MEDECINS SANS FRONTIERES
أطبّاء بلا حدود

WITHOUT BORDERS

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SYRIA
TWO YEARS ON

PUBLISHER

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Front cover photograph:
A boy carries a jerry can and blankets to his family's tent after collecting them from an MSF distribution truck in Syria.
© Nicole Tung

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

Médecins Sans Frontières (MSF, or Doctors Without Borders) 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

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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

* 2012 figures will be available in the upcoming International Activity Report

A doctor from the MSF medical team examines a child with diarrhoea at an MSF clinic in a refugee camp on the outskirts of Pauk Taw township, Myanmar.

Humanitarian Emergency in Rakhine State, Myanmar

Violence and intimidation leave tens of thousands without medical care

Since deadly communal clashes first broke out in Rakhine state, Myanmar in June 2012, tens of thousands of people have been unable to access urgently needed medical care. Médecins Sans Frontières (MSF) is calling on government authorities and community leaders to ensure that all people in Rakhine are able to live without fear of violence, abuse or harassment, and that humanitarian organisations can assist those most in need.

In June 2012, deadly communal clashes in Rakhine state triggered an official state of emergency. An estimated 75,000 people were displaced and many had their homes burned down. Further outbreaks of violence in October exacerbated the humanitarian crisis, forcing an estimated 40,000 people to flee. According to official estimates, the vast majority of the displaced are a Muslim minority, often referred to as the Rohingya.

Acute medical needs

"It is among people living in makeshift camps in rice fields or other crowded strips of land that MSF is seeing the most acute medical needs," says Arjan Hehenkamp, MSF General Director. "Ongoing insecurity and repeated threats and intimidation by a small but vocal group within the Rakhine community have severely impacted on our ability to deliver life-saving medical care."

In addition, hundreds of thousands more people still living in their homes have had very limited access to healthcare because medical services were cut off and in many areas medical services still have not resumed.

Skin infections, worms, chronic coughing and diarrhoea are the most common ailments seen through more than 10,000 medical consultations in the camps since October. During one camp clinic, 40 percent of the children under five seen by MSF were suffering from acute diarrhoea. Malnutrition rates vary, but in several camps MSF's rapid screening has shown alarming numbers of severely malnourished children.

Denied access to water

Although clean water is often available in sufficient quantities, some of the displaced are denied access to it.

The only drinking water pond we have is the one that we have to share with the cattle of the nearby village. Five minutes from here is a pond with crystal clear water. We don't dare to go.

Man living in a displaced persons camp in Pauk Taw township, Rakhine state

Threats and intimidation

Needs remain acute, but MSF medical teams face continued threats and hostility. In pamphlets, letters and Facebook postings, MSF and others have been repeatedly accused by some members of the Rakhine community of having a pro-Rohingya bias. It is this intimidation, rather than formal permission for access, that is MSF's primary challenge. The authorities can, however, do more to make it clear that threatening violence against health workers is unacceptable.

"Our repeated explanations that MSF only seeks to provide medical aid to those who need it most is not enough to forestall the accusations," Arjan Hehenkamp says. "MSF urges supportive community leaders and government authorities to do more to counteract the threats and intimidation so that humanitarian aid can be delivered to those who urgently need it."

Across Myanmar, MSF provides more than 26,000 people with life-saving antiretroviral treatment for AIDS and was among the very first responders to cyclones Nargis and Giri, providing medical assistance and survival items and cleaning water sources for tens of thousands of people.

MSF has worked in Rakhine state for the past twenty years, providing basic and reproductive healthcare as well as treatment for HIV/AIDS and tuberculosis. Prior to June 2012, MSF had been conducting approximately 500,000 medical consultations annually. Since 2005, MSF has treated more than 1.2 million people from all ethnic groups in Rakhine state for malaria.

Syria Two Years On

Humanitarian catastrophe

After two years of violent conflict, the Syrian people face a humanitarian catastrophe. Aid falls drastically short of what is needed and the diplomatic paralysis preventing a political resolution of the conflict can by no means excuse the failure of the humanitarian response.

Despite repeated requests, Médecins Sans Frontières (MSF) has not received permission from the government to work in the country, but has been able to open three hospitals in the opposition-held areas in the north where assistance remains well below the level of the needs. MSF calls on the parties involved in the conflict to negotiate an agreement on humanitarian aid, facilitating its supply around the country via neighbouring countries or across front lines.

An operation to extract a bullet lodged in the abdomen of a patient in the operating theatre of the MSF hospital in northern Syria. © Nicole Tung

Healthcare in danger

Since the first protests broke out in Syria in March 2011, the country has spiralled into all-out war. Violent fighting continues between the national army and opposition groups who have gained territory – and civilians pay a heavy price.

Accounts from doctors and patients revealed that hospitals were being scrutinised by the security forces, and that people were being arrested and tortured inside them. Doctors risked being labelled as 'enemies of the regime' for treating the injured, which could lead to their arrest, imprisonment, torture or even death. People injured in protests stopped going to public hospitals for fear of being tortured, arrested, or refused care, and were essentially forced to entrust their health to clandestine networks of medical workers.

MSF began responding to the conflict in Syria by donating drugs and medical supplies to doctors secretly treating the wounded. In June 2012, MSF set up its first hospital in the north of Syria. In September 2012, MSF opened two more hospitals in Aleppo and Idlib provinces, both in northern Syria and controlled by opposition groups. MSF assesses the security situation of its teams on a daily basis, and ensures that the hospitals remain demilitarised, neutral spaces.

There are great difficulties in providing medical care. Drug production and distribution hubs in Aleppo have shut down, stocks are virtually exhausted and supply from Damascus is no longer possible. Moreover, the power plants serving the Aleppo region have been destroyed. Hospitals are able to run thanks to electricity produced by generators, but obtaining fuel for them is very difficult. Hospitals in Syria are now being used as a tool in the military strategies of the parties to the conflict.

According to the Syrian authorities, 57 percent of public hospitals in the country have been damaged and 36 percent are no longer functional.

For a complete picture of the devastation, makeshift hospitals set up by the opposition and subsequently destroyed by the army must also be added to the tally.

Civilians caught up in the cycle of violence

The violence is directly affecting civilians. Patients injured by shrapnel or bombs at the market or even in the breadline make it to hospital only thanks to the efforts of their fellow citizens willing to help each other despite the distances to health centres and the constant threat of bombings.

The cost of living has increased considerably, bombing has cut off the supply of water and electricity in the north of the country and the price of fuel has risen significantly. Food prices have increased sharply in the northern provinces of Syria where MSF is present (Latakia, Idlib and Aleppo), so there have been major shortages of flour and baby formula. In response, MSF has donated baby formula and several tonnes of flour in Idlib and Deir ez-Zor provinces.

While an increasing number of Syrians are fleeing the country an estimated 2.5 million Syrians have been displaced inside the country since the first protests broke out two years ago. Most of the displaced people are not living in camps – many settle in buildings and public places, or are constantly on the move.

Obstacles to increasing aid for Syria

There are major obstacles preventing the increase of aid to both government and rebel-held areas. The government is limiting humanitarian aid; because of the control exercised by Damascus, assistance can hardly be expanded and aid organisations face huge difficulties crossing front lines. Meanwhile, in the north of the country, insecurity caused by fighting and bombing is compounded by political and diplomatic constraints, seriously limiting the amount of aid.

Though there is currently insufficient humanitarian aid to meet the massive needs, it will be difficult to get more – and more effective – aid into the country. For one thing, the government is not permitting any more international NGOs to work in government-held territory. In addition, humanitarian aid organisations are required to distribute aid through local organisations, who are already operating at full capacity and whose scope of operations is limited geographically.

Meanwhile, indiscriminate or targeted bombing considerably limits the amount of aid provided in the north of Syria. Another obstacle for the provision of aid is of a political nature. In the north of Syria, international aid providers are struggling to find ways to collaborate efficiently with local authorities and Syrian aid networks. The final obstacle is administrative. Though neighbouring countries tolerate NGOs engaged in cross-border humanitarian operations into Syria, they are not willing to grant them the logistical and administrative support that comes with official permission. Aside from slowing down the delivery of aid, this semi-underground status also conflicts with the financing rules for some donors.

MSF's work continues

According to official estimates, 1 million Syrian refugees are registered or awaiting registration in Syria's neighbouring countries, Lebanon, Jordan, Turkey and Iraq, but their actual number could be much higher. Since 2011 MSF has expanded its work with Syrian refugees in Lebanon, Jordan, Iraq and Turkey.

Prior to the Syria uprising, MSF was working in Damascus providing health care for migrants. However, this project was closed in April 2011. Then MSF repeatedly requested official access from the Syrian government in Damascus to be able to provide assistance based on needs, wherever those needs may be. But so far MSF has been denied the ability to work in Damascus and in areas controlled by the government.

Initially MSF started supporting groups of Syrian doctors who were treating the wounded by supplying them with medicines and medical material. MSF re-entered the rebel held areas of the country unofficially in mid 2012 but were unable to enter government-held areas. MSF now has three field hospitals in northern Syria and which the Syrian authorities have been informed of. Whilst initially MSF focused on providing emergency and surgical care, activities have extended to include primary health care consultations, maternal care and organising vaccination campaigns against polio and measles. MSF also provides donations of treatments for cutaneous leishmaniasis; communicable diseases, such as typhoid and chronic illnesses such as asthma, diabetes and cardiovascular diseases.

Hysterical trance while planes fly overhead

Caroline Seguin spent four weeks as the head nurse at an MSF field hospital in Syria. Here she describes some of her experiences.

Planes were flying over our heads and I ran to hide under the staircase. "Is everyone here?" We hoped the staircase would protect us and save our lives. We were staring at each other fearfully. Will the planes fire at us? Will the rockets and the explosive barrels fall on civilians? Will we be able to treat the dozens of wounded who will most likely arrive en masse? But our most urgent question was, "Are we going to die now?"

Our fears grew whenever we heard the planes approaching. At the height of our fears, we would start laughing for no reason whatsoever. We were laughing at each other... as if in some sort of hysterical trance. The minutes seemed to pass like hours, and then the roaring of the planes would fade. We would take a deep breath and pull ourselves together. Everyone would go back to their work station, thinking, "We made it this time."

I worked at the MSF hospital in north-east Syria for four weeks. It was a two-storey house turned into a field hospital. There was an emergency operating theatre and beds to follow–up on the wounded. For complicated operations, the cases were transferred to Turkey whenever the patient's condition allowed it. Most of the cases we witnessed were shrapnel or bullet injuries in addition to building collapse victims. Crowded and populated areas were not spared, and even women and children were victims of rocket fire. Our main mission was to provide treatment to the war victims, but we also provided primary and basic healthcare services to fill the gap set by the deterioration of the health system. We provided treatment for chronic diseases including asthma, diabetes, hypertension, and cardiovascular diseases, as well as neonatal and pregnancy care.

I will never forget Manal, 18, who suffered from fractures in her legs and both knees after the bombing of her home. Her condition was very serious and she could not be transferred to Turkey. We operated immediately and were able to save her life but she had to remain under observation, before we could send her to Turkey for additional surgery. During the morning rounds, she was always sad because she had lost hope in life and in ever walking again. The physiotherapist started talking with her and managed to convince her that she would be able to walk again if she tried hard enough. He managed to get her out of bed and make her exercise. Her eyes were full of life again. In crucial moments, Manal's smile was a genuine motivation and it was able to give a renewed sense of hope.

MSF activities in Syria

544
MSF team members working in and around Syria

By February 2013:

1,560
surgical procedures in three hospitals in Syria, mostly for violence related injuries

20,800
medical consultations, including primary healthcare consultations and emergency consultations

368
babies delivered

68,727
consultations for Syrian refugees in Lebanon, Iraq, Turkey and Jordan

© Nicole Tung

For a copy of MSF's report *Syria Two Years on: The Failure of International Aid so Far* in English or in Arabic, go to **www.msf-me.org**

Children living in a compound in Bagega, Nigeria. Even when compounds are remediated children are exposed to lead through water, food and soil from outside. © Olga Overbeek/MSF

Nigeria

Lead poisoning in Zamfara state

Médecins Sans Frontières (MSF) is encouraged by news that funds to remediate Bagega village, an essential part of the fight against the Zamfara lead poisoning crisis have finally been released. MSF, in collaboration with the Ministry of Health, has been treating victims of the crisis – the worst outbreak ever recorded – since poisoning was first discovered in 2010, and has so far treated over 2,500 children.

"MSF is very happy to see that the work has finally begun after such a long delay. We have long been preparing to provide life-saving treatment to the children of Bagega," says Ivan Gayton, MSF country representative in Nigeria. "We can only begin, however, once the remediation process is well underway, and neighbourhoods are certified free of contamination by environmental engineering experts such as TerraGraphics."

The remediation process removes lead from the environment. Without it, children are continually re-exposed to lead toxins, rendering medical treatment largely ineffective. Acute lead poisoning in children can cause severe brain damage and death. It puts children at risk of loss of appetite, vomiting, abdominal pain and weight loss, as well as long-term mental retardation, behavioural problems and kidney failure.

Ultimately, solving the Zamfara crisis requires a triple approach: medical treatment, decontamination, and safer mining practices.

MSF has been providing emergency medical services throughout Nigeria since 1971.

Laos

MSF to help reduce maternal and child mortality

Following two years of negotiations, Médecins Sans Frontières (MSF) has signed a four-year agreement with the Government of Laos to open a maternal child health project in the remote north-east of the country.

Laos has one of the highest maternal mortality rates in Asia, with 405 deaths per 100,000 births. "There is no reason having a child in Laos should be such a life-threatening experience," says MSF Head of Mission for Laos, Sylvie Goossens. "MSF's experience in other resource-limited countries with similar figures is that expanding access to emergency obstetric care through low-cost strategies can dramatically reduce the risk of women dying from pregnancy-related complications."

Activities in hospitals and health posts will be complemented by mobile medical clinics, improvements to laboratory and pharmacy facilities, as well as to water, electricity and sanitation infrastructure. "Half of the health posts in areas we are targeting are currently not accessible in the rainy season, one is only accessible by foot and many are not yet connected to water and/or electricity, which means the quality of services is currently very low," says Sylvie Goossens. "This is part of the reason why the local population tends to overwhelmingly give birth at home and rely on traditional birth attendants so much."

Lack of qualified staff is another limiting factor and the project will provide training for birth attendants as well as improvements to the rural referral system.

South Sudan

Hepatitis E outbreak escalating in refugee camps

An epidemic of hepatitis E is escalating across refugee camps in Maban County, South Sudan. The first cases appeared in June 2012 and now none of the camps in the county are free of the virus. So far, Médecins Sans Frontières (MSF) has treated 3,991 patients in its health facilities in the camps and has recorded 88 deaths, including fifteen pregnant women.

Hepatitis E, which spreads in environments with poor sanitation and contaminated water, is a virus that causes liver disease. It can lead to acute liver failure and death, and is particularly dangerous for pregnant women. Its symptoms are treatable, but there is no cure.

The Maban refugee camps host more than 110,000 Sudanese refugees and the geography of Maban County – a flood plain in the rainy season and a parched wasteland in the dry season – means that people living in these camps are completely reliant on humanitarian assistance for food, water and healthcare.

As well as caring for hepatitis E patients and treating other patients in field hospitals, MSF teams are carrying out emergency activities. "The refugee camps should not only be a place of safety from conflict, but also a place where refugees can stay alive and are safe from preventable diseases and outbreaks," says Laurence Sailly, MSF emergency coordinator in Doro camp.

MSF has been working in Maban County since November 2011, and is the main healthcare provider across the four refugee camps, running three field hospitals and seven health posts.

Hepatitis E ward Batil refugee camp, Maban County, South Sudan. © Corinne Baker/MSF

Pakistan

Measles cases increasing in Balochistan

Cases of measles are on the increase in east Balochistan. A Médecins Sans Frontières (MSF) medical team in Dera Murad Jamali has treated 159 patients since late December and there have been two measles-related deaths in health facilities supported by MSF in Jaffarabad and Nasirabad districts.

An eight-bed isolation unit has been set up in Dera Murad Jamali Hospital to treat patients with complications and treatment kits have been distributed to locations where MSF runs mobile clinics, including Mir Hassan, Usta Mohammad, Dera Allah Yar and Sobhat Pur.

Worldwide, almost 200,000 children die each year from measles-related complications. "Measles is an extremely contagious illness," says Dr Muhammad Shoaib, MSF's medical coordinator in Pakistan. "If not treated in time, it may result in serious medical complications and even death, especially amongst malnourished patients. In eastern Balochistan, where malnutrition rates are relatively high, chances of complications are even a bigger risk."

MSF has been working with the Department of Health in its hospital in Dera Murad Jamali since 2010, providing emergency obstetric care, a 24-hour delivery room, a neonatal ward, a paediatric ward, a therapeutic feeding programme and a health education programme. MSF has been working in Pakistan since 1986, with Pakistani communities and Afghan refugees affected by armed conflict, natural disasters or who lack access to medical care. MSF teams are currently providing free emergency medical care in Kurram Agency (FATA), Khyber Pakhtunkhwa, Balochistan and Sindh provinces.

Iraq

Kirkuk dialysis unit complete

A dialysis unit support project implemented by Médecins Sans Frontières (MSF) in the Kirkuk General Hospital has been completed. MSF now plans to focus its medical resources on the health of mothers and children by developing new programmes in the maternity and neonatal units of Kirkuk General Hospital to improve care for newborns.

MSF's dialysis unit project was staffed by a team of Iraqi and international medical staff, who worked with Ministry of Health teams to care for patients suffering from severe kidney failure. In 2010 there was capacity for just 22 patients, but by late-2012 there were 100 patients on treatment. MSF's surgical team performed 26 vascular surgeries for end-stage kidney disease patients.

MSF staff also provided technical and medical training, and worked with the hospital to improve sterilisation, infection control and pharmacy management. They set up an infection control committee, installed a sterilisation unit and provided a water treatment system for the dialysis unit. A team from MSF renovated hospital facilities and provided training to help staff maintain facilities in the long term.

MSF is currently providing medical care to Iraqis in Anbar, Baghdad, Najaf and in the northern governorates of Kirkuk, Hawijah and Dohuk. This is in spite of ongoing violence which makes it difficult for MSF's international staff to work in Iraq. Since 2006, MSF has developed activities in the fields of surgery, dialysis, mental health, and mother and child healthcare.

Mobile health clinic, Dera Murad Jamali, Pakistan. © Fathema Murtaza/MSF

Boat carrying supplies and medical personnel to and from Timbuktu, Mali. © Toe Jackson/MSF

Mali

Poor conditions in camps leading to disease and suffering

Conflict in northern Mali is still forcing large numbers of people to flee their homeland and seek sanctuary elsewhere in the countries of the Sahel region, but the conditions in the camps where they are living are themselves leading to disease and suffering. According to UNHCR, approximately 150,000 Malian refugees are living in camps in Burkina Faso (Ferrerio, Dibissi, Ngatourou-niénié, and Gandafabou camps), Mauritania (Mbera camp), and Niger (Abala, Mangaize, and Ayorou camps). Médecins Sans Frontières (MSF) has been working in these camps since March 2012, providing primary and maternal health care, treating malnutrition and vaccinating against measles.

"In Mauritania, as is the case elsewhere [in the Sahel refugee camps], people are suffering from diarrhoea, respiratory infections, and skin infections because of the poor conditions in the camps," says Karl Nawezi, MSF project manager in Mauritania.

In November 2012, a nutritional survey taken in Mbera revealed that nearly one in five children was malnourished and that 4.6 percent of children were suffering from the most severe form of malnutrition upon arriving at the camp. MSF medical teams have expanded their activities to prevent and treat cases of severe malnutrition. "The main challenges are to ensure that children are vaccinated against disease, protected from malaria, and have access to food that's appropriate to their needs," says Karl Nawezi. MSF has set up therapeutic feeding centres to care for the most malnourished children. These facilities have already admitted 1,000 children across Mauritania, Burkina Faso, and Niger. Once admitted, patients are given special milk and nutrient-rich therapeutic food.

MSF is working in Timbuktu, Gao, Ansongo, Douentza, Konna, and Mopti. MSF has also managed a 35-bed paediatric hospital in Koutiala, southern Mali, since 2009. MSF has been working in Mali since 1992.

A mother and her 3-year-old son in the Dolo Health Centre because the little boy was severely malnourished. © Michael Tsegaye

Hear My Voice

Somalis on living in a humanitarian crisis

In 2011-2012, drought and conflict caused widespread food shortages resulting in a malnutrition peak well above emergency levels in Médecins Sans Frontières (MSF) programmes, and spurred the displacement of tens of thousands of people within south central Somalia and to Ethiopia and Kenya. Soaring food prices, insecurity, and the effects of denied humanitarian access by armed groups so exacerbated the crisis that the United Nations declared a famine. Restrictive international donor policies including the criminalisation of aid provision by some governments in some of the worst affected areas controlled by insurgents further hampered humanitarian response efforts leaving large gaps in aid provision.

In February 2012 the famine was declared over and policy makers are now more focused on development, state-building and security than humanitarian aid. While security and access to provide and receive assistance has improved in some areas, large numbers of Somalis still face hardship and violence underscoring the reality that a humanitarian emergency continues in Somalia. As the Somalia government and its donors look toward a new era, humanitarian assistance - including food, water, shelter and healthcare - dissociated from political objectives and processes should remain a priority.

Over the past fifteen months through a questionnaire, MSF has asked over 800 patients about the circumstances that led them to MSF clinics and hospitals in Somalia and the refugee camps in Ethiopia. In addition, individual testimonies were gathered from community members. Drawing on these surveys and testimonies, MSF has released a report titled *Hear My Voice*. The quotes from testimonies allow Somalis to express in their own terms what it means to live under what, for many, are still emergency conditions.

Conflict and food insecurity: Fuelling displacement and suffering

According to 29 percent of the people surveyed, food shortage and related malnutrition is the main challenge. But as evident from their words, these consequences are directly linked to the instability, whether through direct conflict and violence or the indirect consequences of neglect and lack of humanitarian assistance.

Lack of security, lack of food, lack of humanity, lack of freedom and family separation are the hardest things in life. I have been displaced more than ten times in my life. My husband died in an attack, and two of my children died because I was not able to give them food. I try to stay strong but this situation that our county has been facing for too long is killing us.
Woman, 25, from Lower Juba

Displacement: A feature of Somali life for more than 20 years with no end in sight

There are an estimated 1.3 million internally displaced people in Somalia, more than 1 million Somali refugees in neighbouring countries (Kenya, Ethiopia and Yemen) and thousands more on the move to far away destinations. This means that a staggering third of Somalia's estimated 7.5 million people continue to live away from their homes. Violence and fear of attack are reported as the main reason for displacement (46 percent) followed by food shortages due to drought and limited access to assistance (32 percent).

I had to take a decision, die in Somalia, or flee to Ethiopia to survive. I'm a young man, so it was too dangerous to stay where I was. Different groups wanted me to support them and I was afraid to tell them no. I joined them for some time but I was shot and what they are doing is not good for my people. I escaped and now I'm here. I feel naked without my family. My wife is alone with our three children. I'm an irresponsible father but I had no choice.
Man, 28, from Banadir (Mogadishu)

Violence against women: A constant fear

For Somali women, the ever-present threat of sexual violence is an added stress to their already precarious situation. Displaced women fleeing conflict and food insecurity or living in camps are most susceptible to rape as protection mechanisms are usually absent or inadequate. The list of perpetrators is long and includes family members, men in the community, criminal gangs, government officials, and fighting forces. Similar to other countries in conflict, sexual violence has repeatedly been used in Somalia by all the parties involved in the fighting as a weapon of control and power, meant to harm opponents both physically and psychologically.

As a woman travelling alone from Mogadishu you are very lucky if you are not raped along the way, you are lucky if you are raped by one person, and you are unlucky if a gang catches you and several men rape you. I was very lucky.
Woman, 40, from Banadir (Mogadishu)

Healthcare: A key part of a dignified life for Somalis

Access to health care in south-central Somalia remains inadequate to meet the needs of a population caught between conflict, repeated displacement and constant food insecurity. Patients accessing MSF health facilities clarified their desire to access quality health care away from price barriers and traditional healers.

I want to feel like a healthy person and to get my dignity back. My whole life has been anguish and now I am suffering from tuberculosis. It makes me so weak. I want to go back to my family but this disease keeps you in the hospital month after month. We Somalis know how to cope with conflict and drought but without good health care and food there is no future for this country.
Man, 39, from Hiraan

Hope: Access to humanitarian assistance and an end to conflict

Peace and good governance would improve the situation according to 38 percent of the patients questioned. Twenty one percent believe life will be better when humanitarian assistance, especially food and health care, is more accessible while 23 percent (mainly men) expressed the desire to work and to being able to maintain their families.

The situation can only improve if Somalia gets a functioning government and the fighting stops but for this to happen, my children need education. If not they will be forced to fight.
Woman from Lower Juba

Peace would decrease our constant fears.
Woman from Lower Shabelle

As development, state-building and security plans are drawn up for Somalia's newly-elected government, MSF calls for the prioritisation of emergency life-saving assistance to the Somali population.

In order to ensure that humanitarian assistance remains reactive, timely and relevant, it must not take a back seat to, or be subsumed into, political processes but should be independent, netural and impartial. As described here in their own words, many Somalis continue to face acute food and physical insecurity, and lack access to health care and other basic needs for survival and a dignified life. Their right to seek safety and assistance across borders must be preserved and efforts to assist them inside Somalia stepped up.

All new arrivals are screened for diseases and malnutrition when crossing the border into Ethiopia. © Samuel Hauenstein Swan

Vaccinations in an MSF mobile clinic, Somalia. © Feisal Omar

Hear my voice
Somalis on Living in a Humanitarian Crisis

For a copy of the full report in English or in Arabic, go to www.msf-me.org

MSF has worked continuously in Somalia since 1991, and does not receive any government or institutional funding for its Somalia programmes. Despite a reduction in activities over the past two years related to insecurity and attacks on MSF staff, MSF continues to provide life-saving medical care to hundreds of thousands of Somalis in ten regions of the country, as well as in neighbouring Kenya and Ethiopia.

On October 13, 2011 two MSF workers, Montserrat Serra and Blanca Thiebaut, were abducted in Dadaab refugee camp in Kenya. MSF believes that its two colleagues are being held in Somalia and appeal for their unconditional release.

Vaccines

Each year, Médecins Sans Frontières (MSF) teams vaccinate over 10 million people, primarily as outbreak response to diseases such as measles, meningitis, diptheria, pertussis, and yellow fever. MSF also supports routine immunisation activities in some projects which provide healthcare to mothers and children.

In 1999, after being awarded the Nobel Peace Prize, MSF launched the Access Campaign the purpose of which has been to push for the access to, and development of, life-saving and life-prolonging medicines, diagnostics and vaccines for patients in MSF programmes and beyond. Here, we take a closer look at some of the issues affecting vaccines.

Relatives of newborn babies line up for a first round of vaccinations at the Gondama Referral Centre in Bo, Sierra Leone. © Lynsey Addario/VII

Making vaccines easier to use

Immunisation is one of the most effective ways of saving young lives, but every year one in five children born - 22 million - is left without this basic protection from disease. Why? It's because existing vaccines are hard to use in the places where many of these children live. Vaccines have been developed for use in wealthy countries, with strong health systems and good infrastructure. In trying to use these vaccines in countries which don't have the advantages of good roads, reliable power supplies, and adequate numbers of trained staff, it becomes clear why so many children in developing countries fall through the immunisation net.

What is needed to ensure that vaccines reach these children?

Vaccines with simplified dosing schedules

I know how important vaccines are for my babies to be healthy, but I was unable to travel the long distance to hospital for my twins to get their vaccinations.

Aquil Bol Mallien, a mother of three children at an MSF clinic in South Sudan explains the challenges she faces in getting her children protected through vaccination

Heat stable vaccines

For the national health authorities, just maintaining the fridges in working order is hard to guarantee, and then there's the need to produce enough ice packs so that the vaccines are still cold by the time we get to the children. Getting the vaccines out to the villages is a huge logistical effort in itself.

Dr Michel Quéré, MSF Medical Advisor

Vaccines that are easier to administer

With an oral vaccine like the one used for polio, almost anyone can take droppers to households, and give the two drops to all children aged under five. Having an easy-to-deliver vaccine has made a massive difference to the fight against this disease.

Kate Elder, MSF Access Campaign Vaccines Policy Advisor

Vaccines that address developing country disease epidemiology

Vaccine developers have not taken into account the full context of disease in places that are hardest hit by diarrhoeal illness and deaths caused by rotavirus. There's a growing body of research that underscores the need to ensure that vaccines are developed that effectively address the specific needs of developing countries.

Dr Ann-Laure Page, Epidemiologist with MSF's research arm, Epicentre

Strengthened health systems

Focusing on the newest vaccines without boosting existing systems is not a strategy that will benefit the most children: we can't just keep piling on new vaccines and fail to get the basics right.

Dr Estrella Lasry, MSF Tropical Medicine Advisor

What needs to happen?

- The global vaccine community should do more to ensure that developing better-adapted vaccines is part of the wider strategy to increase coverage.
- The GAVI Alliance should support development of more appropriate vaccines for its eligible countries and use its purchasing power to encourage more research and development in this area.
- Epidemiologic surveillance of diseases should be improved to tailor development of vaccines more effectively.
- Governments of developing countries should set priorities and feed information needed for suitable product development to vaccine developers.
- The World Health Organisation should increase investment into operational research in developing countries to see how to improve the delivery of vaccines.

Measles vaccination campaign with a target population of 800,000 children, DRC. © Marcel Bickert

The price of protecting a child

Vaccinating with new vaccines should save many more lives, but high prices could prevent this from happening. Ten years ago, it cost countries less than US $1.50 to buy the main recommended vaccines to protect a child's life. But today, the lowest price for the recommended package of vaccines has risen to nearly $40. That's because not only are more vaccines now included in immunisation programmes, but many new vaccines cost much more than older traditional vaccines.

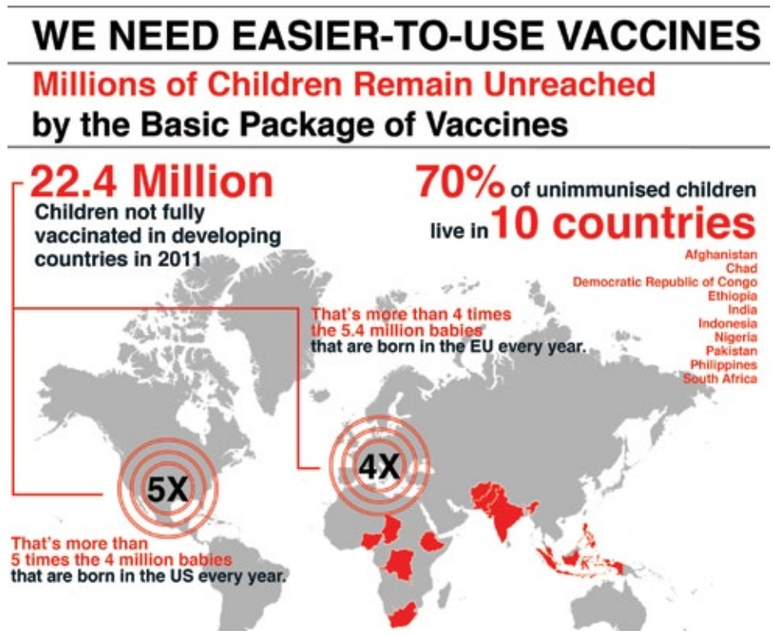
Two new vaccines alone - against rotavirus and pneumococcal disease - now make up around three quarters of the total cost of vaccinating a child. While adding more vaccines to the basic package is a good thing, these high prices pose a threat to the sustainability of efforts to get more children protected.

Most children in developing countries would not be able to benefit without the substantial financial support they currently receive from the GAVI Alliance, a public-private partnership set up over a decade ago to finance the introduction of new vaccines in developing countries and to support basic immunisation activities.

However, as rising per capita incomes leave countries ineligible for donor support, they are hit with a double burden: they no longer receive subsidies, and at the same time they also lose access to GAVI-negotiated prices for newer vaccines. It is therefore critical to bring vaccine prices down to ensure wider and sustainable access in the long run. In 2015, sixteen countries - just under one quarter of those currently eligible for GAVI support - are due to graduate from eligibility. This will present many countries with considerable financial challenges - a bill they will find very hard to foot.

What needs to happen?

- The global vaccine community should do more to ensure that bringing high vaccine prices down is part of the wider strategy to increase access to vaccines, so that many more children can be protected.
- GAVI, UNICEF and others involved in vaccine procurement should use their purchasing power to further drive prices down.
- More lower-cost manufacturers should be encouraged to enter the vaccines market, including through technology transfer, in a bid to develop affordable products.
- Countries buying vaccines should pool their orders to increase their purchasing power.
- UNICEF and others should continue efforts to increase vaccine price transparency.
- GAVI prices should be extended to non-government organisations working in the countries it supports.



A consultation in the outpatient department of MSF's clinic in Pibor. © Robin Meldrum/MSF

The Clinic Deep in the Bush

David Bude is a Médecins Sans Frontières (MSF) clinical officer working in a remote outreach health clinic in the village of Lekwongole in South Sudan's violence-wracked Jonglei State. When fighting erupted in August 2012, he and the rest of the population fled. He describes how he used his medical skills to save lives in exceptionally difficult circumstances.

Fleeing for our lives

We ran from Lekwongole when there was shooting. I said to my wife that if we stay we will also be killed. It is better to run to the bush because we know where we can hide ourselves.

We crossed the river using plastic sheeting as boats. We ferried our children to the other riverbank, and then we ran, all of us, with our children and families.

Deep in the bush

We were deep in the bush, thick grass and undergrowth everywhere. No roads or tracks. I was scared - everyone was scared. There are lots of dangerous things: snakes, hyenas, we heard lions at night, and even rebels or militia. You don't know what will happen at night, or even during the daytime.

The area was flooded and most people were sleeping under trees without anything for shelter. Some people had plastic sheeting and when it rained they would ask children to come under to shelter. People were helping each other because we were all there in the bush together.

The clinic under the tree

I chose a big tree with plenty of shadow. I had a plastic sheet and my wife made a sort of rough shelter. I made a wooden platform to keep the medicines off the ground. This was my pharmacy.

We made benches so there was a waiting area for people to sit, and with poles and mud I made a sort of consultation room so when a patient needed treatment I would see them in this 'room'.

We got a message to the MSF team in Pibor, and they sent some supplies to the closest place a boat could get to – medicines for ante-natal care, malaria, diarrhoea and malnourished children; antibiotics; dressings; even a register for keeping records.

Spreading the word

I found two of the health promoters from the MSF Lekwongole team. They went around passing the message that if your child is sick with anything, diarrhoea, eye infections, respiratory diseases, fever, injuries or anything, to come and see us.

A lot of people came. Sometimes I saw 50 patients in one day. Malaria was common, and pneumonia, children who were malnourished, diarrhoea because there was no clean water and even a TB patient we were following-up. I kept going until the medicines ran out.

Running out of medicine

In early September we finished the stock of medicines, so I went to Pibor. I went by foot, but the floods had been bad so there was water everywhere. Even the smallest streams, I had to swim. I walked and swam for nearly two whole days.

The MSF team in Pibor found a boat for me to go back. When we finished that stock, I went back by foot, with three guys from my medical team and again we came back by boat with the medicines to the clinic under the tree.

Saving lives

We definitely saved lives. People were in real difficulties in the bush: not enough food; mosquitoes; bad water.

I remember a young man who came during the night with severe malaria. He was crying out in the darkness, writhing around. So we tried to calm him and I did a rapid malaria test, which showed positive. So I started administering Artemether injections. This was just after midnight.

We had a sort of inpatient department. I had nowhere to keep inpatients, but I made sure they stayed nearby so if I needed to follow-up or give them medication, I could find them. I kept children with severe malaria right by the clinic until they showed signs of improvement. It was important for me to find the mothers of sick children to make sure they remembered what I had said about the medicines, and I had to do follow-up checks and sometimes give out new drugs.

What if?

None of the patients I treated died, but it is hard to know how many people died because they fell ill and couldn't come to be treated.

I think about the people who fled to places that were too far from my clinic. We saw many cases of malaria, so what happened to the people who could not get treatment? The situation for them must have been very bad indeed.

Our clinic was not perfect, but it was better than nothing, and we saved lives.

Psychosocial counsellors at a paediatric TB hospital in Dushanbe, Tajikistan, work with young patients to encourage adherence to treatment. The counsellors have developed a star chart to motivate children with multidrug-resistant tuberculosis (MDR-TB) to take their drugs on a regular basis. © Natasha Sergeeva/MSF

Tajikistan's "Heartbreaking Mosaic of Family Tuberculosis"

Cindy Gibb is a nurse from New Zealand working in Médecins Sans Frontières' (MSF) groundbreaking treatment programme for children with drug-resistant tuberculosis in Tajikistan, Central Asia.

It is 8 am in Dushanbe, the capital of Tajikistan, and already it's hot in the summer sun. Today I need to find time to work on the sputum induction protocol. It's difficult to diagnose tuberculosis in children bacteriologically, because most kids, especially the younger ones, can't produce enough sputum for the tests. Paediatric tuberculosis is a neglected disease, and there isn't enough research and development, or any clear-cut advice, on how to treat it in children. Our project is significant because we are developing guidelines that haven't existed before.

My time is divided between the office, the children's tuberculosis hospital in Dushanbe, and the tuberculosis hospital in Machiton where MSF has just opened a specialised ward for treating children with drug-resistant tuberculosis (DR-TB). I also do home visits.

At 9.30 am I am in the children's tuberculosis hospital with our doctor. Children are admitted from as far away as Khatlon province and Sogd, some for six to eight months of treatment. We've been busy recently, with three patients in our programme discharged within one week. They will receive the rest of their treatment at home. Yesterday I visited Nadira, a mother with multidrug-resistant tuberculosis (MDR-TB) and her two little boys, who are also sick with tuberculosis. They live in a village north of Dushanbe. It's just 40 kilometres away, but around two hours' drive each way due to the poor condition of the road. We always climb the last 20 minutes on foot. The earth road will barely be passable from autumn until springtime, and in the winter the villagers will be cut off from the highway by snowfalls.

When a child is discharged from the tuberculosis hospital, I have to prepare everything for their smooth passage: I make sure that the drugs are available, the nurse at the local health post is trained to work on the case, and that transport is available if the family needs to travel to the nearest clinic. Usually, the local community nurse observes the daily intake of drugs and gives the injections, but in the case of Nadira's family, we have trained a volunteer who is also a distant relative. She has no formal health training but neither does anyone else in their village. We provide 'enablers' such as transport and mobile phone credit to the families and care providers performing home visits.

Next week I'm going to visit the family of Nadira's sister, Gulnara, another part of the heartbreaking mosaic of "family tuberculosis." Both Gulnara and her two children, Hassan and Dilnoza, are sick with MDR-TB. Identifying close family contacts is an important part of the project, given the strong family ties and the tradition of extended families living together in one household.

Lunch in the office is the time when all the team comes together and discusses work and non-work related issues. I also have my regular hour of Tajik language lessons.

The doctor and I, along with our translators and a driver, will drive for three hours, then will stay overnight in Shaartuz. The following day we will see our patient and family and check on the local health post and medical staff.

In the car, I eventually have some time to work on the policy on sputum induction in children with tuberculosis. The rest of the trip we practice our Tajik. The project is growing, we will have more and more patients receiving outpatient care, and I am looking forward to finding a Tajik staff nurse to help me.

يضم قسم طب الأطفال ١٤ سريراً، أربعة منها مخصصة للأطفال المصابين بسوء التغذية الحاد مع تعقيدات طبية أخرى. ومنذ شهر أبريل/نيسان ٢٠١٢، دخل المستشفى ١٥٤ طفلاً يعانون من سوء التغذية الحاد، بينما تمكنت برامج التغذية التنقلية، التي أطلقتها المنظمة في القرى المجاورة، من الوصول إلى ٢١٥٢ مريضاً. كما أجرت المنظمة في المجموع ٥٦٠١ تلقيحاً، ١٧٢٨ منها خاص بالحصبة.

There are fourteen beds in the paediatrics ward, four exclusively for severely acutely malnourished children who have complications. Since April 2012, 154 children have been hospitalised for severe acute malnutrition, while MSF's ambulatory feeding programmes in the surrounding villages have so far reached 2,152 patients. A total of 5,601 vaccinations have been carried out, 1,728 of those against measles.

مالي

يوم في مستشفى تمبكتو

منذ أن بدأت العمليات العسكرية في شمال مالي شهر يناير/كانون الثاني، واصلت منظمة أطباء بلا حدود عملها في مدن مابوتي وغاو وأنسونغو وكونا ودوينتزا وتمبكتو، حيث تقدم العلاج المنقذ للحياة والجراحة الطارئة إلى مرضاها.

وتعمل المنظمة في منطقة تمبكتو منذ أكثر من عام، وتواصل توفير العلاج لأعداد كبيرة من المرضى. وفي عام ٢٠١٢، أجرت ٥٠،٠٠٠ استشارة طبية (نحو ثلث الحالات المصابة بالملاريا)، واستقبلت في المستشفى ١٦٠٠ مريض، وأجرت أكثر من ٤٠٠ عملية جراحية.

جميع الصور © تريفور سناب

Mali

A day in Timbuktu Hospital

Since military operations began in northern Mali in January, Médecins Sans Frontières (MSF) has continued its work in Mopti, Gao, Ansongo, Konna, Douentza, and Timbuktu, providing life-saving treatment and emergency surgery to patients.

MSF has been working in the Timbuktu region for more than twelve months and continues to handle large numbers of patients. In 2012, MSF conducted 50,000 medical consultations (approximately one-third of them for malaria), hospitalised 1,600 people, and performed more than 400 operations.

All images: © Trevor Snapp

تعمل منظمة أطباء بلا حدود جنباً إلى جنب الطاقم القليل من وزارة الصحة الذي بقي بعد اندلاع العمليات العسكرية. فقد هرب معظمهم إلى باماكو وغيرها من المدن بعدما سيطرت الجماعات المسلحة على تيمكبو السنة الماضية.

MSF staff work alongside the few ministry of health staff who remained after military operations began. Most fled to Bamako and other cities when armed groups took over the city last year.

يتلقى هذا الطفل العلاج في المستشفى منذ شهر واحد.

This boy has been at the hospital for one month.

هذا الطفل يتعافى من الأكال (الغنغرينة) بعد إصابته بجرح التهب في جسده.

Recovering from gangrene from a wound that became infected.

يُعد ارتفاع ضغط الدم أمراً شائعاً بين المرضى.

High blood pressure is common amongst patients.

تُعتبر الملاريا من بين أخطر المشاكل الصحية في البلاد.

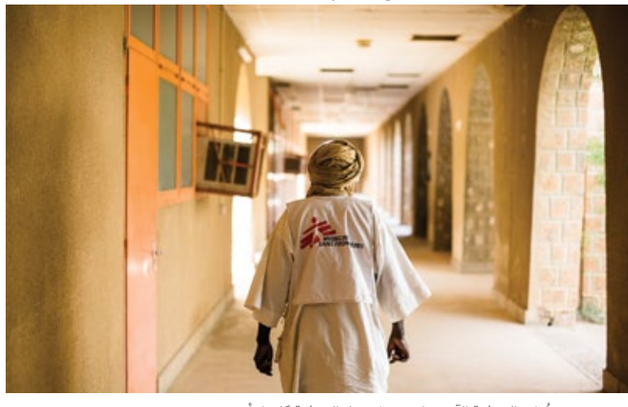
Malaria is one of the country's most serious health concerns.

يراقب الطاقم الطبي صحة الأمهات بعد الولادة.

Medical staff monitor mothers after they have given birth.

يضم قسم الأمومة عشرة أسرة.

The maternity ward has ten beds.



يرتدي حُراس المنظمة الآن سترات تحمل شعار المنظمة كإجراء أمني.

The MSF guards now wear MSF jackets as a security measure.

يتكون فريق المنظمة من طاقم وطني وآخر أجنبي.

The MSF team is composed of national and expatriate staff.