Nations estimates. Yet in September 2008, MSF and other international aid agencies were ordered to leave the Vanni, just prior to the escalation in fighting. This left the International Committee of the Red Cross (ICRC) as the only international aid agency allowed into the war zone, where Sri Lanka’s doctors struggled to keep hospitals functioning.

The ICRC, as well as the government, evacuated thousands of wounded civilians over several months when breaks in fighting allowed, transporting many of them to MSF’s surgical program at Vavuniya hospital. Frustrated at being unable to enter the war zone to evaluate the medical needs of the civilians trapped there, MSF called upon both sides of the conflict to uphold their responsibility to ensure the safety of civilians and to allow access to humanitarian assistance.
Or one is taking care of wounds in a foot and the others are treating chest wounds.”

This was not the first time during the recent fighting that Vavuniya hospital had been over capacity with war-wounded patients. On April 21, some 60,000 civilians managed to escape the Vanni and hundreds of severely wounded children, women, and men were in dire need of assistance. Over a 36-hour period, medical staff treated 400 patients with life-threatening injuries. Within two days, 1,700 patients were sleeping on mattresses on the floor, in hallways, and under beds occupied by other patients. MSF surgeon Dr. Paul McMaster and his colleagues had been working without pause to treat the constant influx of patients. “These are deeply, deeply traumatized people,” he said on April 22. Nearly every patient had lost family members to the violence or did not know where their families were, he said, including many children. “We’re seeing children that have no parents with them. We had a little boy with a blast amputation of his leg; I think he’s about five, and he’s being looked after by his big brother, who’s about seven. We don’t know where the parents are or whether they’re even alive. But these two little children are in the middle of a very traumatic hospital setting on their own.”

The massive increase in patients meant that staff at the hospital were stretched thin and the quality of post-operative care suffered. Doctors, nurses, and others were working 24 hours a day treating so many people that it was difficult to move inside the wards, said Dr. McMaster. “There are simply too many people to treat them all; we are not able to save some people because we need to provide more aftercare. There are simply not enough nurses.”

**HUGE NEEDS CONTINUE IN CAMPS**

In the 43 displaced persons’ camps run by the government, the trauma and needs continued. There were reports of chicken pox breaking out due to people’s extremely weak immune systems. MSF had limited access, but was able to distribute supplementary food to children under five, pregnant and nursing mothers, and other vulnerable groups in five of the camps around Vavuniya.

MSF head of mission in Sri Lanka, Annemarie Loof, described the camps. “The camps are surrounded by two rows of barbed wire, with about six feet...
between them. People outside and inside look at each other, trying to recognize relatives. There are no lists showing who is living in which camp. The people are not allowed to leave and they cannot have contact with the outside world.”

People inside the camps were desperate, said Loof. “They ask, ‘Can you help me? I am looking for my child.’ ‘I am searching for my husband.’ ‘Do you know who is in the other camps?’ I spoke to a woman who had eight children. She had been separated from her husband. Her eldest child, age 17, and her youngest, only four months old, were both dead. Her 15-year-old son could no longer speak. They come up to you, hold you tight and begin to cry. The fear is deep inside of them.”

**AFTER THE CONFLICT, MSF BEGINS NEW ACTIVITIES**

In late May, MSF set up a new 100-bed field hospital in Manik Farm, a camp in northern Vavuniya district sheltering about 220,000 people, according to the United Nations. This was in response to the camp receiving 23,000 people during three days after the end of the conflict. Also in May, MSF was supporting the Ministry of Health-run Pampaimadu Ayurvedic Hospital in the north of the district, and was preparing to start treatment there for the hundreds of people discharged from hospitals who were still in critical need of post-operative care.

MSF has provided medical care in Sri Lanka since 1986.
THIS YEAR MARKS THE 100TH ANNIVERSARY OF THE DISCOVERY OF CHAGAS DISEASE, OR AMERICAN TRYpanosomiasis, YET IT REMAINS ONE OF THE WORLD'S MOST NEGLECTED DISEASES.

Primarily affecting poor people throughout Central and South America, an estimated 14 million people have Chagas disease, and about 15,000 die from it every year. The disease is caused by the parasite Trypanosoma cruzi and is mainly transmitted through the bite of the vinchuca, a beetle-like insect. Pregnant mothers can pass the parasite to their babies; it can also be transmitted through blood transfusions, organ transplants, and, much less often, through contaminated food or drink. Since 1999, Doctors Without Borders/Médecins Sans Frontières (MSF) has provided free diagnosis and treatment services for Chagas disease in countries including Honduras, Nicaragua, Guatemala, and Bolivia, which has the largest number of cases in the world. In Cochabamba, central Bolivia, MSF operates a free Chagas treatment program that is unique in that it treats both children and adults.

At least 10 percent of Bolivia's population is believed to be infected with Chagas, the world’s highest rate of the disease. Chagas typically affects those living in mud or straw housing, where cracks in the walls and roofs harbor the vinchuca insect.

At some point, perhaps as her family was sleeping one night, 10-year-old Araceli Espinoza was bitten by a vinchuca and infected with Chagas disease. Espinoza shares a tiny room with three siblings and their grandmother in a mud-brick home in Los Pinos, a poor neighborhood on the outskirts of Cochabamba. “The house was filled with vinchucas,” said MSF physician Victor Condé. “They were in the bedsheets, under the mattress, and in the children’s clothing.

Though they had seen vinchucas in their home, the family knew little about Chagas disease before Espinoza became sick. “It happened one day when I was at school. It hurt here, in my chest. I couldn’t run, and I was very tired.” By the time Espinoza was diagnosed with Chagas and began treatment, the parasite had already caused serious damage to her heart. “She is doing much better, but we fear that the damage is irreversible. We are also concerned about the other members of her family,” said Dr. Condé.

After public health authorities fumigated the house, MSF nurses visited the family to test Espinoza’s brothers, sister, and uncle for the disease. Test results were negative, but
the team remains skeptical. According to MSF nurse Teresa Lencina, “If the infection was recent, the test doesn’t always pick it up. We will have to test them again in a couple of months to be sure.”

In Bolivia and elsewhere, Chagas remains a neglected disease, poorly understood by its victims and medical personnel alike. It is perceived as a complicated disease to diagnose and treat, especially since an infected person can live for several years without showing symptoms. About 20 to 30 percent of those infected will develop the chronic form of the disease up to two decades after they first contracted it. Then the parasite begins to cause organ damage or even death, usually attacking the cardiac or digestive systems. Heart failure is a common cause of death among young adults with Chagas. In many cases, seemingly healthy people die of complications from Chagas without ever knowing they were infected.

Currently, only young patients like Espinoza are offered treatment through Bolivia’s national Chagas disease program. Adults’ increased vulnerability to drug-related complications makes many medical personnel reluctant to offer medication. MSF began its program in Cochabamba in 2007, with the goal of extending access to treatment for patients up to 60 years old. This makes it one of the few programs in the world offering Chagas treatment to adults. For physician Wilma Chambi, who has worked with MSF in other Chagas programs since 2002, this is a positive step. “It was very hard as a doctor to say, ‘I can treat your child, but not you.’” MSF hopes the success of the Cochabamba program—where Bolivian medical personnel have been trained to diagnose, treat, and manage the disease—will encourage widespread treatment of Chagas by primary caregivers.

Adriana Villa, 35, encountered barriers to treatment when she learned, in 2007, that she had Chagas, a disease she calls “the kiss of death.” She was living in Bolivia’s capital, La Paz, where Chagas is not endemic. “I don’t know when or how I got infected,” she said, “maybe when I was a child, or visiting someplace where there were vinchucas. I went to various doctors asking what could be done...What they told me was, ‘Your heart is fine, don’t worry, everything will be fine.’ They told me there was no treatment for Chagas.” Villa persisted in seeking treatment. “I learned about someone else in the same situation who was getting treatment from MSF. We moved here, to Cochabamba, so I could begin the treatment.”

During the course of treatment, Villa met another obstacle: adverse reactions to the drug. The medications used to treat Chagas, benznidazole and nifurtimox, were developed in the 1960s and 1970s, and little research has been done since that time. The drugs can provoke side effects, some serious, which are more common in adult patients. “After two
weeks, a rash broke out on my skin, my face was feverish but my body was cold. The MSF doctors told me to suspend the treatment and to rest." After two months, she began treatment again with a second-line drug. The treatment will last 60 to 80 days and require weekly visits to a doctor.

Villa uses her experience to raise awareness of the need to get tested and of the availability of treatment. "I speak with everyone I know and encourage them to get tested," she said. As a result, some of her friends learned they, too, had Chagas and have begun treatment. "They were people who seemed healthy," she said. "Many people don’t even know they have it."

Dr. Chambí wants that to change. "Here in Cochabamba, MSF’s experience is encouraging the staff of health centers to diagnose and treat Chagas. When we started, the staff didn’t trust that the treatment really worked. Once they were convinced that the treatment worked, they feared the adverse effects." Chambí and other MSF staff have trained doctors to manage the side effects of treatment: "If it’s taken care of right away, the patients don’t have to get worse. The doctors have been very receptive; now they have confidence." Reflecting on the centennial of Chagas’s discovery, she adds, "Hopefully, 100 years from now, Chagas will be just a story we tell."

Clockwise from top left: Patients’ Chagas test results are displayed on a desk at an MSF clinic in Cochabamba. Bolivia 2009 © Anna Surinyach; Vinchucas often live in the mud walls of houses like this one in Cochabamba. Bolivia 2009 © Mary Vonckx/MSF; An MSF staff measures out medicine for patients; An MSF patient is tested for Chagas disease. Bolivia 2006 © Juan Carlos Tomasi

CHAGAS EVENTS
MSF and the Drugs for Neglected Diseases Initiative (DNDi) will co-host a public event on October 1 and a scientific symposium on October 2 focused on Chagas disease in the Americas. To be held in Los Angeles, the events aim to raise awareness of the public and of the health community, to discuss patient needs and treatment challenges, and to put forth recommendations for action to address the hidden burden of Chagas disease.

For more information, go to doctorswithoutborders.org/alert

WHAT NEEDS TO BE DONE TO FIGHT CHAGAS

- Research and development of affordable, more efficient, and less toxic treatments for Chagas disease
- Development of a pediatric drug formulation for treatment
- Research and development of an effective rapid test that can diagnose patients in rural primary health clinics, without a laboratory
- Expansion of treatment programs to include adults
PHOTO ESSAY

ZIMBABWEANS IN SOUTH AFRICA: STRUGGLING TO SURVIVE

“All these people are not here because they want to be here. They are here because they are suffering. The masses are running away from their own country.”
— a Zimbabwean man in Musina, South Africa, March 2009

Violence, sexual abuse, harassment, appalling living conditions, and a serious lack of access to essential health care define the lives of thousands of Zimbabweans in South Africa today. Doctors Without Borders/Médecins Sans Frontières (MSF) is calling on the government of South Africa and UN agencies to urgently address the humanitarian needs of vulnerable Zimbabweans falling through the cracks of South African society.

Of the 30,000 Zimbabweans who applied for asylum in South Africa between July and December 2008, just 53 were granted refugee status, according to the South African Department of Home Affairs. The government provides no shelter or services for them; many have been aggressively deported, and many more report being denied access to health care, which is guaranteed to foreign nationals under the law.

In Musina, South Africa, a small town 18 miles from the Zimbabwean border, newly arrived Zimbabweans seeking asylum sleep at temporary shelters offered by churches. This men’s shelter is only a few tent structures with canvas roofs and little protection from the wind and cold.

All photos: South Africa 2009 © Austin Andrews
About 4,000 Zimbabweans take shelter at night in downtown Johannesburg’s Central Methodist Church. When they leave Musina, Zimbabwean asylum-seekers often come to Johannesburg to find work and shelter, but they are not welcomed with open arms.

Half of them must sleep outside, huddled as close to the church as possible, as it is the only place they feel safe from arrest, harassment, and deportation.
MSF runs a primary health clinic next to the church in Johannesburg and mobile medical clinics in Musina. In both places, staff frequently treat patients for upper respiratory tract infections and other conditions due to sleeping outdoors. During their journey, and also while trying to survive in South Africa, many women and men have been raped. The clinic also provides HIV testing and mental health counseling. About 30 percent of those tested for HIV are positive.

The most vulnerable of the asylum-seekers are the unaccompanied minors, children who left Zimbabwe alone. Some are orphans, and some have family in Zimbabwe who could not take care of them anymore. In June, 150 unaccompanied minors were staying at the Central Methodist Church every night. MSF has established a basic mentorship program in order to identify and keep track of them.

A man waits with hundreds of others outside a Department of Home Affairs office at night in Johannesburg. People often sleep in line for days in order to apply for or receive their temporary asylum-seeking permits. Many Zimbabweans with or without their papers have faced harassment by South African police.

Read the MSF report “No Refuge, Access Denied: Medical and Humanitarian Needs of Zimbabweans in South Africa” at doctorswithoutborders.org
Kaci Hickox, a nurse from Texas, worked as the primary health care manager for Doctors Without Borders/Médecins Sans Frontières (MSF) programs in northern Rakhine state, Myanmar, from May 2007 to March 2009.

The majority of MSF patients in this area, on the border of Bangladesh, are part of an ethnic and Muslim group called the Rohingya. They have great difficulty receiving any health care, as travel restrictions or fees for travel permission keep them confined to their own villages. Even if they can reach health care facilities, often members of this group cannot afford to pay and are subjected to discrimination at government-run hospitals or health centers.

During the two years she worked in northern Rakhine state, Hickox’s primary responsibility was managing three rural clinics that serve approximately 110,000 Rohingya people.

I fell in love with the primary health program in Maungdaw, Myanmar, before my first week was completed. With such a diverse set of activities a health professional could never complain of boredom, and direct contact with the community drew me into the culture and concerns of the people.

There, we used what I have come to call the “bridge or barefoot” approach to primary health care in a unique rural setting—you must be creative in your program and be prepared to walk barefoot through the rain and mud when the bridges are broken.

BY TRACTOR OR BY FOOT

A typical day would begin with my waking to the sound of geckos singing from our bamboo shelter, having kauk hnin pauk (sticky rice with shaved coconut) for breakfast, and then off to work in surrounding villages. I would set off with my team, composed of two nutrition-support staff and one male and one female health educator for each of the three clinics, in a Chinese tractor—our main mode of transportation. The tractor could carry many staff patients, and food supplies to nutrition sites, where we would screen and monitor progress of children in our outpatient feeding centers and distribute nutrient-rich, ready-to-use foods. Teams from each MSF primary health care clinic took turns visiting nine nutrition sites once a week for screening and treatment of patients.

During the rainy season, which would coincide with the hunger gap—the time just before the next harvest when food stocks dwindle—we would treat more than 1,200 severely and moderately malnourished children every week. Because of this great need, we refused to allow anything to interfere with our activities. When a bridge broke down near the MSF clinic in Inn Din, my team and I walked four miles in the mud, wind, and rain to reach the nutrition site. It was exhausting, but the smile of a malnourished child who had gained weight and seemed to come alive again made the damp and dirt well worthwhile.

As in other developing tropical countries, the most common ailments were pneumonia, diarrhea, and malaria. Some of the most fascinating, yet frustrating, times for me included seeing and treating diseases that most medical professionals working in the US only read about in books. There was the two-year-old girl with swollen legs, hands, and face due to kwashiorkor, the most deadly form of malnutrition; the six-year-old boy whose bones were deformed due to rickets caused by a vitamin D deficiency; and a four-year-old boy with the classic fever, runny nose, cough, red itchy eyes, and rash from measles, a vaccine-preventable disease.

Many of the health-related difficulties we treated were directly linked to poverty, and we saw its effects daily on our patients. Infrastructure in the area is poor and most villages are without covered and lined wells for safe drinking water. There is also a lack of sanitation, leading to contamination of other water sources like ponds and enabling diarrheal disease. Aside from this, most people live in crowded bamboo and thatched huts, a likely contributor to the spread of respiratory infections and tuberculosis.

MEDICAL MIRACLES THROUGH MULLAHS

In Rakhine it was critical to gain the trust of the population, and a highly effective way of doing this was working through community leaders. I wish I could say it was my idea to train mullahs—Muslim men educated in Islamic theology who are religious leaders of the community—to help health education activities. In most villages where we worked, the population was 90 to 95 percent Muslim.

As in many religious communities around the world, family planning and condom use were met with great resistance in Rakhine, but these are two critical aspects of health promotion. HIV has continued to spread.
Top and bottom photos: Rohingya refugees who fled Myanmar take shelter in Tal camp, a collection of shelters in extremely poor condition off the highway leading to Cox’s Bazaar. Bangladesh 2007 © Eddy van Wessel.

Middle photo: The tractor that transported Hickox and her team every day. Myanmar 2009 © Kaci Hickox/MSF
ROHINGYA IN BANGLADESH AND THAILAND

MSF began providing health services in Bangladesh for Rohingya refugees in 1998. MSF has assisted about 7,500 people who were struggling to survive, otherwise unaided, in atrocious conditions in Tal camp near the border. “The overcrowded, unhygienic living conditions were a breeding ground for respiratory tract infections and skin diseases,” said MSF medical coordinator in Bangladesh, Gabi Popescu. Diarrhea and malnutrition were rife, and mental health problems added to the burden, Popescu said. MSF also initiated a mental health program to support those struggling with the psychological impact of life in the camp.

Many Rohingya who make the dangerous journey across the Andaman Sea to reach Thailand perish while en route. “At sea, I saw another boat carrying around 80 people sink in front of my eyes. I think everyone died,” said a Rohingya man who arrived in Thailand in 2008. MSF has been granted access to groups of Rohingya detained by the Thai authorities on a number of occasions in recent years. Medical staff treat them for dehydration and skin diseases, but many detainees have also shown signs of severe psychological trauma.
**BOOK EXCERPT**

**THE PHOTOGRAPHER**

*The Photographer: Into War-Torn Afghanistan with Doctors Without Borders* is a book that uses photographs, illustrations and text to tell the powerful story of clandestine operations Doctors Without Borders/Médecins Sans Frontières (MSF) undertook to assist Afghan people after the 1979 Soviet invasion.

The story begins in 1986 in Peshawar, Pakistan, where photojournalist Didier Lefèvre and an MSF team of five prepared to cross into Afghanistan on donkey and horseback, while dodging Soviet bombers. We see the story unfold through Lefèvre’s eyes and photographs and through illustrations by graphic novelist Emmanuel Guibert, of an ever more challenging journey through an occupied and war-torn country to bring emergency medical aid to people trapped and wounded by violent conflict.

Originally written in French and published in 11 languages, *The Photographer* has just recently been released in English by First Second Books.

An excerpt of *The Photographer* appears on the following two pages—it begins as Lefèvre and the MSF team are arriving, after a long trek, at Zaragandara in the Yaftal Valley.

“An unflinching and gripping photographic memoir, *The Photographer* takes you on a breathtaking journey through the best and worst humanity has to offer in times of war. I love this book.”

—Angelina Jolie, UNHCR Goodwill Ambassador

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**A BRIEF HISTORY OF MSF IN AFGHANISTAN**

During the Soviet-Afghan conflict of 1979 to 1989, MSF ran about 15 assistance programs providing services from heavy war-surgery in Mazar and Herat Provinces, to immunization campaigns carried out by some 35 international staff and hundreds of Afghans. Meanwhile, Soviet forces frequently bombed medical facilities and attacked MSF supply caravans. In 1984, Afghan political parties established in Pakistan, MSF’s primary contacts, requested that MSF stop using female staff. MSF decided to cease its operations under these constraints, given the threat to its operational independence and the impact removing female staff would have on access to medical care for women and children, and the request was eventually dropped. In 1987, two MSF teams transporting tons of medical supplies were kidnapped by militant Islamic extremist groups and five Afghan MSF staff were killed. MSF continued to provide assistance in Afghanistan during the civil war from 1989 to 1996, suspending operations for two years starting in 1990 when an MSF logisticiant was killed. MSF clashed with the Taliban regime in certain regions over restrictions on women’s access to medical care. However, in other areas under Taliban control, such as Ghazni, where a female Afghan pediatrician ran several wards of the hospital, MSF did not have the same constraints experienced by other teams. MSF teams evacuated Afghanistan after the September 11, 2001, attacks in the US but returned after the Taliban was ousted and treated tens of thousands of people displaced and injured in the continuing violence.

In June 2004, five MSF aid workers were killed in a targeted attack on their vehicle in Baghdis province. With the government unwilling or unable to prosecute those responsible and the continuing threat of violence, MSF withdrew from the country after 24 years.

To read more or purchase *The Photographer*, go to doctorswithoutborders.org/thephotographer
Once again, I see the sun rise. To make up for the time spent treating patients in typing we walked a good part of the night. We are so exhausted when we stop for a break that even the horses have to lie down.

I must say that one of the things that makes my trekking even more exhausting is that I constantly carry my messenger bag across my shoulders, with my four cameras and some of my film. But I feel safer that way. I'm too frightened that, if I leave my equipment on a donkey, it might disappear with him down a ravine. When I sleep, I always keep my bag near my head.

In the morning, still hazy in my sleeping bag, I peek out at the usual commotion around me. A few tall mu are talking three feet away from me.

I know I should take a picture, but I feel so empty.

I fumble in my bag and weakly pull out the first camera I feel.

Barely frame the picture.

There, so be it.
HAVING WOKEN UP, I STROLL AROUND AS THE CARAVAN SHAKES OFF ITS SLEEPS. I’M GLAD TO CATCH A TYPICAL LOCAL GESTURE THAT I LIKE. IT’S SILENT AND IT MEANS, “WHAT DO YOU WANT?” IT COULD BE VAGUELY ITALIAN. I HAVE AN ITALIAN GRANDMOTHER.

MY MISGIVINGS ABOUT LOADING MY BAG ONTO A DONKEY ARE BORNE OUT BY SEVERAL FALLS IN THE COURSE OF THE DAY. ONE OF THEM IS PREVENTED AT THE LAST SECOND BY THE DONKEY Handlers. IF THAT DONKEY HAD FALLEN, THAT’S WHERE HE WOULD’VE LANDED, DOWN BELOW.
EDITOR’S NOTE - ‘GAZA: A DEVASTATING DISREGARD FOR CIVILIANS’

A number of our supporters were upset by the article, “Gaza: A Devastating Disregard for Civilians,” on the Israeli-Palestinian conflict published in the Spring 2009 edition of the Alert newsletter.

At Doctors Without Borders/Médecins Sans Frontières (MSF), we pride ourselves on transparency and accountability to our donors and to an open and constructive dialogue with those who believe in supporting the principles of providing assistance to victims of violence and disease regardless of political, religious, or economic affiliations.

We recognize the legitimacy of the concerns expressed that the Alert article was too one-sided in its presentation of the Gaza conflict. The article, as it was written, did not sufficiently contextualize the Israeli incursion into Gaza as a response to the long-standing and indiscriminate rocket attacks being launched by Hamas from the Strip into Israel. In no way was the omission of the broader context intended to diminish the suffering caused by these attacks on Israel. Human suffering is deplorable in all its magnitudes. At MSF, we pride ourselves on a constant reflection on our medical humanitarian action and speaking out.

This is a daily engagement playing out in our headquarters and among our field teams around the world. As our supporters, you are a vital part of this reflection. Just as MSF is an association composed of medical and non-medical staff from across the globe, bound by independent, impartial, and neutral medical action, we are a movement supported by millions of individuals like you.

We thank you for the vitality of your engagement in our collective endeavors, and in difficult economic times need your continued support more than ever. Please continue to challenge us, in all aspects of our work, in the days ahead.

ON DOCTORSWITHOUTBORDERS.ORG

MSF IN SRI LANKA

Go to doctorswithoutborders.org/alert to see a video with MSF surgeon Dr. Paul McMaster, who was in Vavuniya hospital in Sri Lanka when the 450-bed hospital gained 1,700 patients in two days. And listen to audio interviews with Dr. McMaster describing what was happening on the ground during the massive influx of patients.

ZIMBABWEANS STRUGGLE TO SURVIVE IN SOUTH AFRICA

See an audio slideshow that explains the enormous obstacles Zimbabweans face when they seek asylum in South Africa.

READ MORE ABOUT MSF-RELATED BOOKS

Read additional excerpts from the graphic novel The Photographer. And read Suddenly…Sudan—the blog that gave rise to the new book Six Months in Sudan, written by MSF doctor James Maskalyk.

PODCASTS

June: Hear how MSF is running the only program in Bolivia that treats adults for Chagas disease. Also listen to reports on MSF’s medical activities in eastern Balochistan province, Pakistan, and on providing mental health care on the Philippine island of Mindanao.

May: MSF is leaving a camp for Hmong refugees in northern Thailand and denouncing the Thai government’s forced repatriation of the refugees back to Laos. Also hear about an MSF project that treats victims of violence in Papua New Guinea.

April: Hear a report about MSF carrying out its largest-ever vaccination campaign to fight a meningitis epidemic in West Africa. And hear MSF field workers in Haiti describe the overwhelming need for medical care in that country.
WORK WITH MSF
Attend an online recruitment Webinar Tuesday, September 8. All prospective medical and nonmedical aid workers are invited to attend this online presentation and question-and-answer sessions to learn more about how to work with MSF in the field. A recruiter will be on hand to discuss requirements and the application process. Go to doctorswithoutborders.org and click on “Events”.

MAKE A GIFT FOR LIFE
The Charitable Gift Annuity makes it easy to provide for our future as well as your own. When you set up a gift annuity of at least $5,000 with MSF, you will receive fixed payments for life and an immediate income tax deduction. Minimum age when payments begin is 65.

For more information about Charitable Gift Annuities, including a complimentary personalized illustration of how a gift annuity could work for you, please contact: Beth Golden, Planned Giving Officer at (212) 655-3771 or plannedgiving@newyork.msf.org.

‘SIX MONTHS IN SUDAN’ BOOK RELEASE
Dr. James Maskalyk left Toronto for Abyei, Sudan, in 2007 on his first MSF assignment. During his time in this contested area between north and south Sudan, he treated malnourished children, dealt with a measles epidemic and 120-degree heat. Exhausted by the struggle to meet overwhelming needs in a resource-poor area, Dr. Maskalyk returned home six months later more affected by the experience than he had anticipated.

The book, Six Months in Sudan: A Young Doctor in a War-Torn Village began as a popular blog that Dr. Maskalyk wrote from his hut in an attempt to bring his family and friends closer to his life in Sudan. It is a story about the people of Abyei who suffer the hardships of living there because it is their home, and about the doctors, nurses, and countless volunteers who leave their homes to make another’s easier to endure. With great hope and insight, he illuminates a distant place, its heat, people, poverty, and war, to inspire possibilities for action. It was published in the US in May 2009 by Spiegel & Grau Hardcover and is available online at amazon.com and bn.com.

HOLD A FUNDRAISER FOR DOCTORS WITHOUT BORDERS
Are you a marathoner, a triathlete, or just want to get out there and walk for a good cause? Are you planning a wedding, a birthday party, or Bat Mitzvah? Connect with friends and family to make a real difference and raise awareness in your community by holding a fundraising event for MSF. Join a committed group of thousands of people around the country who are helping MSF deliver emergency medical assistance to people affected by crisis and exclusion from health care in more than 60 countries around the world.

We’ve made it easy to plan a successful fundraiser. Visit doctorswithoutborders.org/donate/fundraiser to get ideas and use our online resources to create your own fundraising webpage, print flyers, and request our official Action Kit. Together, we can save more lives.
Several countries in West Africa, including Nigeria, Niger, and Chad, faced a major meningitis epidemic this spring. Hundreds of Doctors Without Borders/Médecins Sans Frontières (MSF) field workers collaborated with Ministry of Health staff to carry out vaccination campaigns that reached 7.5 million people. This is the biggest vaccination project MSF has ever carried out.

Nigeria saw the worst meningitis epidemic the country has experienced since 1996. “There are numerous epidemic hotspots all across northern Nigeria,” said Dounia Dekhili, MSF emergency coordinator in Nigeria. “The situation evolved rapidly, but the number of deaths remains relatively low.” More than 50,000 cases of meningitis were recorded by MSF teams, who visited health facilities across nine states, along with Ministry of Health staff, reviewing patients, organizing drug supplies, and collecting data. Niger was relatively less affected but the epidemic spread in some southern areas. MSF and Ministry of Health staff vaccinated patients in the Dosso, Maradi, and Zinder regions and assisted local health staff with treatment support and training. In Chad, MSF and government health staff provided vaccinations and treatment in Durbalı, Pala, and Goundi districts, as well as in the capital, N’Djamena.

Meningitis is an infection of the meninges—the lining of the central nervous system. It occurs worldwide on a sporadic basis, but the vast majority of cases and deaths occur in sub-Saharan Africa. On average, meningitis kills half of all infected people if not treated; and one in 10 if treatment is provided.