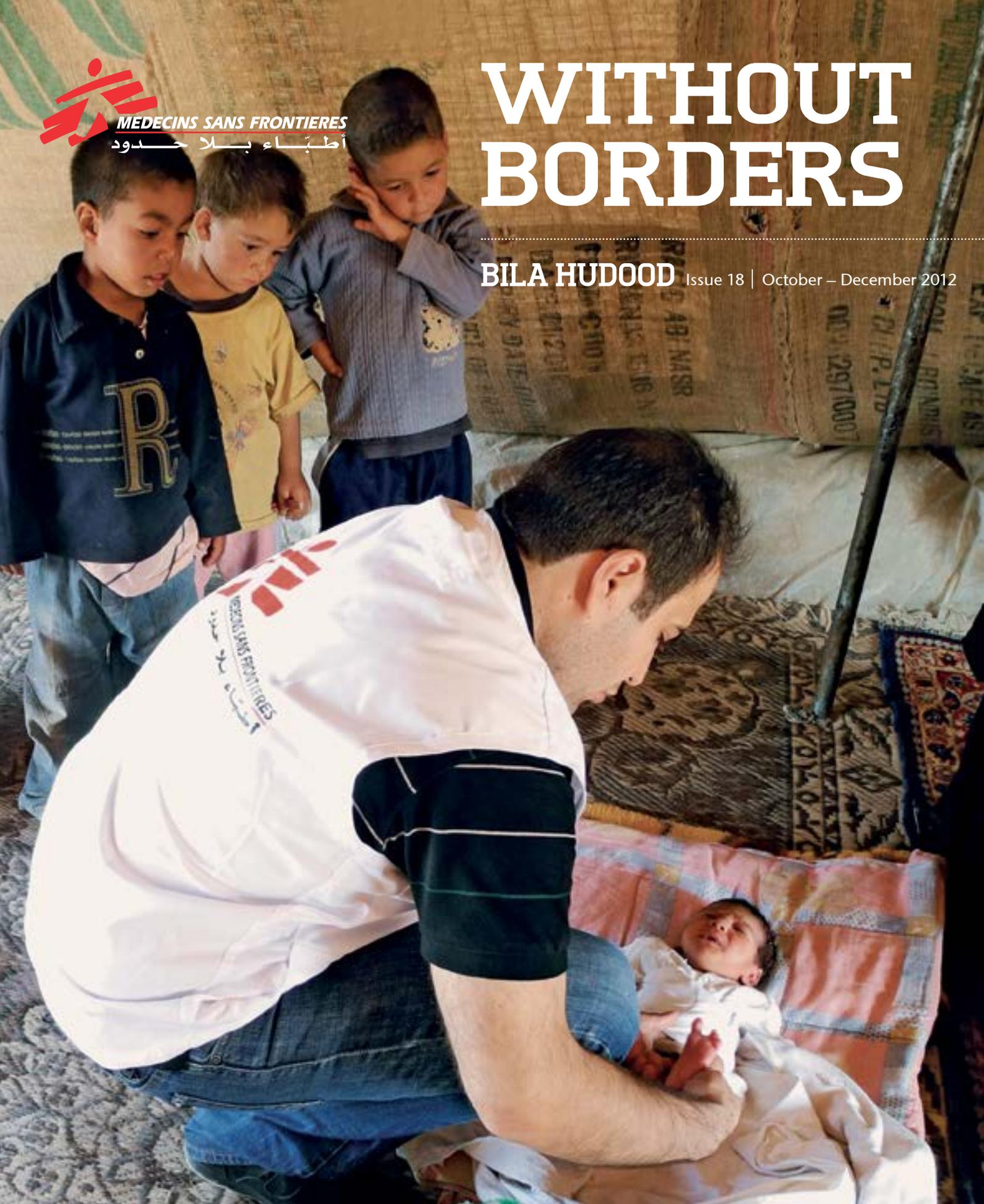




MEDECINS SANS FRONTIERES
أطباء بلا حدود

WITHOUT BORDERS

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Health emergency
in refugee camps

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Front cover photograph:
 Bekaa Valley, Lebanon. An MSF doctor examines a newborn baby in a make-shift encampment sheltering Syrian refugees. © Nagham Awada

MSF has been in the UAE since 1992 under the patronage of His Excellency Sheikh Nahyan Bin Mubarak Al Nahyan.

Médecins Sans Frontières/Doctors Without Borders (MSF) is an independent medical humanitarian organisation that delivers emergency aid in more than 60 countries to people affected by armed conflict, epidemics, natural or man-made disasters or exclusion from healthcare.

MSF's principles

As an independent organisation, MSF's actions are guided by medical ethics and the principles of impartiality and neutrality.

Independence

Nearly ninety percent of MSF's overall funding comes from private donations; this guarantees our independence of decision and action.

Impartiality

MSF offers assistance to people based only on need and irrespective of race, religion, gender or political affiliation.

Neutrality

In a conflict, MSF does not take sides and provides medical care on the basis of need alone.

In 1999, MSF received the Nobel Peace Prize

In 2002, MSF received the Emirates Health Foundation Prize

In 2004, MSF received the King Hussein Humanitarian Leadership Prize



South Sudan: A young girl stands in a transit site where Sudanese refugees were transported before being relocated to Batil camp. © Shannon Jensen

MSF in numbers (2011)

Our impact on the ground

Activities in 68 countries
 8.4 million medical consultations
 446,197 admitted patients
 73,135 major surgical procedures
 Nearly 350,000 children treated for severe malnutrition

Our human resources

Over 31,000 field staff
 92% are national employees hired locally
 8% are international staff

Our financial efficiency

899 million euros spent – nearly \$1.1 billion
 82% spent directly on medical assistance
 89% of funding comes from private donations



Income
 ● Private 89%
 ● Public institutional 9%
 ● Other 2%



How the money is spent
 ● Operations 82%¹
 ● Fundraising 12%
 ● Management, general and administration 6%



Event triggering intervention
 ● Armed conflict 39%
 ● Epidemic 37%
 ● Health exclusion 19%
 ● Natural disaster 5%



Project locations
 ● Africa 62%
 ● Asia 26%²
 ● Americas 11%
 ● Europe 1%

¹ Programmes, HQ programme support cost, awareness raising and other humanitarian activities

² Asia includes the Middle East and the Caucasus

Sudanese refugees face an ongoing health crisis

Some 170,000 Sudanese refugees have taken refuge in South Sudan after fleeing fighting and food insecurity in neighbouring Sudan. The refugees have made the harrowing trip from the Sudanese states of Blue Nile and South Kordofan into South Sudan where they are settling in overcrowded camps and struggling to survive in inhospitable and harsh conditions.

Resources in the camps are stretched extremely thin, and more refugees continue to arrive. Heavy rains have exacerbated the situation, flooding camps and leaving refugees—many of whom have already endured the journey from Sudan on foot—vulnerable to diseases like diarrhoea, malaria, and cholera. Infrastructure, health care and water are extremely limited, and people in the camps are now wholly dependent on humanitarian agencies.

Since November 2011, Médecins Sans Frontières (MSF) has been working in response to this crisis and now has field hospitals in five refugee camps in Unity and Upper Nile states in South Sudan (Batil, Doro, Jamam, Yida, and Gendrasa).

As well as treating thousands of patients, MSF is also distributing basic survival items (like plastic sheeting, blankets and jerrycans), operating water and rehydration points, monitoring the mortality and morbidity among newly arrived refugees and providing emergency assistance to refugees who were moving from the border towards and between camps.

“We’re pushing the boundaries of what’s possible logistically to get staff and supplies here and continue saving lives.”

The refugee camps are situated on a flood plain, and initially there were no services in place for the refugees arriving there. Everything had to be started from scratch: health care, access to clean water, and hygiene and sanitation systems. It was very difficult to imagine where people would actually live and how they would survive. This is an extremely remote area of South Sudan and road access is nearly impossible. Everything has to be flown in.

In early July the health situation in the camps was described as catastrophic. “With half the children under two years old malnourished, and living in cold, wet conditions, and hundreds falling ill with diarrhoea and respiratory diseases, our field hospital is overwhelmed with critically ill patients. We’re pushing the boundaries of what’s possible logistically to get staff and supplies here and continue saving lives,” said Helen Patterson, MSF’s medical coordinator for Batil camp.

The scale of the MSF response to this refugee crisis is enormous, with more than 180 international staff and more than 1,000 local staff on the ground in the five refugee camps in Upper Nile and Unity states. This huge scale up of medical care by MSF has helped reduce the number of people dying in the camps.

Living conditions in the refugee camps remain a concern though, as does the high prevalence of disease. The main causes of mortality have not changed since July, when the situation reached a critical threshold, so MSF is continuing with its efforts.

“This is what we’re good at and what we’re here for: responding to the most urgent and immediate medical needs. It is incredible what we have been able to achieve, but it’s not enough. There is always something more that can be done,” says Patterson.

Syria Crisis: MSF's Emergency Response

Since the crisis began in Syria in March 2011, the ability for international organisations, including Médecins Sans Frontières (MSF), to provide aid inside Syria has been severely restricted. Despite difficulties accessing the country, MSF has been working in Syria for the past three months, trying to provide humanitarian assistance to people affected by the conflict. MSF has also strengthened its response to the refugees who are flowing across the Syrian borders into countries such as Lebanon, Jordan and Iraq.

Inside Syria: Treating the wounded

MSF has been working on the ground in Syria since June. With the help of the Union of Syrian Medical Relief Organisations, in six days a team was able to transform an empty house into an emergency hospital, where wounded people could be operated on and hospitalised.

As of mid-September, MSF has admitted more than 1100 patients to this facility and carried out 350 surgeries. The injuries have been largely conflict-related and caused mostly by tank shelling and bombing. Many patients have suffered gunshot wounds.

The majority of the patients have been men, but up to one-in-ten are women, and approximately one-in-five are under the age of 20. According to the medical team, two-thirds of the procedures were emergency surgeries.

However, the future of the project is uncertain. In addition to the fact that MSF is working without authorisation from the Syrian authorities, our activities are under threat by the changing nature of the conflict, difficulties accessing supplies, and the challenges the injured face in reaching the hospital.

Considering the level of violence that is rife in Syria today, the MSF team, comprising national and international staff, is only able to provide a limited amount of medical support. This assistance is nonetheless essential for the survival of the people treated at the hospital.

Aside from the surgical project, MSF has donated a shipment of relief items and medical supplies to the Syrian Arab Red Crescent in Damascus. The donated supplies complement tons of medical supplies and relief items MSF has dispatched to field hospitals and clinics over the past year.



MSF's medical team working to provide emergency medical assistance to patients wounded in Syria. © MSF

MSF is also organising relief operations for displaced people in the north of Syria, by providing water and organising sanitation.

Responding to medical needs of Syrian refugees in Lebanon

Meanwhile in Lebanon, MSF has expanded its activities to provide urgent assistance to the tens of thousands of refugees who have fled from neighbouring Syria. MSF has opened new medical projects in the north of Lebanon in the Wadi Khaled area, in Tripoli, and also in various locations in the Bekaa Valley. From March to September this year, MSF medical staff conducted more than 11,600 general healthcare consultations, and psychologists and psychiatrists carried out 1,700 consultations.

Many of the refugees are living in overcrowded conditions, fearful for their safety, suffering psychological distress and unable to afford medical care.

In June 2012, MSF carried out a survey to understand the living conditions and health needs of the refugees and the major issues facing them. Many of the refugees are living in overcrowded conditions, fearful for their safety, suffering psychological distress and unable to afford medical care. Most refugees are settling in economically disadvantaged regions of Lebanon, placing an additional burden on already overstretched resources. Gaps are appearing in refugees' access to medical care, particularly hospital care and treatment for chronic diseases.

"The refugees are really being tested," said Fabio Forgione, MSF's head of mission in Lebanon. "When they arrive, most are struggling to deal with the consequences of direct violence and loss; then they have to face the reality of not being able to go home. Many lose all hope."

Of the 5,000 refugees interviewed by MSF, three-quarters fled Syria as a direct result of the conflict and 40 percent have lost family members to the violence. The majority say they have not found the security they sought. Lebanon is itself unstable as a result of the Syrian crisis, evidenced by recent violent tensions in the country's second city, Tripoli.



Fleeing the violence in Syria
Syrian refugees in Lebanon

Read the full report on the living conditions and health needs of Syrian refugees in Lebanon at www.msf-me.org

Feelings of hopelessness and alienation are widespread. Nine out of 10 people interviewed see their future as highly precarious and do not know if they will be able to return home.

As more and more Syrians cross into Lebanon, living conditions for the refugees are deteriorating.

"There are severe overcrowding problems in Wadi Khaled in northern Lebanon and in Aarsal in Bekaa Valley, while in Tripoli, rental costs are beyond what they can afford," said Forgione.

Most Syrian refugees in Lebanon rely on humanitarian assistance, which is now coming under threat. So far, the combined support of host communities, the government, and humanitarian organizations has averted a major health crisis. Individuals within the Lebanese community have made tremendous efforts to integrate and help the refugees, but financial constraints are limiting what they can do. Reductions in assistance could put the refugees' health in danger.

Providing surgery for wounded Syrians arriving in Jordan

Refugees fleeing the conflict in Syria are also arriving in Jordan every day. They follow different routes but almost always end up in one of the refugee camps set up at the border crossing in the Jordanian town of Ramtha.

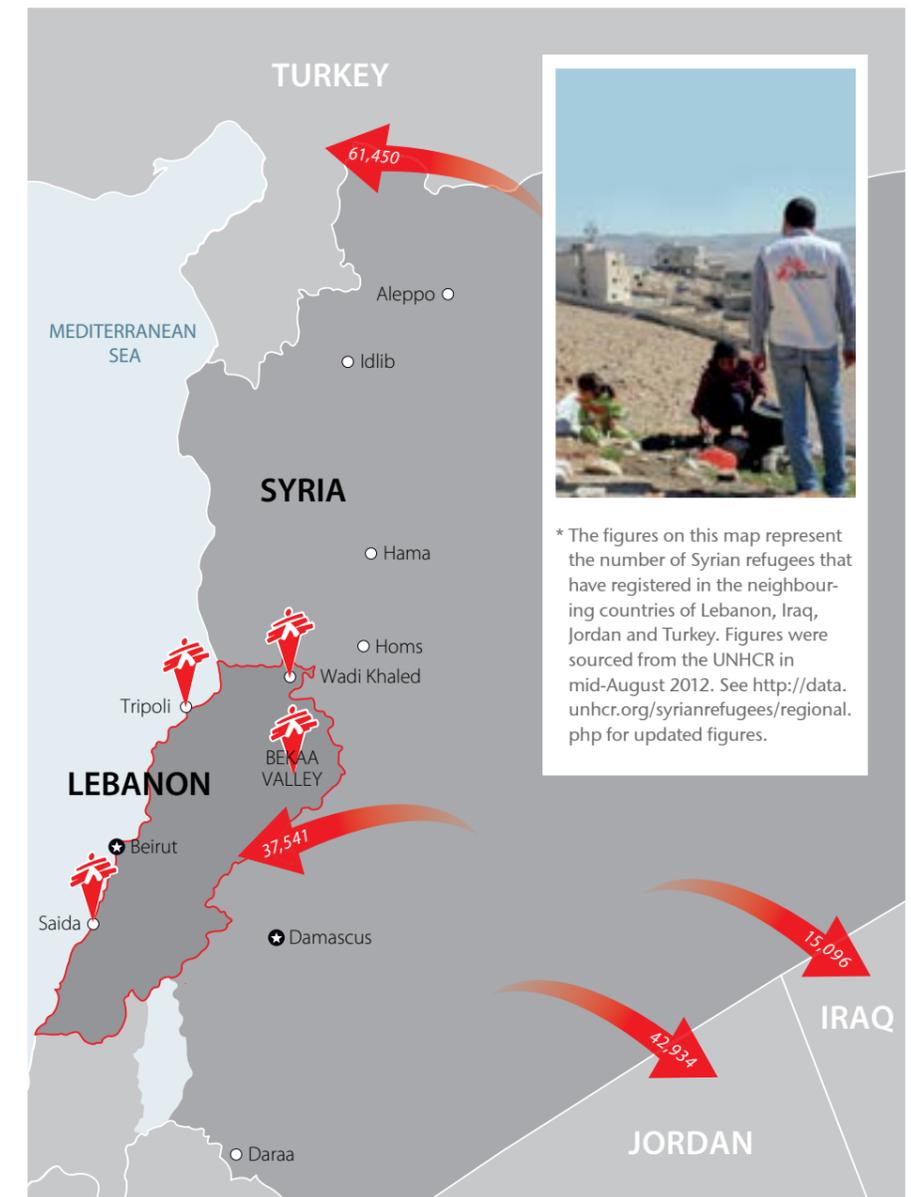
For many of the refugees who arrive wounded and requiring medical attention, a specialized MSF surgical team performs operations in a hospital in nearby Amman. An MSF doctor comes to Ramtha every few days to determine whether any of the new arrivals are in need of surgery.

At present, the MSF reconstructive surgery project in Amman is admitting about 50 injured Syrians a month.

Initially, the MSF team in Amman performed only reconstructive surgery, treating victims of violence from Iraq, Libya, Yemen, and other countries. However, the number of Syrian refugees arriving in Jordan with bullet wounds and other injuries has grown steadily since the revolt broke out in their country.

As a result, MSF has strengthened its orthopedic surgery team. An MSF surgeon examines five to ten patients weekly at the hospital, about one-third of whom require orthopedic surgery. Another third receive physical therapy and the remaining third are monitored. X-rays are performed regularly to observe their fractures.

"On the other hand," says Dr. Mohamed, a member of the MSF team, "people who are in very serious condition remain inside Syria and can't make it here."



* The figures on this map represent the number of Syrian refugees that have registered in the neighbouring countries of Lebanon, Iraq, Jordan and Turkey. Figures were sourced from the UNHCR in mid-August 2012. See <http://data.unhcr.org/syrianrefugees/regional.php> for updated figures.



© Nagham Awada

Despite difficulties accessing Syria, MSF stands ready to send its medical and surgical teams to areas most affected by violence, and is determined to operate independently, providing care to anyone in need. MSF's 2012 budget for Syria-related activities is currently estimated at nearly \$6.5 million.



An MSF doctor tends to a malnourished child at Boost hospital in Afghanistan. © MSF

Afghanistan

MSF treats malnourished children in Helmand

MSF is running a therapeutic feeding center in Boost hospital in Lashkargah, the capital of Afghanistan's Helmand province. This specialized unit helps children on the verge of starvation gain weight through assisted feeding.

Boost hospital, where MSF has been working since 2009, is one of only two hospitals in all of southern Afghanistan. Helmand is one of the country's most war-ravaged provinces. It is home to a largely poor, rural population, even if there are signs of a growing middle class in Lashkargah.

"Some children weigh as little as two kilos when they first come in," says Christwish Wenyika, nurse supervisor of the feeding center and pediatric ward at Boost hospital. "Malnutrition is one of the main causes of death among children under five years of age here in Helmand."

Seven months after opening, the 22 beds of the feeding center are full. About 15 new children arrive every week—some less than a month old.

"It is heartbreaking to see the condition some of the children are in because their mothers don't have enough to eat," says Christwish. "We start with assisted feeding immediately, as soon as they arrive. The different supplements provide vital nutrients that the children are missing."

Most children stay between one and three weeks in the feeding center, by which time they are well enough to be discharged.

Yemen

MSF treats bomb-blast and landmine victims

On August 4, a suicide bomber attacked a funeral service taking place in the southern town of Jaar in Yemen's Abyan province, killing over 40 people and injuring many more. Some 50 casualties were admitted to the MSF emergency surgical hospital in the town of Aden, where medical staff worked through the night to manage and treat the influx of patients.

The following day, three people—two of them children—were admitted with severe blast injuries after coming into contact with unexploded devices in Jaar and Zinjibar.

The year long fighting between militants and the Yemeni armed forces has left many areas contaminated with landmines and unexploded ordnance. After the fighting subsided in June and internally displaced families began to return to their homes in Jaar, Zinjibar and Lawdar, MSF witnessed a sharp rise in the number of patients who had died or suffered serious injuries after inadvertently coming into contact with explosive devices.

Over 24 cases have been referred to MSF's surgical hospital, many of whom have presented with life-threatening injuries and severe limb fractures and amputations that require emergency surgery and long-term rehabilitation.

"It is children who have been most affected. They play with objects they find, knowing at times that it is dangerous, and their lives are shattered as a result," says MSF project coordinator, Anne Garella.

Democratic Republic of Congo

MSF helps to limit the spread of Ebola

MSF and other organisations are making efforts to contain an Ebola outbreak in northeastern Democratic Republic of Congo (DRC) in which 34 people have died, according to data from the Ministry of Health.

Since August, MSF's medical teams have been doing their utmost to improve the well-being of patients, providing them and their relatives with care and psychosocial support.

Twelve new cases have been confirmed since 11 September, and four patients are currently being cared for in Isiro hospital, the epicentre of the outbreak.

"Lots of people have died, but we have also seen six people discharged after surviving Ebola," says Alfonso Verdú, MSF's emergency coordinator in Isiro. However, with the most recent new case of Ebola reported on 27 September, the intervention is still far from over.

MSF, the Congolese Ministry of Health, the World Health Organization (WHO) and the Centers for Disease Control (CDC) are together responding to the outbreak and trying to put it to an end. At the same time, MSF is stepping up its health promotion activities so that the community is better informed about the virus.

Ebola haemorrhagic fever was detected for the first time in humans in Zaire (now DRC). It is transmitted through bodily fluids and has a high mortality rate, which fluctuates from 30 to 90 percent depending on the strain of the virus and people's genetic susceptibility to the disease.



MSF staff at an ebola treatment centre © Agus Morales/MSF



MSF staff providing emergency assistance to people affected by floods in the Bulacan province in the Philippines. © Antoine Prus/MSF

Philippines

MSF provides medical assistance after floods

Following the severe floods in the Philippines in early August, which left 80% of the capital Manila under water, MSF has been providing emergency medical assistance in two neighbourhoods where healthcare has been particularly difficult to access.

The floods have affected an estimated 4.2 million people living in 17 provinces in and around the capital, Manila. A total of 109 people have died, mainly as a result of drowning or landslides. The floodwaters have now mostly receded, and people are returning to their homes, however a huge clean up job remains.

"The disruption to the barangays [local neighbourhoods] has been fairly catastrophic and everyone has been involved in the cleanup – men, women and children," says Brian Moller, MSF's project coordinator for the Philippines' emergency response. "Although monsoonal floods are frequent in the Philippines, they still have a big impact on people."

MSF is operating mobile clinics in Hagonoy and Calumpit municipalities, in Bulacan Province, north of Manila, where medical needs remain high. The most common medical complaints are respiratory infections, skin infections and chronic diseases such as hypertension.

MSF is also working to improve sanitation to reduce the spread of water-borne diseases, and is focusing on surveillance and treatment of diseases such as leptospirosis.

Around the World

Novartis urged to drop its case

In the past few months, in cities as far apart as New York, Nairobi, Delhi, Cape Town, Paris, Barcelona and Rome, MSF and others took to the streets to call for Novartis to stop its attack on generic medicines in India.

For six years the drug company Novartis has refused to back down on its legal case to stop the production of affordable generic medicines in India. MSF, with others, continues its opposition to this attack on life-saving medicines that save millions of lives around the world.

The final hearings in the Novartis vs. India court case are now underway at the Indian

Supreme Court in New Delhi. A ruling in favour of Novartis could severely limit the availability of low-priced versions of medicines used to treat life-threatening diseases.

MSF relies on affordable generic drugs produced in India - including drugs for HIV, malaria and tuberculosis - to carry out its work in 68 countries.

"Because India is regarded as the pharmacy of developing countries, the importance of this case extends far beyond India," said Manica Balasegaram, director of MSF's Access Campaign. "Novartis' legal proceedings are a direct threat for the lives of millions of people in developing countries."

You too can join MSF and tell Novartis that people matter more than profits. To participate in the Stop Novartis campaign, visit:

msfaccess.org/STOPNovartis



In July, MSF organised a street art event in Paris to raise public awareness about the Novartis case. © Samantha Maurin

Malnutrition in the Sahel

One million children treated, but what's next?

A mother hangs her laundry to dry at the MSF Guidan Roumdji hospital in Niger. Some mothers stay at the hospital for long periods of time waiting for their children to recover from illness. © Tanya Bindra

One million severely malnourished children will be treated this year in the countries of the Sahel, according to UNICEF. Every year, the region faces a hunger gap between June and October, depending on the country, a time period between the depletion of the previous year's food stocks and the next harvest. Malnutrition rates always hover near warning level in this mostly desert region, but during the hunger gap, the number of cases spikes and hundreds of thousands of children become at risk of death.

Between January and June, 56,000 children were admitted to Médecins Sans Frontières (MSF)'s nutritional programmes in seven Sahelian countries, a number that is higher than, although still comparable to, the number of admissions over the same period last year. In June, malnutrition cases admitted into MSF's Sahel programmes exceeded 3,000 admissions per week. Growing awareness of the situation has led to improved care, but the "permanent crisis" of malnutrition in the Sahel will require a new approach to prevent children from suffering year after year.

In this interview, MSF pediatrician Susan Shepherd and MSF nutrition specialist Stéphane Doyon discuss the situation in the region.

One million children suffering from severe malnutrition will be treated this year by governments and aid organizations across the Sahel. How should we interpret this number?

Susan Shepherd: It's both a failure and a success. The failure is that each year, countries

within the Sahel will face recurrent, large-scale nutritional crises that are growing even worse in some countries. One million malnourished children—that's an enormous figure. But the most important take away from this year is how all of the aid actors—governments, United Nations agencies, and NGOs—have managed the crisis. Because of this, the major success is that for the first time, one million malnourished children will be treated in the Sahel, and the vast majority of these one million children will recover.

Stéphane Doyon: Prior to the 2005 nutrition crisis in Niger, malnourished children didn't receive treatment and childhood malnutrition was virtually unrecognized. One million malnourished children receiving treatment doesn't necessarily imply things are getting worse, but rather implies a major step forward in treatment. Improved malnutrition management results in large part from the political will summoned by the governments who wish to tackle this pathology.

For the first time since the 2005 nutritional crisis in Niger, the most-affected countries have implemented ambitious response plans for treating malnourished children and establishing early preventive measures. Donors have committed to funding programmes for therapeutic foods and nutritional supplements that are adapted to the needs of infants, even if all the funds have not yet been released.

Is this year's situation worse than usual?

Susan Shepherd: For young children in the Sahel, every year is difficult. The Sahel region

is without a doubt the deadliest region in the world for young children. Malnutrition, early-childhood diseases and malaria are devastating. Between fragile health care systems and inadequate immunization coverage, all the necessary conditions exist for high infant mortality rates.

Nonetheless, there is some good news. We are beginning to see the extent of the malnutrition problem in this region. Effective prevention methods are now available, thanks to ready-to-use nutritious food supplements that contain milk and are adapted to the needs of children. A child who is immunized, is shielded from malaria, and eats the right kind of food will not become malnourished.

Stéphane Doyon: Treating a million children is ambitious, but remains realistic. Each of these countries faces its own particular constraints, but the will and the means are there.

In Chad, for example, we are almost starting from zero: the response to the nutritional crisis this year will have to be built on top of a very weak health system and the intentions are to treat twice as many children this year (127,000) compared to the number treated in 2011 (65,000). And the impending rainy season will make the deployment of aid even more complex.

In Mali, political instability and the risk of kidnapping just create additional challenges. In Niger the situation is substantially different. In recent years, the country has addressed the issue of malnutrition head-on by improving

treatment and conducting prevention campaigns to reduce the impact of the crisis among young children. Despite all of these measures, almost 400,000 malnourished children will likely be treated this year in Niger, a number which is higher but comparable to the two last years. This is because Niger's malnutrition problem, just like the malnutrition problem in the other countries of the Sahel, is endemic.

If we really wish to change things, our entire approach to malnutrition needs to be re-imagined in order to blunt its impact and lessen infant mortality.

How can we break the cycle?

Stéphane Doyon: Today, the management of this nutritional crisis is done in emergency mode. When we speak of an emergency, we are mostly referring to humanitarian interventions. This is where we run into one of the major challenges to enacting true change: for governments, these models of humanitarian action are difficult to repeat and to sustain over the long term.

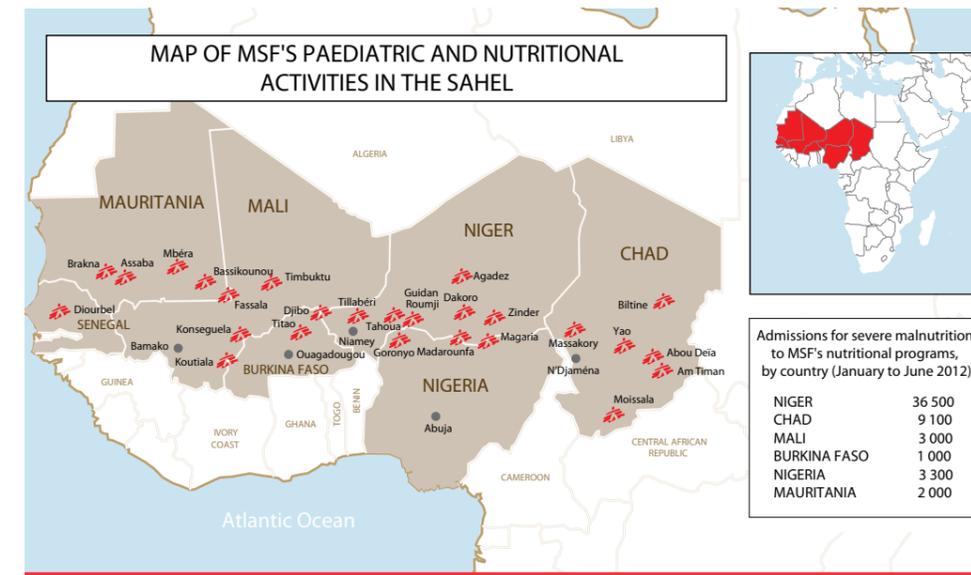
Therefore, we have to break out of this emergency response model and start developing a longer-term approach. Another challenge lies in understanding what exactly malnutrition is: a medical problem, related to a lack of food that satisfies the particular needs of children. Countries which have successfully addressed the problem of childhood malnutrition include nutrition in health systems. Long-term solutions should therefore include medical responses; development, agriculture and treatment of malnutrition are all complementary.

Susan Shepherd: Malnutrition should be treated any time and any where it occurs, just like any other early-childhood illness. Early treatment and malnutrition prevention measures should be implemented just like immunizations for childhood diseases. Food for a young child is just as important as being immunized and sleeping under a mosquito net!

The idea is therefore that the treatment and prevention of malnutrition should be integrated into a country's health system and treated as part of true public health measures. However, to reach this point, we need to make prevention and treatment as simple as possible for mothers. It is thanks to the mothers that the treatment of children can now be done at home instead of in the hospital.

Mothers are also the ones who have made the preventive distribution of ready-to-use supplementary foods such a success, since they are the ones who administer foods to their children.

Today, in MSF's nutritional programmes throughout the region, we are trying out different operational strategies as a way to



A child suffering of malnutrition in an MSF intensive therapeutic feeding centre in Niger. © Julie Remy

find the most practical and effective approach possible. For example, we are thinking of having the mothers themselves measure MUAC (middle upper arm circumference) to assess the nutritional status of their child. The solutions are out there, we just have to find them.

MSF runs 21 nutritional programs in the Sahel region, nine of which opened this year in response to acute needs in parts of Chad, Mali, Senegal and Mauritania. Of the 56,000 severely malnourished children treated by MSF in the Sahel between January and the end of June, more than 36,000 were treated in Niger.

MSF teams are also working in northern Mali, Niger, Burkina Faso and Mauritania to assist people displaced by conflict in Mali.



To learn more, download the MSF briefing document at www.msf-me.org

MSF's Emergency Team

How MSF responds when a crisis erupts



Dr. Mego Terzian started working with MSF in 2000 and has completed assignments in a dozen countries including Afghanistan, Pakistan, Niger, Liberia, and Iran. Since 2009, he has led MSF's Emergency Team in Paris, one of five based in MSF's operational centers in Europe, which can rapidly respond when crises erupt and often represent the first stage of MSF's intervention in a conflict, natural disaster, refugee crisis or other emergency situation. We talked to Dr. Terzian to find out more about how the Emergency Team works.

How does an Emergency Team differ from a regular MSF team?

The Emergency Team is always on standby to intervene in sudden crises. If we are already running programmes in the country affected, we send in the Emergency Team to act as reinforcement. It carries out an exploratory mission, recommends any programme openings, then sets them up using a parallel coordination system to allow the regular team to carry on its original programmes as best it can.

Who is on the Emergency Team?

In Paris, we have 20 people in our Emergency Pool right now—doctors, nurses, surgeons, anesthetists, pharmacists, logisticians. We need many different profiles. They've all left their regular jobs and are on standby to go within 48 hours to an emergency mission anywhere in the world. They are under contract for at least 12 months. We have Africans, Americans, Europeans, many different nationalities in the pool.

To qualify, you need to have at least 24 months of MSF field experience in different types of missions. One must be epidemics, and one must be conflict zones.

How does MSF decide when the Emergency Team should be deployed?

It depends if MSF has a presence in the country or not. If we have no presence in a country, like in Libya and Ivory Coast last year, we have to start from scratch. For instance, in Libya, we started off by using the media and contacts we have on the ground to follow the beginning of the armed revolution.

Then three or four days after the violence started in the east of the country, we sent a small exploratory mission of three people—a doctor, a logistician, and a coordinator—to Misrata. They had to go by boat because the whole town was surrounded by government troops and this was the only way to gain access.

After two or three days, the team proposed we open a trauma center, so we sent in reinforcements and materials, again by boat. We were there with the Emergency Team from Brussels, which decided to run a hospital for women and children in the same town.

Were there any particular difficulties?

A major difficulty was finding local nursing staff. Before the war broke out, most nurses came from overseas—including India and the

Philippines—and they had all left. So, despite the security risks, we sent in 19 international staff—including surgeons, nurses, and doctors—to set up 25 trauma beds. For at least two months, the team managed this small 24-hour trauma center with very few national staff members with them.

In six months in Misrata, we treated 1,200 men, women, and children, all trauma-related, and conducted 525 surgical interventions, all violence-related.

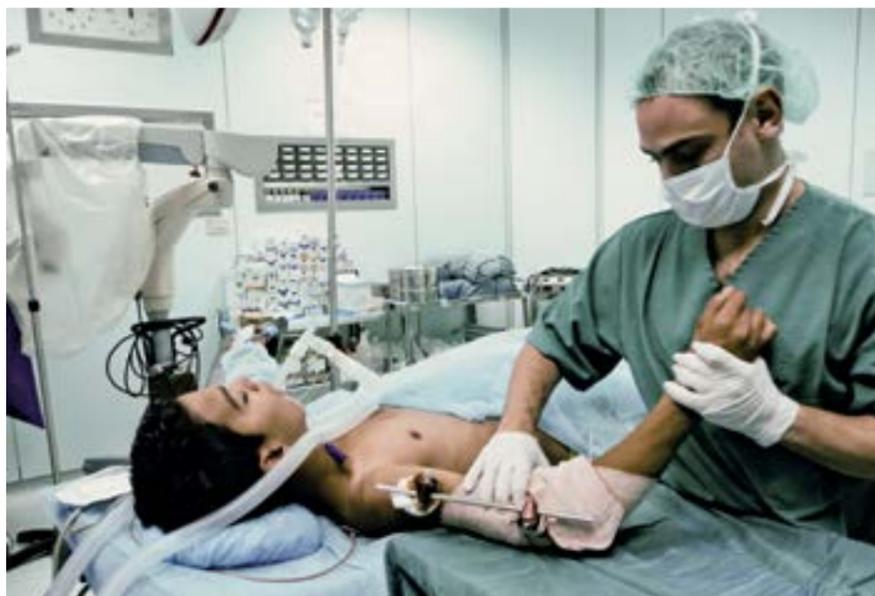
And in Ivory Coast?

For Ivory Coast, it was the same process. The crisis started in late 2010-early 2011, following the elections. We followed the situation at HQ for two to three weeks via the media and the local network we were still in touch with, having worked there previously. We then sent in one coordinator, one doctor, and one logistics officer to evaluate the situation. They proposed an intervention and we sent in reinforcements and supplies right away.

How do you get permission to set up so quickly?

Because we are a medical organization, the Ministry of Health is always our first contact. And because our organization is well-known, even if we are not operational, we don't usually have any problems setting up meetings.

The Ministry of Health describes the situation and makes recommendations on where we should go and what we should do, and once we have the green light, we do our own evaluation and decide what to do and what not to do. We worked in one hospital in an Abidjan neighborhood where there was a lot of violence going on. The Ministry of Health



An MSF doctor tends to a boy shot during last year's fighting in Libya. © Niklas Bergstrand



Haiti, where in 2010 MSF launched the largest emergency effort in the organisation's history. © Katrijn Van Giel

staff had left this particular hospital, so we set up an emergency room, operating theater, and a hospital ward for post-operative care. We stayed throughout the fighting.

How long does the Team normally stay in-country?

Every emergency mission opens during the acute phase—which lasted two months in Ivory Coast. Then we must stay on for a few months to hand over the project to the Ministry of Health, because following the emergency phase, local authorities are always in difficulty. We stayed in Abidjan for seven months.

How does the Team work when there is an MSF presence in the country already?

If we have a presence in the country already, like in Pakistan during the floods, or more recently in South Sudan, things can go very quickly because the Emergency Team will not have to spend time contacting the authorities, finding cars, or identifying a place to set up an office and a place to sleep. All this is done by the national coordination team already in the country. If we have no offices or presence in a country we probably lose at least 48 hours setting everything up.

Traditionally there is a separate coordination for emergency programmes so as not to disturb the ongoing programmes. Just recently, for example, around 20,000 refugees arrived in a place called Yida in South Sudan. The national coordination team sent

an experienced colleague to evaluate the situation and after two days, he recommended MSF open a primary health clinic and a 20-bed hospital for secondary care. So they turned to us, and we sent an Emergency Team, which immediately set up a coordination office in the capital, Juba, that could also oversee any new explos [exploratory missions] and programme openings. We opened two new projects in one month, managed them for three months, then handed them over to the national coordination team.

What operations do you feel MSF did well?

I would say, in recent years, our response to the earthquake in Haiti, and then, several months later, the cholera outbreak. It was a big emergency and a big intervention from our Emergency Teams across the network. Ivory Coast, too, was very significant. I only talked about one project, but we actually opened five projects last year.

Libya was very important, as well, the fact we were capable of sending a team of 19 people to Misrata, which was surrounded and only accessible by boat. It was very dangerous and one of our most important missions.

Do you provide psychological support to Emergency Team members?

We were a bit late to address the mental health needs of our staff, but now we have a special psychologist dedicated to supporting people returning from the field, and especially

from insecure and dangerous places. They meet with the psychologist and are provided with follow-up support if they need it.

Where are your people right now?

We have a team in Mali working with people affected by the violence there, and another working with refugees who've fled to Niger. We also have teams working on the nutritional crises in Mauritania and Senegal.

Are there different security protocols from regular programmes?

On its first expo, the Emergency Team normally takes some time to understand the country, including meeting with other non-governmental organizations working there, before doing its own security evaluation. Two to three weeks after opening a project, it creates the first security guidelines and rules we need to follow in the country.

How could MSF improve its emergency responses?

I think we were a bit late with the Arab countries. We were late deciding what to do after the demonstrations started. In Tunisia and Egypt, we overestimated local capacity in terms of medical response and underestimated the needs, so it was several weeks before we even sent in expo teams. We learned that we need to be more reactive. Even if we estimate there is good quality of care in a country, we realized we need to at least send in a team.



MSF doctor Brian D’Cruz and nurse Ursula Dagnan begin treatment for a young girl who is suffering from sleeping sickness. Central African Republic. © Sebastian Bolesch

Sleeping Sickness Treating a neglected disease in Central African Republic

As 11-year-old Natacha tosses and turns in a hospital bed in a village in Central African Republic (CAR), her parents sit close by, their faces drawn with worry. A doctor and nurse from MSF are preparing to treat Natacha for sleeping sickness (human African trypanosomiasis), a tropical disease that penetrates the liquid around the brain and that is fatal if it is not treated quickly enough.

Natacha first showed symptoms three months earlier, but armed groups were roaming the area in which she lives, making all travel risky and forcing her parents to delay seeking treatment. As her condition worsened, her parents heard through the village leader that MSF doctors were treating people with sleeping sickness in the nearby town of Mboki. “We decided to take the risk and make the trip,” says her father.

Sleeping sickness, which is transmitted by the tsetse fly, is mainly found in central Africa. During the first stage of the illness, people feel feverish and weak, but once the parasite enters their central nervous system, their symptoms change, and they become confused, lose their coordination, and suffer sleep disturbances

and personality changes. Their mental faculties deteriorate until eventually they sink into a coma—the long sleep which gives the illness its name.

This past July, MSF’s mobile sleeping sickness team spent 18 days screening and treating people for the disease in Mboki, in CAR’s Haut M’boumou region. In the week before screening started, community health workers, with the help of local authorities, traveled around the area raising awareness of the disease and passing on the message that free testing and treatment were available.

Since 2006, monitoring and controlling sleeping sickness in the remote and inaccessible southeast of CAR has been particularly difficult due to cross-border attacks by the Ugandan rebel group known as the Lord’s Resistance Army.

During 18 days in Mboki, MSF staff screened 4,534 people. Thirty were suspected of carrying the disease and six cases were confirmed.

Currently, the most common treatment for the disease is nifurtimox-eflornithine combination therapy (NECT) which, while an improvement on previous treatments, is still complicated to administer, requiring multiple injections and close patient monitoring, which are frequently unavailable in sub-Saharan Africa.

One of those diagnosed in Mboki was Marie Claire, a young woman in the early stages of pregnancy. To protect her unborn child from the toxic drugs, she will not start treatment

until the second trimester of her pregnancy. In the meantime, MSF staff based permanently in Haut M’boumou will monitor her closely.

“For now she is in good health, but sleeping sickness is a chronic disease and she will need to be evaluated weekly,” says Brian d’Cruz, a doctor with the MSF mobile team.

Marie Claire is fortunate in that she was diagnosed before the disease did permanent damage. But for others, treatment comes too late. Tragically, 11-year-old Natacha died two days after arriving at Mboki hospital.

MSF’s sleeping sickness specialists are determined that deaths like Natacha’s will soon be something of the past, and that incidence of the disease will be reduced in central Africa. Over the past decade, the number of reported sleeping sickness cases has dropped, while treatments have improved, and MSF teams in CAR have seen significant progress in the areas in which they have worked.

One major obstacle to eliminating the disease is the lack of easy-to-use tests and oral medicines suitable for remote settings. Two oral drugs are currently being developed, but the national sleeping sickness programmes that will one day need to deliver them to patients often lack staff and funds.

Until sleeping sickness is finally banished, MSF will continue to work to improve access to quality care to people suffering from this neglected but devastating disease.

Starved for Attention documentary series nominated for Emmy award

A groundbreaking multimedia documentary series exposing global childhood malnutrition, a collaboration between MSF and the renowned VII photojournalism and media company, has been nominated for a News and Documentary Emmy Award, a milestone recognition of an innovative form of advocacy journalism.

The joint project, Starved for Attention, is composed of eight short multimedia documentaries shot in Bangladesh, Burkina Faso, Democratic Republic of Congo, Djibouti, India, Kenya, Mexico, Somalia and the United States.

The documentaries form the core of a global campaign launched by MSF in 2010, with the goal of achieving key reforms of a global food aid system that has failed to ensure that young, vulnerable children receive foods that actually meet their specific nutritional requirements.

The unique form of advocacy journalism has exposed a woefully underreported—yet surmountable—global health challenge, and has galvanized action by policymakers.

Visit the Starved for Attention website: www.starvedforattention.org



International Activity Report 2011

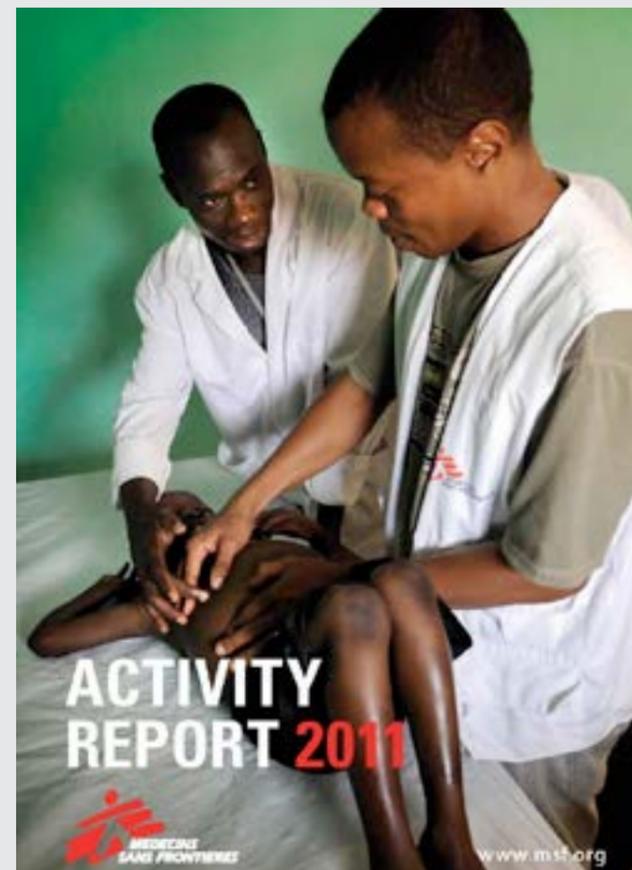
Every year MSF publishes an international Activity Report that gives an overview of its work around the world. The MSF Activity Report for 2011 is now available in print and online.

In 2011, MSF had operations in 68 countries. Close to 32,000 MSF staff worked in 436 programmes. Most programmes (62 per cent) were in Africa, while 26 per cent were in Asia and the Middle East, and 11 per cent in the Americas.

Almost 70 per cent of operations were carried out in settings of armed conflict or instability, including Afghanistan, Chad, Ivory Coast, Libya, Pakistan, Somalia and Sudan, among other countries. MSF teams also brought assistance to people in the aftermath of natural disasters, including tsunami victims in Japan, earthquake survivors in Turkey and people affected by flooding in Brazil, Guatemala, Honduras, the Philippines and Thailand.

The 2011 Activity Report provides a global overview of operations during the year, and gives details of the medical assistance provided in all the countries where MSF worked. The report also features several articles on themes of special interest, and provides a round-up of financial information.

The 2011 Activity Report can be downloaded at www.msf-me.org





معالجة الكوليرا في سيراليون

في شهر فبراير/شباط من هذا العام، أُبلغ عن تفشي لوباء الكوليرا في عاصمة سيراليون، فريتاون. وقد أدى هذا الوباء إلى إصابة ١٢,٥٠٠ شخص فضلاً عن موت ٢٢٤ مريضاً في البلاد. في هذا الصدد، قامت الفرق الطبية التابعة لمنظمة أطباء بلا حدود، بالتعاون مع وزارة الصحة، بإدارة عدد من مراكز علاج الكوليرا وعالجت أكثر من ٥,٠٠٠ مريض. وفي شهر أغسطس/آب، بدأ عدد الإصابات بالكوليرا ينخفض، ومع احتواء الوباء، تكون المنظمة قد أنجزت تدخلها الطارئ.

هذه الصفحة

يمين: أطفال يجمعون دلاء المياه بالقرب من مجاري المياه المفتوحة في ساحة مايبلا في فريتاون. تُساهم المناطق المكتظة بالسكان التي تعاني من انعدام المياه النقية وشبكات الصرف الصحي في انتشار الكوليرا، وهو مرض ينتقل عبر المياه وينتشر خاصة خلال موسم الأمطار.

أسفل: الممرضة حواء لامبوا تكتب ملاحظات في سجل روغياتو، الحامل في شهرها السادس، والتي تعاني من الكوليرا، في مركز مايبلا لعلاج الكوليرا في فريتاون. تتسبب الكوليرا في معاناة المريض لعدة أيام من الإسهال والتقيؤ وتشنجات المعدة. كما تختلف حدتها من مريض لآخر، ولكن الأعراض تظهر أحياناً بسرعة كبيرة بحيث يُعاني شخص معافي من الوهن الشديد في ظرف ساعة واحدة من ظهور العلامات الأولى للإصابة. بالنسبة للحالات الحادة، يتلقى المريض سوائل لإعادة الإماهة عبر الوريد من أجل ضمان تعويض السوائل التي خسرها الجسم جراء الإسهال.

الصفحة المقابلة

أعلى: أمي تطعم سيلفيستر، ١٦ سنة، عصيدة مقواة بالفيتامينات والمعادن في مركز ويلينغتون لعلاج الكوليرا، في فريتاون.

وسط: مركز لعلاج الكوليرا بطاقة ٧٥ سريراً في عاصمة سيراليون، فريتاون. تتمتع المنظمة بخبرة واسعة في مكافحة هذا المرض، حيث عالجت أكثر من ١٣٠,٠٠٠ مصاب بالكوليرا عام ٢٠١١ في مختلف أنحاء العالم.

أسفل: مرشدون صحيون من منظمة أطباء بلا حدود يتحدثون عما يمكن السكان فعله لتفادي الإصابة بالكوليرا، وينصحونهم بشأن أنواع العلاج المتوفرة.

جميع الصور: أغسطس ٢٠١٢ © هولبي بيكيت



Treating Cholera in Sierra Leone

In February this year a cholera epidemic was declared in Sierra Leone's capital city, Freetown. The epidemic affected over 12,500 people and claimed at least 224 lives in the country. MSF's medical teams, in collaboration with the Ministry of Health, ran several cholera treatment centres and treated more than 5,000 patients with the disease. The number of new cholera cases started falling in August, and with the epidemic now under control, MSF has completed its emergency cholera intervention in the country.

This page

Above: Amie feeds Sylvester, 16, a fortified porridge at Wellington Cholera Treatment Center in Freetown. Cholera causes days of diarrhoea, vomiting, and stomach cramps. It varies in severity but symptoms sometimes develop so rapidly that a healthy person can be debilitated within an hour of the first signs appearing.

Middle: A 75-bed capacity cholera treatment center in Freetown. MSF has extensive experience dealing with the disease, treating more than 130,000 cholera patients worldwide in 2011.

Bottom: MSF health promoters talk to people about what they can do to avoid catching cholera and advising them on what treatment is available.

Opposite page

Top: Children collect buckets of water next to an open sewer in Mabela quarter, Freetown. Overpopulated slum areas with poor water and sanitation facilitate the spread of cholera, a waterborne disease that thrives during the wet season.

Bottom: Nurse Hawa Lamboi writes notes on the chart of Rugiatu, who is six months pregnant and suffering from cholera, at Mabela Cholera Treatment Center in Freetown. In severe cases, patients receive fluids through intravenous rehydration to ensure the rapid replacement of fluids lost through diarrhoea.

All photographs: August 2012 © Holly Pickett

