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Reflections on the Tsunami, Darfur and AIDS Crises

Two and a half months ago the tsunami hit the coast of South Asia, battering Indonesia's Aceh province, Sri Lanka and India the hardest. It was an unexpected and devastating blow. Four thousand people died in its wake in a matter of hours; close to a million people lost their homes and found shelter either in public buildings or with neighbors and relatives.

Two years ago, an armed rebellion started in the western region of Sudan called Darfur, and in the massive repression, organized by the government of Sudan and affiliated militia groups, that ensued hundreds of villages were attacked and burned. Tens of thousands of people were killed and more than a million were forcibly displaced to camps where they continue to strive to survive.

Today, an estimated six million people in developing countries are living with HIV/AIDS and require antiretroviral therapy that could significantly improve their health and extend their lives, but only 12 percent of the six million are receiving it. There's no vaccine or cure in sight and the disease continues to spiral out of control. In 2003 there were more than five million infected people who died of AIDS or related complications.

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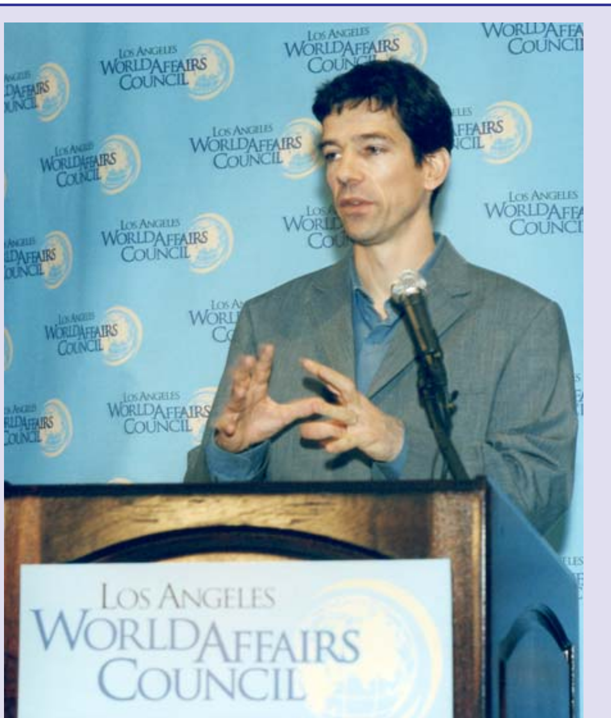
In all three cases—tsunami, Darfur and the AIDS pandemic—there has been a massive loss of life. There are people today in acute crisis situations that require immediate assistance. In short, that's why I want to talk to you about these three crises.

As a humanitarian organization our straightforward and only goal is to save lives and to relieve suffering so that people can move on and make their own choices and rebuild their own lives. We feel we have a responsibility to do our utmost to provide effective medical care to these victims, to those in most urgent need, and to draw attention to their plight. So I'd like to share with you this evening a little bit of what we have done and what we continue to do to help those affected by the tsunami, Darfur and HIV/AIDS.

Given the magnitude of the problems that I've briefly described, many questions immediately emerge: are we doing a good job? How effective are we? What kind of objectives can we have in this situation? More fundamentally, beyond our own work, are we making an impact? Is the situation of these people, these victims, improving? To even start to answer the question of our broader impact, I think it's impossible to look at [Doctors Without Borders'] work in isolation. Natural disasters like the tsunami, wars like Darfur and pandemics such as HIV/AIDS are often described as humanitarian crises, but in many ways that's a very serious misrepresentation. While failing to do justice to the nature of the problems that are leading to such terrible human consequences, calling them humanitarian crises can also give the misleading impression that emergency aid is *the,* or even one of the key solutions; in fact, the hallmark of these problems, of these crises, is generally political failure—that governments neglecting or even turning against the population, particularly the most vulnerable and powerless. And while this is political failure, governments not living up to their responsibilities, makes the intervention of humanitarian organizations necessary in the first place, this political failure also underscores the limits of our action. Political failure is what we have to challenge in our acts on the ground and in our advocacy work.

Since this organization was created we always felt that medical action on the ground need to be united with raising awareness when it comes to announcing the immediate cause of the suffering and the obstacles to delivering effective aid. In this sense, by its very existence humanitarian action should shame the powerful and contribute to holding them to account. We must at the same time do everything we practically can to relieve suffering through effective medical work, but in doing so we can never let those who created the problem in the first place, and those who have the power and responsibility to effect fundamental change, off the hook.



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I want to talk first about the tsunami. The tsunami has been an extraordinary crisis in many different ways. It was an extraordinary event, it had an extraordinary impact, and the media coverage and the global generosity and relief efforts that ensued were extraordinary. Doctors Without Borders moved quickly to assess the situation. We had teams in most of the affected countries already and we dispatched them quickly to assess what was going on. We deployed additional emergency teams and chartered planes with medical supplies and logistical materials from our headquarters, and within days we had a significant presence on the ground, especially in Sri Lanka and Indonesia, which were the hardest-hit areas. Logistical difficulties were particularly hard there, with a lot of the infrastructure, as you know from what you have seen and read, destroyed. We had to use helicopters and barges and boats to get to the remote are as. Fortunately, most of what was predicted, based on past experience after natural disasters, the medical catastrophes that the media wrote and warned about, did not materialize—in large part, because of much-underreported local and national aid efforts. In the media we heard a lot about the outside helpers, rescuers coming to provide assistance, but even as quick as MSF was, we did not reach Aceh or Sri Lanka in time to deal with patients who were already suffering from life-threatening injuries. We arrived in Aceh 48 hours after the tsunami hit. That was too late for people who were suffering life-threatening injuries. It was the national medical staff, the Indonesian staff, that were already there, who handled these cases. International help was useful to deal with the more minor wounded patients, infected wounds, and to provide additional human resources, especially nursing staff for post-operative care.

Also, there have been no epidemic outbreaks. You've all heard the warnings about cholera and, malaria; this is not taking place among the displaced population. We've had tetanus cases in Aceh from people who were wounded during the waves when houses collapsed. In part, the reason why there has not been an epidemic outbreak is because the population was in relatively good health and there were no large over-crowded groupings in big camps. Aid also arrived relatively quickly; a lot of it was organized in Sri Lanka with an incredible national mobilization. They arrived quickly, although it was not that quick elsewhere, particularly in Indonesia. The provision of water to the displaced and items such as tents and plastic sheeting were activities that our team carried out in the field. Also, from our experience we started on treating psychological trauma. Many people suffered from that early on.

So this South Asia crisis has been a very significant emergency situation for us and for other aid groups. We deployed over 200 national medical staff to the field. Contrary to many other crises that we deal with, there were a great many groups, ranging from national armies, the U.S. army, Australian, the French army, U.N. agencies, and other nongovernmental organizations which were also present very quickly, and this limited the need for additional intervention. At one point, there were 16 doctors from other organizations that joined our medical team in one of the hospitals where we were present. It was very rational, seeing the situation, that

the hospital administration and our doctors recognized that our help there was no longer required.

We have moved really beyond the emergency phase in many aspects and the major needs are purely economic and infrastructure reconstruction, which will require special expertise and also will be subject to major political pressures and constraints.

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Aceh was a conflict area that was almost completely closed off to the world before the tsunami. There were only two international aid workers in the whole of Aceh before the tsunami hit. The Indonesian government did not want anyone to be present there to see what was happening. The Red Cross had two workers in Banda, Aceh and that was it. Right after the tsunami, there were 5,000 international staff from armies, U.N. agencies and nongovernmental organizations. So this is a conflict area and reconstruction is a tricky thing. The Indonesian government and army has already expressed its intentions to regain control of the reconstruction process and the aid effort. As media and international attention fade away aid agencies that received a lot of support for their activities feel the pressure to carry out a lot of activities to help the displaced. It will be very important for us all to watch out for the conditions of the relocation and reconstruction process. For those reasons we want to stay in Aceh. We were unable to gain access before the tsunami to assist people related to the conflict and we feel that now we have an opportunity to stay on and to provide assistance and to monitor what's going to happen.

The tsunami brought another unprecedented situation for Doctors Without Borders. Within a week, we had received such an incredibly generous outpouring of support that we assessed that we had received sufficient funding for our emergency response in South Asia. This outpouring of support came from the United States and from our offices around the world. At that time, after one week we received approximately $50 million, which is unprecedented for us. $20 million was from the American public, much donated over the Internet. So for reasons of accountability and transparency we took the unprecedented decision in our history to inform the public that we would stop accepting donations earmarked for the tsunami. We, of course, encouraged donors to support our efforts in other crises that are not in the immediate spotlight. Two months later, there were still a lot of gifts coming in. We know it's not like flipping a switch where if we make a decision that our operations were sufficiently funded the giving would stop. We estimate now that we have received $115 million worldwide for the tsunami efforts and the budget for emergency operations to date is approximately $35 million. So we have more money than we feel we can effectively use for the emergency response for the tsunami. In recent weeks we have contacted supporters who gave for the tsunami to consider giving us permission to de-restrict their gift for use in other emergencies—underreported and neglected crises—where there are unmet and urgent needs. No donations earmarked for the tsunami relief will, of course, be used for any other purpose without the consent of the donors. A great majority of the donors have already contacted us have agreed to de-restrict. In a few cases where the donors would rather have the money returned, we have honored that request.

In 2004, Darfur was our largest operation. We had large teams deployed in Darfur providing medical and nutrition care. If we look at the situation today, the camps and locations where we have been able to put a lot of effort, we generally have positive medical and health results. Since the middle of last year, the health situation in the main camps in which we worked has stabilized. The combination of providing water and sanitation, vaccinating kids against measles, providing primary and secondary health and hospital care, focusing on malnutrition—rehabilitating some really malnourished kids, and feeding for all of the under-five children to prevent them from relapsing into severe malnutrition—has been paying off. For months now the mortality rate in these main camps is below the emergency

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threshold, which is one death per 10,000 people per day, to the extent that we have been able to close most of our therapeutic feeding programs for malnourished kids.

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This sounds like a pretty good outcome, but I think we have to provide many caveats to this seemingly positive situation. The first one is that the surveys that we conducted last year in west Darfur show that most deaths occurred before people reached aid in the camps or before aid reached them. The attacks against the villages where people were living were devastating. We found for instance, that five percent of the 80,000 people in one of the biggest camps in Darfur had died in attacks on their villages or on the way to the camp—five percent of those 80,000 people had actually died in the attacks against the villages. Most of those were men. There was specific targeting of the men in the attacks.

Once people were in the camps and after the aid had arrived mortality rates dropped quite dramatically, but this is a massive failure. We have failed all the people that we did not reach in time. Could we and other aid agencies have reached more victims? Could we have reached them earlier? I think these are questions that we have to ask ourselves. This is a crisis that has been going on since February 2003. Most of the major displacement took place in the fall of 2003 and early 2004, and although we had teams in Sudan and were pressing for access to Darfur knowing that the situation was very serious—we had refugees coming into Chad who were telling us the horrible stories of the attacks and the repression—we could not get into Darfur. It was very difficult for us because we had only a small foothold in the country and we feared that by speaking out too loudly we might be expelled or denied even what we had achieved. So, it was a difficult situation. We did try to talk about it, and only when the word started getting out in the media and political pressure started did the government of Sudan in the spring of 2004—very late—allow aid groups to come in.

The second caveat is that aid delivery remains extremely fragile in Darfur today. There is aid in Darfur but the organizations that are there—the U.N. agencies in particular—depend heavily on sustained government funding. Now that the media spotlight has flooded Darfur this past summer, many of us feel that this funding could now be curtailed. I just got communication from a colleague from UNICEF in Chad and he described the effect of the tsunami. Government donors focusing on South Asia had resulted in the UNICEF program on the border of Chad dealing with refugees from Darfur only receiving 12 percent of its 2005 budget to date—an obvious paradox when you think about the hundreds of millions of dollars that UNICEF and other groups have received for the tsunami response. But the second caveat is that the aid is very fragile.

The third one, and probably the most severe one, is that the conflict continues. Attacks against villages and violence in the area surrounding the camps continues to take place. The massive campaigns of repression, the scorched earth campaign that has taken place since last year has abated somewhat but continues. Let me just report some figures from our medical practice in 13 locations in south and west Darfur. We have treated 289 victims of rape and sexual violence since October, just over four months. This is only the tip of the iceberg, because we know that most victims of rape and sexual assaults don't report them because it's such a shameful experience for the victims. There's so much social pressure on the victim that it's hard for them even to seek out medical care. Eighty percent of the victims that we have been able to treat were assaulted when venturing out of the camps, the relative safety of these big camps, to collect firewood or forage for food, and they were attacked by armed men, militia groups in particular. So, violence continues and we have a kind of unacceptable and very fragile status quo. A large part of the population were forcibly regrouped into camps with relative safety but are actually dependent on outside assistance that is itself fragile. They would love to go back to their villages and resume their lives but they fear to do so because of security reasons and the continuation of the violence. So

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we ask the question: what will happen if the funding decreases for the aid effort or if the government [places] restrictions on aid activities? We know in the past it denied access, what will happen to the population in the camps? The

government wants to promote the return of these people to their villages. Will aid organizations be pushed to support that, even though we know that conditions are not ready? So it is a fragile, unstable, untenable and unacceptable status quo that we have in Darfur today, with continuing violence and very fragile aid efforts, even though the medical situation of people in the camps has improved somewhat thanks to the aid efforts that have already taken place.

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Thirdly, I wanted to talk to you about AIDS. The numbers that I quoted at the beginning speak for themselves about the magnitude of the pandemic. We're concerned about AIDS, not just because it's a disease and we're a medical organization, but it's also an issue that triggers our responsibilities as a humanitarian actor. HIV/AIDS disproportionately affects the poor, the powerless and the weak. Victims are dying in huge numbers for lack of effective response. In many ways the lack of effective response is due to political neglect and political failure. We see this in the way medicines that treat AIDS are developed or priced, we see it in the way that attention is given by national and international governments to this issue.

At MSF we have had AIDS patients in our programs since 2001. We have started to treat AIDS patients, finally, complementing our prevention activities, and we currently have sort of a comprehensive approach to this issue and to the patients' needs. We have about 25,000 patients now under antiretroviral treatment. Many more of our patients are HIV positive and are being treated against infections. The figure is from an active file that we follow. As the patients deteriorate and they become sick we put them on antiretroviral therapy. We have projects in 27 countries today, from Peru and Zimbabwe to the Ukraine and China. By many counts our treatment projects and programs are successful and our clinical results parallel in other wealthy countries. Patients' immune systems are stronger, our patients are gaining weight, they are able to live longer, healthier, and more productive lives. For them, AIDS is no longer an automatic death sentence.

The broader impact is positive as well. The stigma and shame associated with the disease has decreased. People coming forward for voluntary testing and to discuss AIDS have increased. [Our efforts to] introduce and develop preventative activities have been enhanced by that. We've also learned a lot about providing treatment for poor people in poor countries. We have simplified treatment regimes using a combination of the three antiviral drugs in one pill, which is a simplification, and increases compliance, people take their drugs. We've simplified the way patients are included in the program in rural areas and have nurses in clinical offices instead of only doctors providing the care. We've seen the benefit of having community participation and free treatments and how that enhances the effectiveness for our treatment projects.

So again, a lot of positive achievement, but immediately behind that are the challenges that are threatening the expansion of treatment beyond the 25,000 patients that we have, and endanger the prospects of longer-term survival for our patients. I want to list some of these challenges for you.

The first challenge is that we really lack the appropriate medical tools to effectively treat the patients that we have. A good example is children with HIV/AIDS—pediatric AIDS. There are about 2.2 million children with HIV/AIDS in the world today, and many of those require antiretroviral therapy, but we are having difficulty treating them appropriately. We're missing the very young. With kids who are less than 18 months old we have difficulty in the field verifying their status as HIV positive or whether they're just carrying over the indication of HIV from their infected mothers. There's no way to know whether we need to put them under antiretroviral therapy right away, and 50 percent of these infected kids die before two years. Children are very hard to treat because there are no adaptive

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medicines. There are no pediatric formulations of the medicines so we have to adapt the treatments by cutting pills. The syrups that exist are very cumbersome to use, the dosage schedules are not very well determined and the medicines for children is, oddly enough more expensive. So we lack the tools to treat these kids appropriately.

Another good example is patients who require a second-line therapy. We put them on the first-line therapy but resistance will emerge. Some of the treatments fail. We've had a few cases up to now, but this will increase as we put more people on the new treatment and we have them under treatment for longer. It's hard for us to know when to switch them effectively from first- to second-line, to be able to diagnose that quickly. Also, the price of second-line drugs is two to 12 times more expensive than the most affordable first-line combination.

This lack of tools is largely due to the second challenge, inadequate investments into research and addressing the needs of patients in developing countries. On pediatric AIDS, the good news is that there are very few children born with HIV/AIDS in the United States. There's effective prevention of mother to child transmission in this country. In a way, though, this is bad news for the 2.2 million kids in the developing world because it means that there's no financial incentive for research and development from the drug companies or the government to address the needs of kids in developing countries. The same can be said for many other needed tools to treat poor patients in poor countries, such as diagnostic tests for HIV kids that detect the infection stages, or to detect TB in patients living with HIV/AIDS. TB is the most common opportunistic infection and a leading killer of patients with HIV/AIDS, but it's almost impossible to diagnose TB in people with AIDS given the current tests that we have. So, we have a huge unmet research need to be able to treat people appropriately.

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The third challenge is of course, by definition, marginal compared to the need. I talked about 25,000 actual patients, but the patients requiring treatment is six million, and only 12 percent, or 700,00 in total, are getting treated in the developing world. Despite a lot of declarations, a lot of initiatives, and even commitment of funding by the U.S. government, the response from governments both nationally and internationally, when you look at the pandemic, is late, uncoordinated and overall ineffective. This is important to all the patients waiting for treatment. It's also important for us because we want to hand over our projects to governments. We don't want to do this for the long-term when there is a crisis. We want for Ministers of Health to treat their own patients and their own population.

If you look at a country like Uganda, it's a success story in attacking AIDS with all the initiatives that are present: global funds to fight against HIV/AIDS, TB and malaria, the president's emergency plan for AIDS relief, we have the world bank, all the bilateral donors. But when we look at the treatment situation in that country there are only 20,000 people nationwide out of 110,000 who need the treatment who are receiving it in Uganda. We had 1,500 patients in our program and it was basically one of the only ones that was providing ARV treatment for free in the whole country. So, even if you look at Uganda, which is the model success story, things are not looking very good.

I think I have stressed this evening the beneficial impact of medical work for tsunami victims, displaced people in Darfur, AIDS patients in programs that we have, and I think we should stress that humanitarian work, medical work, does save lives, is effective and helps people directly. And although the ambition of humanitarian action is modest and limited, it does save lives. It's a worthwhile and vitally important thing to do. Humanitarian action is indispensable, and you cannot think about all of the other requirements and necessities such as resolving conflict, reconstruction, development, all of these things are completely inconceivable if the survival needs of people are not met first. So, that's an important point. A second point is also important—the larger picture—and that's much more complex. Are we able to [have an] impact on the response of other aid organizations and on the access to political power and governments? Are we successful in doing that, or is our work and the fact that we're doing something being used

by others to defuse and delay their own response? I think that what my discussion of the tsunami, Darfur and AIDS suggests is that we must never be satisfied with our own achievement. We must constantly try to improve what we do, push the envelope and challenge others to take on their own responsibilities.

In closing, I want to say something about your role as individuals and concerned people in relation to these humanitarian crises and aid organizations. I think the response to the tsunami has demonstrated that solidarity exists and people can mobilize very quickly, very effectively, very generously when they feel a connection to the victims. People want to help and want to support. The challenge that we face is to create this connection—that people felt with the victims of the tsunami, and that we saw in the generosity of the response—with other victims, victims of conflict and disease, where things are not so clear.

With the tsunami you had the blameless victim and a natural disaster striking everyone. It's harder for us to mobilize around conflicts where there's always this idea that people have their own responsibility and there may be a reason why they're suffering so much. Same thing for AIDS and you know all the connotations that are linked to that. It's something that we have to do and I want to stress the critical role of concerned people like you meeting here in helping us make that connection and helping us also respond to these crises where the need the greatest. If we had waited for governments, for instance, to acknowledge the problem and to provide funding to start treating AIDS patients we would have lost a few years and many lives.

It's only because we had the support of individuals and financial support from a broad range of people that we were able to provide assistance where it was most needed and to do it effectively and independently. Our example has helped push governments to take on their own responsibility to provide treatment themselves. Only three years ago the head of USAID said that we cannot fight treatment for AIDS in Africa because Africans can't tell time. And it's only because of the positive experience of agencies actually doing it, proving it can be done. So, the support that we receive from individuals helps us to carry out effective medical care and also helps push others to take responsibility. I want to thank you for doing that and I want to encourage you to do more in the future.

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