AID AND ACCOUNTABILITY: MSF’S PERSPECTIVE
Dear Friends,

Last year, a host of newspaper articles, blogs, and TV reports questioned the efficacy of the international aid system, particularly with regard to its role in the crises in Haiti and Pakistan. At Doctors Without Borders/Médecins Sans Frontières (MSF), we welcome this debate. Some of the criticisms leveled are valid, some are not. But it’s a conversation that should be had.

In this issue of *Alert*, we discuss core underpinnings of our work, principles that have evolved over 40 years of delivering medical humanitarian aid in some of the world’s most complex humanitarian crises.

We are constantly re-examining our humanitarian medical practice in light of our core tenets of independence, neutrality, and impartiality in highly politicized contexts. Today, that includes places such as Haiti, Afghanistan, and Pakistan. In years gone by, it might have been Rwanda, North Korea, or Angola. It’s in the organization’s DNA to work this way, to continuously seek ways to improve our programs.

The same instincts inform our desire to be accountable to the public and transparent about how we use the funds with which donors generously entrust us—as evidenced by the reports on our operations in Haiti in the year after the earthquake there and in Pakistan after last summer’s floods (available on doctorswithoutborders.org). It also compels us to openly discuss what we could and could not do following the horrific earthquake in Japan, and why, given our limited role in the immediate aftermath, we were not accepting earmarked donations for the relief effort.

At the same time, we will continue to express our own dissatisfaction with aspects of the international aid system: the close relationship between government funders and aid actors, for example, and the misuse of the word “humanitarian.”

This approach yields tangible effects, we believe. It was a critical examination of the aid system—and the drug development system—that led MSF to co-found the Drugs for Neglected Diseases initiative to stimulate the production of treatments for diseases doctors and nurses were seeing but were unable to treat because the relevant drugs were ineffective, toxic, or nonexistent. In this issue, Rachel Cohen, the new executive director of DNDi North America, talks about DNDi’s promising work with Chagas disease, sleeping sickness, and pediatric AIDS.

You’ll also find updates from southern Sudan and Papua New Guinea, examples of the medical care our teams are providing—and re-examining—in more than 60 countries. We hope you find this informative and that you, too, will join in this discussion. Please send thoughts to AlertEditor@newyork.msf.org.

Sincerely,

Sophie Delaunay
Executive Director, MSF-USA
AID AND ACCOUNTABILITY: A NECESSARY DEBATE
BY SOPHIE DELAUNAY, EXECUTIVE DIRECTOR, MSF USA

Editor’s Note: This is an expanded version of a recent “Insider’s Letter” that drew a great deal of feedback, convincing us it was worthwhile to delve further into the issues discussed.

In 2010, the international aid system came under scrutiny in the media, sparked in great part by its responses to the crises in Haiti and other parts of the world. “Where is the money going?” became a common question from donors, reporters, politicians, and beneficiaries alike. The charge that humanitarian agencies are accountable to nobody, that they can support local war economies, and that, in the worst case, they do more harm than good was leveled in several forums—most pointedly in “The Crisis Caravan” by Dutch journalist Linda Polman, in reviews of her book, and in articles by journalists such as The New Yorker’s Philip Gourevitch, who used Polman’s book as an entry point for a broader critique of the delivery of humanitarian assistance.

I’d like to share with you our thoughts on these issues—the nature, value, and accountability of the international aid system—and take the opportunity to reflect on Doctors Without Borders/Médecins Sans Frontières (MSF)’s role and responsibilities when it comes to humanitarian action today.

RWANDA
In 1994, MSF was running programs for Rwandans taking shelter in Goma, Zaire (now Democratic Republic of Congo), where conditions for the huge refugee populations were extremely dire. But members of the Interhamwe, the militia that carried out the genocide, were using the camps as a base to recoup and re-arm for more fighting. After an extensive, exhaustive, and very difficult debate, MSF decided it couldn’t be a party to this, even if it meant civilians would not get care they needed. © Roger Job
MSF puts a high value on critiquing the quality of our programs. From our earliest days, we have been examining the ways our decisions impact the communities in which we work and seeking to identify strategies to achieve the best outcomes for patients. Given the nature of our work, we confront these dilemmas as a matter of course, and while we disagree with much of the commentary that has been put forth, important questions have been raised—for individual organizations, for the broader international humanitarian effort, and, most importantly, for the people aid workers are ostensibly trying to serve.

Can a humanitarian agency do more harm than good? Yes, if that organization takes action without paying sufficient attention to the potential impact of its work on the socio-political environment. MSF understands this only too well. In 1994, for example, hundreds of thousands of refugees fleeing the genocide in Rwanda gathered in camps in Goma, on the eastern edge of the Democratic Republic of Congo. MSF immediately mounted an enormous emergency response—only to realize, as the months went on, that much of the international aid pouring into the area was being diverted to support the Interhamwe, the militias that had perpetrated the genocide and intended to continue the fight. We risked violating one of the primary tenets of both medicine and humanitarianism: do no harm.

In the end, MSF decided to withdraw. We did this due to our publicly-stated belief that if we remained, we risked strengthening groups that had perpetrated a horrific genocide and intended to continue the fight. We risked violating one of the primary tenets of both medicine and humanitarianism: do no harm.

In 1998, we faced a similar situation in North Korea. MSF had been providing massive nutritional and medical support to the national health system for three years. But we had been unable to secure the government’s approval for direct access to health centers and to the most impoverished regions of the country, which we knew had been ravaged by years of starvation and natural disasters. Despite facing one of the worst famines in the nation’s history, the North Korean government insisted that aid be channeled only through the Public Distribution System and that aid organizations be restricted from independently assessing the needs and providing direct assistance.

We had thoroughly studied the structure of this system and were fully aware that it classified aid recipients according to loyalty to the regime. If we could not independently access the population and make choices based solely on medical and nutritional needs, any assistance we gave would be funneled through this same discriminatory system. It would be given first to Party members, to the elite, and to loyalists, rather than the most vulnerable members of the population—the priority for anyone providing humanitarian assistance.

As it happens, I was working with MSF in Rwanda in the immediate aftermath of the genocide there and was later responsible for developing direct operational strategies to reach the North Korean beneficiaries. It was excruciating to pull out of these places. But we believed it was the right decision for MSF given our principles and given the conditions with which we were confronted.

These are just two examples. If we looked at MSF’s outspokenness against the Thai government’s plans to forcibly repatriate Hmong refugees to Laos in 2005, our work in rebel-held areas during the Angolan Civil War, our decision to pull out of Afghanistan after five staff members were killed there in 2004, or our work in Sierra Leone when British-sponsored forces were being employed to fight militias in that country—to name just a few—we could find more instances...
when the organization’s medical work took place in contexts that were far from black-and-white. Trying to aid communities in need is not a zero sum game, after all. There are almost always shades of gray, shifting parameters, and innumerable cultural, political, and historical factors at play. The task in every situation is to understand the environment and the ways in which MSF can, or cannot, assist.

**THE MEANING OF HUMANITARIAN ACTION**

Humanitarian aid should not be complicit with the perpetuation of suffering. That much is clear—at least in theory. In practice, it can prove to be more complex. There are times when it is very possible, perhaps even inevitable, that an organization trying to achieve humanitarian ends will in some roundabout way provide support to a warring faction or oppressive regime. Its work can be co-opted. Its presence can confer a sense of legitimacy on certain groups or be seen as absolving them of responsibilities to the population—an outsourcing of functions they’re unwilling to perform. Movements and assessments can be confined to certain areas.

This is why aid groups need to take responsibility for ensuring that their socio-political impact remains as minimal and impartial as it can be, and that the populations most in need gain the most benefit from humanitarian efforts. Speaking about conflict situations, Fabrice Weissman, the director of MSF’s Center for Reflection on Humanitarian Action (CRASH) writes, “humanitarian organizations firstly need to recognize that the risk of humanitarian aid being co-opted materially or symbolically in the war effort is real and that it should be taken into consideration when setting up operations.” The organizations themselves are responsible for making sure that their work is not proscribed, exploited, or misused to the extent that they are, in fact, doing more harm than good.

We have a duty to question our actions whenever we see this balance tipped. That is why independence matters so much to us at MSF. By remaining independent, by staying out of agreements that would leave us beholden to the agenda of any interested government, party, or faction, we can make choices based first and foremost on the reality of a given situation.

Questions should be asked about the quality and accountability of humanitarian action. It can be done badly.

Both Polman and Gourevitch criticize the humanitarian community for relying too much on self-criticism as an accountability tool. That is a valid point, and we welcome thorough examinations of our work. But I would also submit that in the 40 years of its existence, MSF has been one of the toughest critics of our own operations, and that our own examinations are often far more stringent and, yes, critical, than those from the outside. We have a host of accountability measures in place and some highly empowered mechanisms that review operations, push for improvements in our field work, and advocate for the best possible outcomes for patients. These include not only our regular program evaluations but also our research and inves-
During the military’s furious final assault on the Tamil Tigers, the government denied MSF and other organizations access to the war zone or the camps in which Tamil civilians fleeing the fighting had been placed. In this instance, MSF accepted restricted mobility and a restricted ability to independently assess the needs and performed surgeries and delivered other care for war-wounded civilians in hospitals outside the camps. © Anne Yzebe/MSF

Investigation centers: Epicentre (www.epicentre.msf.org/), which focuses on epidemiological dynamics, and CRASH (www.msf-crash.org/en), which performs critical reviews of our interventions, taking into account the political context in which they occur, in order to find lessons that can be used in the future. MSF’s best critical mechanism, however, is its associative structure, which means that the organization is governed by a board elected by people who have worked or are working in the field and can challenge executive decisions and operational priorities at any time, forcing changes if need be.

In this discussion, it is important to clarify what actually constitutes humanitarian action. Humanitarian action, by definition, must be provided by independent actors who have no stake in the crisis, who seek no profit from their work, and who provide assistance based on need and need alone. Yet what is commonly labeled humanitarian action often has little to do with this definition. The word “humanitarian” is often used interchangeably when describing experienced aid agencies such as MSF, whose work is based on medical ethics, independence, impartiality, and neutrality; aid agencies contracted by warring parties in an effort to win the hearts and minds of the local population or to further long-term agendas (thus forcing people to “choose sides” if they accept assistance); or individuals who turn up in a crisis with good intentions but no real way of responding to people’s needs. Polman and Gourevitch, among others, fail to make these distinctions, which is unfortunate. A vigorous and transparent debate about the international aid system is absolutely necessary, but the debate often ranges far off target, with something as basic as the meaning of the term humanitarian—
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which is clearly defined under international law—misinterpreted again and again.

 Millions of people depend upon assistance for their very survival, but the lack of understanding about what actually constitutes humanitarian action undermines the reputation of humanitarian action itself and those who carry it out. In the worst case, people don’t get the help they need. That is why it is incumbent on both the media and aid organizations to clarify what humanitarian action is—and incumbent on NGOs to adhere to humanitarian principles, particularly independence.

At MSF, we find ourselves constantly revisiting this issue, and restating our position, in meetings with governments, militaries (particularly the American military and NATO), the European Union, indigenous factions, journalists, in public communications, and with other NGOs. We take the position that humanitarian action is more than simply providing assistance. It must be carried out based solely on need and delivered independent of political, social, or religious agendas.

THE QUESTION OF ACCOUNTABILITY

When it comes to concerns about accountability, Gourevitch and Polman are not alone. There have been a number of articles in recent months questioning the accountability of aid organizations—particularly with regard to shortcomings in the international responses in Haiti, Afghanistan, Pakistan, and elsewhere. At MSF, we welcome this debate. Ideally, of course, we should be accountable to the beneficiaries of our work, to our patients. But in reality, despite our best intentions and our best efforts on their behalf, this is something of an illusion. We must acknowledge that the victim in a crisis is seldom in a position to exercise choice or to challenge our work or presence.

We are, however, very much accountable to our donors and to the governments or authorities in the countries where we work. This accountability alone does not guarantee the quality of our interventions—just like democratically-elected governments are never a guarantee of good governance—

AFGHANISTAN

In 2004, MSF pulled out of Afghanistan after five staff members were murdered and no serious investigation was launched. Despite the widespread needs in the country, a conclusion was reached that staff safety could not be insured. Following extensive meetings with all parties involved in the conflict to reiterate MSF’s principles of independence and impartiality, the organization returned to Afghanistan in 2009 and now supports hospitals in Kabul and in Helmand Province. © Didier Lefevre
but it does provide control through a legal and regulatory framework. In project countries, we usually sign a Memorandum of Understanding with the host government. This is not an endorsement of that government or its policies, but rather an agreement that defines the scope of our intervention and our obligations. With our donors, we have a system for reporting our activities and for maintaining transparent accounting to explain how funds are being spent—and, in some cases, such as the Indian Ocean tsunami of 2005 or, more recently, the earthquake in Japan, why there are limitations to the services we can provide (and why we are therefore not actually in a position to spend donations supporters would like to earmark for a given emergency). Should MSF not live up to the standards inherent in these systems, donors can choose to discontinue their support. And if governments excessively restrict MSF’s ability to provide care to those who need it, MSF can decide that it can no longer be party to the arrangement.

At the same time, it is important to remember that the role of humanitarian organizations, and MSF in particular, is very specific. It is not our job to come up with political solutions. That is the job of governments and political actors. The role of humanitarian agencies is, or should be, quite limited and decidedly pragmatic: to bring quality care to people caught in crises with a view to alleviating their suffering. As part of a broader aid community, we often find ourselves working in the same areas as other humanitarian agencies, local NGOs, government-funded NGOs, and government actors. This broader international aid community has an obligation to provide the best quality services with the resources at its disposal.

This is an ironic moment, however. Never have there been so many resources devoted to some of today’s humanitarian crises, and never has MSF felt so alone in dealing with some of these emergencies. This is particularly true in Haiti’s health sector. It is of great concern to us that cholera, an easily preventable and treatable disease, claimed the lives of more than 3,700 Haitians between October 2010 and March 2011. Despite the proliferation of aid organizations that flocked to the country following the earthquake in January 2010, our medical teams treated more than 60 percent of all cholera patients in the country. And what’s more, there has been insufficient progress made on sanitation, shelter, and other key concerns that could have prevented an outbreak of the sort that occurred.

AN ONGOING PROCESS

There are right now more than 22,000 people working with MSF in more than 60 countries around the world. They are responding to wars, political upheavals, natural disasters, neglected diseases and neglected communities, and they are doing so because they believe providing medical care to people who need it—whose lives may well depend on it—is a worthwhile undertaking.

We are also more than happy to talk about the work that these people are doing in the field, about the work that headquarters staff does to support them, and about the choices we make regarding where we work and why we work there. And we are more than happy to have open discussions about the broader aid system, such as it is, or to bring criticism to bear on our own operations. This is how we get better at getting people the assistance they need.
This past January, the people of southern Sudan voted overwhelmingly for independence, and in July the world will see the birth of a new country. It will be a country that faces enormous challenges—not least the urgent medical and humanitarian needs of millions of people.

Sudan’s brutal civil war began in 1983 and ended in 2005 when a peace agreement was signed between the North and the South, presaging the recent referendum. Doctors Without Borders/Médecins Sans Frontières (MSF) medical teams were active throughout (and prior to) the civil war, providing emergency medical humanitarian assistance in multiple locations.

The conflict destroyed what little infrastructure there was in the South and contributed to the region’s appalling health indicators. It is estimated that 75 percent of people in the nascent nation have no access to basic medical care. One in seven women dies in childbirth. Malnutrition and disease outbreaks are perennial concerns as well. This accounts for MSF’s continued presence in many areas. In fact, MSF’s work in Sudan is one of the organization’s largest interventions.

While the elections in January were conducted in relative peace, sporadic fighting erupted in late February and March in Upper Nile and Jonglei states, as well as in the disputed oil-rich border district of Abyei—clear evidence that considerable tensions remain. In Abyei, for example, an outbreak of violence in late February forced tens of thousands of people from their homes. MSF’s hospital in Agok, 24 miles south of Abyei, treated 21 wounded people for gunshot wounds. MSF also donated drugs and equipment to the Ministry of Health hospital in Abyei, while mobile teams were dispatched to assess the needs of people displaced by the fighting.

Two weeks later, following clashes in western Upper Nile State, an MSF surgical team at Malakal Hospital provided urgent medical care to 24 people and performed 18 surgical procedures for gunshot wounds. Only a month earlier, 33 wounded people had arrived at the same hospital, six of them in urgent need of surgery.

In these volatile regions, MSF constantly stresses its neutrality and its independence from any political faction or ethnic group, and regularly calls for the rights of people to access emergency medical care to be respected.

Violence is not the only issue, however. MSF clinics in the area admitted 13,800 patients suffering from severe malnutrition in the first 10 months of 2010, a 20 percent increase from the same period in 2009 and a 50 percent increase compared to all 2008. South Sudan also recently experienced the largest outbreak of kala azar in the region in eight years. Kala azar, or visceral leishmaniasis, is a deadly disease spread by the bite of the tsetse fly that is fatal if untreated. MSF teams opened programs to support the kala azar treatment unit in Malakal Teaching Hospital and established five kala azar satellite clinics in neighboring Rom, Adong, Khorfulus, Atar, and Pagil, treating thousands of patients in the latter half of 2010.

As the region and its people prepare to become an independent country, MSF’s programs in the transitional areas are poised to respond to any increase in fighting. At the same time, regardless of any increase in violence, the country’s dire medical needs mean that MSF will continue to run lifesaving programs for millions of people.
DNDi AND NEW DRUGS FOR NEGLECTED DISEASES

Founded in 2003, the Drugs for Neglected Diseases initiative (DNDi) brings together the academic, medical, public health, and pharmaceutical worlds to create effective drugs to treat neglected diseases like Chagas disease, sleeping sickness, and visceral leishmaniasis. DNDi has developed an innovative not-for-profit model for drug research and development that is patient-centered and based on needs rather than profits. In just seven years, under the leadership of former General Director of MSF in France, Dr. Bernard Pecoul, DNDi has introduced four new treatments: two treatments for drug-resistant malaria that have already reached 80 million people; the first new treatment in 25 years for the advanced stage of sleeping sickness; and a new combination therapy for treatment of visceral leishmaniasis in Africa.

Rachel Cohen, the Regional Executive Director of DNDi’s North America office—and previously MSF’s Head of Mission in South Africa and Lesotho and US Director of MSF’s Campaign for Access to Essential Medicines—talks about DNDi’s current projects and goals.

How did DNDi get started?

DNDi shares the same roots as MSF’s Access to Essential Medicines Campaign: doctors and nurses who were increasingly frustrated by the lack of medicines and diagnostics to treat diseases patients present with in their clinics and hospitals.

At first, the Campaign focused on five main diseases: HIV/AIDS, tuberculosis, malaria, visceral leishmaniasis (or kala azar), and sleeping sickness (or Human African trypanosomiasis). But it became clear that for the most neglected diseases it was not a matter of advocating for reduced prices and overcoming patent barriers on existing drugs, as was the case with HIV/AIDS, but rather that safe, effective, and easy-to-use drugs didn’t exist. Existing drugs were either highly toxic or very difficult to administer—or both. The people suffering from neglected diseases in Africa, Asia, and Latin America were not an interesting enough market for a pharmaceutical industry that bases its success in large part on its ability to generate profits.

So in 2003 MSF brought together five prominent public sector research institutes—Brazil’s Oswaldo Cruz Foundation, the Indian Council for Medical Research, the Kenya Medical Research Institute, the Ministry of Health of Malaysia, and France’s Pasteur Institute—and the UNDP/World Bank/World Health Organization’s Special Program for Research and Training in Tropical Diseases to create DNDi.

Part of what’s so interesting is not just that we have created a successful non-profit model for making lifesaving drugs for people who need them, but that we are strengthening research and development capacity in countries where these diseases are endemic. To date, DNDi has delivered four treatments and has five other projects in clinical development. And we’ve built the most robust pipeline that exists for the specific group of neglected diseases we focus on.

The World Health Organization lists 17 neglected diseases. Why does DNDi focus on three?
Quite simply because these are the most neglected and are fatal if left untreated. There were no adequate medicines or diagnostics, and they affect the poorest, most vulnerable communities.

Sleeping sickness, for example, is transmitted by the bite of the tsetse fly that puts victims into a coma before they die. It’s endemic in 36 African countries. For decades the most widely available treatment was melarsoprol, an arsenic-derivative that killed one in 20 patients. Eflornithine, a far more effective treatment, went out of production for a while because the producer could not make a profit.

DNDi decided to see whether using existing drugs in new combinations would improve treatment options—a short-term strategy that goes hand-in-hand with our longer-term strategy to look for new compounds. The result was NECT, a combination of nifurtimox and eflornithine, the first new treatment for sleeping sickness in 25 years. It reduces the number of intravenous infusions of eflornithine from 56 to 14 days and shortens hospitalization from 14 days to 10. NECT has been added to the WHO’s Essential Medicines List and is being used in 10 African countries right now.

**How does DNDi go about its work?**

Our approach is patient-centered. It’s not just a matter of finding a drug that works against a particular parasite but a matter of finding a less toxic, better tolerated, easy-to-take drug appropriate for poor women in rural areas, for example, or children. We bring together many different players, particularly from disease-endemic countries, in a process to create what we call “target product profiles.”

Take Chagas. It is endemic in the Americas, where 100 million people are at risk and 8 million are affected annually. Chagas is tough to diagnose. It’s transmitted by something called the kissing bug because its bite is so gentle that you don’t know it bit you. Some people live for years without showing symptoms. Then they can develop organ failure—usually the heart is most affected—but the disease goes undiagnosed. In the acute phase, one in 20 infected people die, primarily children. Current treatments—benznidazole and nifurtimox—only work for acute and early symptomatic Chagas. It takes 30 to 60 days to treat and is quite toxic. There’s no treatment for the chronic phase, and no pediatric formulation, despite the fact that children are the disease’s main victims in its early stages.

A key focus of DNDi’s work on Chagas is developing treatments that work for and are adapted to children—treatments that taste OK, come in small tablets, and so forth. To tackle this, DNDi brought together a state pharmaceutical lab in Brazil, a hospital in Argentina, an R&D center in Argentina, the University of Liverpool in the UK, biotech companies and screening companies in Australia, Barcelona, and the US into an incredible virtual network.

**What is the role of the North American office?**

A bit like MSF, DNDi is an international network of people working toward the same goals. In the US, our most important role is facilitating good strategic relations with policy-makers, civil society organizations concerned with global health and R&D, academia, the pharmaceutical and biotech industries, and advocating for the US government to finance research into neglected diseases and adopt policies that will enable greater needs-driven R&D. We also need financial support from private US donors—foundations, certain corporations, and individuals who believe in what we are doing.

**Why does DNDi include pediatric HIV in its portfolio?**

DNDi fights for new treatments for neglected patients, not just neglected diseases. If we see a glaring gap and think we are uniquely situated to help, we’ll get involved. Some 2.5 million children under the age of 15 have HIV. More than 90 percent of them are in Africa. Without treatment, one-third will die by the age of one, and half will die by the age of two. Yet only a fraction has access to antiretroviral therapy, partly because diagnosis is difficult in children, and partly because of a lack of child-friendly formulations. There are not many children with HIV in wealthy countries, which means children with HIV are not a lucrative market for the pharmaceutical industry.

Our first step is to identify key experts and potential partners in this field, and to create a target product profile to guide our strategy. It’s already clear that first-line treatments for children under the age of three are what is most needed right now.

**How is MSF field work different from drug development with DNDi?**

The time horizon is different, but the needs are just as urgent. There is definitely an MSF heritage in DNDi, a similar drive coupled with a realistic sense of how long it will take to bring improvements to patients. We need to make sure neglected diseases are on the political agenda, that the money is there for R&D, that the pharmaceutical industry, policy-makers, academic researchers, and governments get the message. We are talking about developing drugs for the future, but the actual needs are for today.

To learn more and find out how to support DNDi, go to DNDi.org
PAPUA NEW GUINEA:
TREATING SURVIVORS OF AN OVERWHELMING VIOLENCE

Papua New Guinea (PNG) is a resource-rich land that won independence from its southern neighbor, Australia, in 1975 but has lagged in terms of development. The population is made up of several hundred ethnic groups that speak different dialects. Poverty is widespread, and PNG has the highest incidence of HIV/AIDS in the Pacific region. It has also long been plagued by high rates of crime and extremely high rates of domestic violence and violence against women. Seventy percent of women in PNG say they’ve been physically abused by their husbands, according to the PNG Law Reform Commission, and in some parts of the country that number reaches 100 percent.

MSF runs the Family Support Center, a clinic for the treatment of victims of domestic and sexual violence, in the regional hospital in the town of Lae and a similar program in the inland city of Tari. They are the only two facilities of their kind in PNG. Both provide medical exams, treatment, and counseling.

All photos: Papua New Guinea 2010 © Fiona Morris
Top left: A survivor of sexual violence receives drugs to prevent sexually transmitted diseases. Rape survivors are also tested for and given post-exposure prophylaxis for HIV. They receive wound care and vaccinations and are offered emergency contraception and mental health counseling. The project also supports women and children taking legal action against their attackers or seeking protection from them.

Top right: A survivor of domestic violence is treated by MSF medical staff in Tari. Frederic Sanchez, MSF’s operational advisor for PNG, said that the roots of violence in PNG are deep and have various components, from women’s place in society to alcohol abuse, from the complicated coexistence of tribal law and the democratic government’s law to the rapid rate of development.

Middle: An MSF doctor examines a victim of domestic violence at the center in Lae.

Bottom: An MSF outreach worker talks to students at Milford Haven Primary School in Lae. MSF staff saw an average of 45 new sexual violence victims every month last year in its facilities, but this likely represents only a fraction of the needs. Outreach teams spread the word that treatment programs exist and talk about the dynamics and impact of domestic and sexual violence.
Hannah Megacz, a New York City-based nurse, has worked with MSF in Cameroon, Niger, the Democratic Republic of Congo, and, for much of 2010, in Dadaab, Kenya, in the Dadaahaley Refugee Camp, the largest of three refugee camps set up in the 1990s for refugees fleeing war in Somalia. Originally established to accommodate 90,000 individuals, the camps are currently struggling to support 300,000 refugees. More than 100,000 now live in Dagahaley alone, in fact. The needs are significant and the resources far too few, especially as it pertains to food, water, sanitation, and shelter. MSF has spoken out about the need to provide more care for these refugees, something that seems ever more urgent as the numbers look likely to continue increasing.

When I left we were seeing about 6,000 new arrivals each month. The rainy season had begun. Due to the overcrowding, many families still lived on the outskirts of the camp, unprotected. MSF was carrying out rapid medical screenings, referring people in need of care to health facilities, providing shelter materials, and, together with other agencies, ensuring the supply of water.

Despite the difficulties, there are many ways MSF is improving the health situation for the refugees. MSF is in the process of renovating Dagahaley’s hospital and the four health posts in Dagahaley. I was a part the opening of the new maternity ward in the hospital. It had new equipment and enough space for all our patients. The 27 beds can be arranged for prepartum, postpartum, or labor. We can also handle situations where there is labor distress or complications.

To reduce maternal and neonatal death, we have been encouraging women to deliver in the hospital. This is particularly important with complicated births. One example was a woman named Fatouma, who came to the ward in the late stages of labor, pregnant with twins. The maternity staff reacted quickly, and the first baby was delivered pink and crying. But the second child emerged blue. The staff brought the child to the resuscitation table and after rubbing, warming, and a little bit of oxygen, he was pink and crying right along with his sibling.

The renovation also included the construction of an operating theater. This was the first surgical project we opened in the area, and it complemented the maternity ward because it allowed us to perform C-sections if needed.

A woman named Nasro came in with life-threatening eclampsia, which occurs when the mother’s body “rejects” or has an “allergic reaction” to the fetus. It can kill the mother, the child, or both. Even in the most developed medical centers, a C-section often is the only way that both can survive.

Oftentimes, the staff has to explain the necessity of the operation to the mother and family. I was called in to counsel Nasro and her family. They asked questions ranging from “Will she be able to have more children?” to “What happens if the anesthesia doesn’t work?” They gave their consent, but the child was delivered limp. The OR staff carried out resuscitation measures and revived the child. Then Nasro and her son had a full recovery.

We enlisted community health workers and traditional birth attendants to speak throughout the camp. In August, they visited 27,000 families to talk about the importance of giving birth in a maternity hospital, basic hygiene, and the services MSF was offering. Over time, we saw an increase in the number of women delivering in the hospital.

This was one of the first full-service projects that I’d worked in with MSF. In addition to our maternal and surgical ward, we have an adult ward, a pediatric ward, an emergency department, and a therapeutic feeding center to treat malnutrition. We also have an outpatient department that offers HIV and tuberculosis care. Throughout the hospital we admit more than 600 patients each month. We also run the four health centers in Dagahaley, providing vaccinations, antenatal care, and mental healthcare to more than 10,000 patients per month.

There are now generations of Somalis who don’t know life outside of a refugee camp. I often wonder how they will eventually, or ever, be able to settle back into Somalia. This is a chronic conflict with emergency medical implications.
UPCOMING EVENTS AND FUNDRAISING NEWS

WORK WITH MSF
Between April and June 2011, MSF will hold recruitment information sessions in the following cities: Albuquerque, NM; Austin, TX; Boston, MA; Chicago, IL; Denver, CO; New Orleans, LA; New York, NY

All prospective medical and non-medical aid workers are welcome to join us for a presentation, film, and question-and-answer session to learn more about MSF’s field work. A human resources officer will discuss requirements and the recruitment process, and an experienced MSF aid worker from the area will share stories of life in the field. Check doctorswithoutborders.org/events/public for more information, and to register. Or please participate in one of our regularly scheduled recruitment webinars.

Please note that there is an urgent need for operating room staff and for French-speaking applicants to work in countries such as the Democratic Republic of Congo, Chad, Niger, and Haiti, where some of MSF’s largest projects are located.

STARVED FOR ATTENTION ACTION KITS
Last year, MSF and VII Photo launched “Starved for Attention,” a multimedia campaign that exposes the grave crisis of childhood malnutrition. The exhibition has been staged in cities across three continents, and now you, too, can be a part of the effort to rewrite the story of this largely invisible disease.

An estimated 195 million children worldwide suffer from the effects of malnutrition, with 90 percent of them living in sub-Saharan Africa and South Asia. In fact, malnutrition contributes to at least one-third of the eight million annual deaths of children under five years of age.

Order a free, specially designed, two-disc Action Kit to create your own event. You can screen documentaries and images collected by some of the world’s top photojournalists, inspire your community to join the effort, and collect signatures for the petition calling for better quality food aid that will be presented to world leaders at the G8 meeting later this year.

ORDER YOUR FREE KIT at www.starvedforattention.org/action-kits.php. The kit includes a DVD of the documentaries, background materials, outreach materials, fact sheets, and a copy of the petition.

JOIN OUR LEGACY SOCIETY
Naming MSF as a beneficiary on a retirement or other account is a simple way to leave a legacy to MSF without writing or re-writing your will or living trust. Please ask your retirement plan administrator or institution for the appropriate form.

If you have already named MSF as a beneficiary of your estate, please tell us so we can welcome you to our Legacy Society.

To learn more about beneficiary designations for MSF or other legacy giving opportunities, please contact: Beth Golden, Planned Giving Officer (212) 655-3771 or plannedgiving@newyork.msf.org

You can also learn more by visiting us online at www.doctorswithoutborders.org/donate/multiyear.
After hiding out in the forest for two weeks, this family from the Ivory Coast crossed the river that separates their troubled homeland from Liberia’s Nimba County, then paused before resuming a journey they hope leads to safety. Ivory Coast has been convulsed by months of post-election strife that has forced hundreds of thousands of people to seek sanctuary elsewhere.

Doctors Without Borders/Médecins Sans Frontières (MSF) has been supporting a Ministry of Health hospital in Abidjan, which is plagued by violence and shortages of medicines and other supplies, and in a number of areas throughout the country where people displaced by fighting have settled temporarily. Many cannot reach the care they need, however. “It is critical for patients to have access to health facilities,” said Mego Terzian, MSF emergency coordinator. “MSF medical teams, who strictly adhere to the principles of impartiality and neutrality, must be able to care for patients, regardless of their affiliation.”

In Liberia, MSF teams are supporting health centers close to the border with Ivory Coast and operating mobile clinics and a medical facility in the Bahn refugee camp. As of early March, some 70,000 Ivorian refugees had been registered in Nimba County. “People are afraid and do not speak of returning,” said Helga Ritter, MSF coordinator in Liberia. “And they fear for those who have remained in Ivory Coast.”