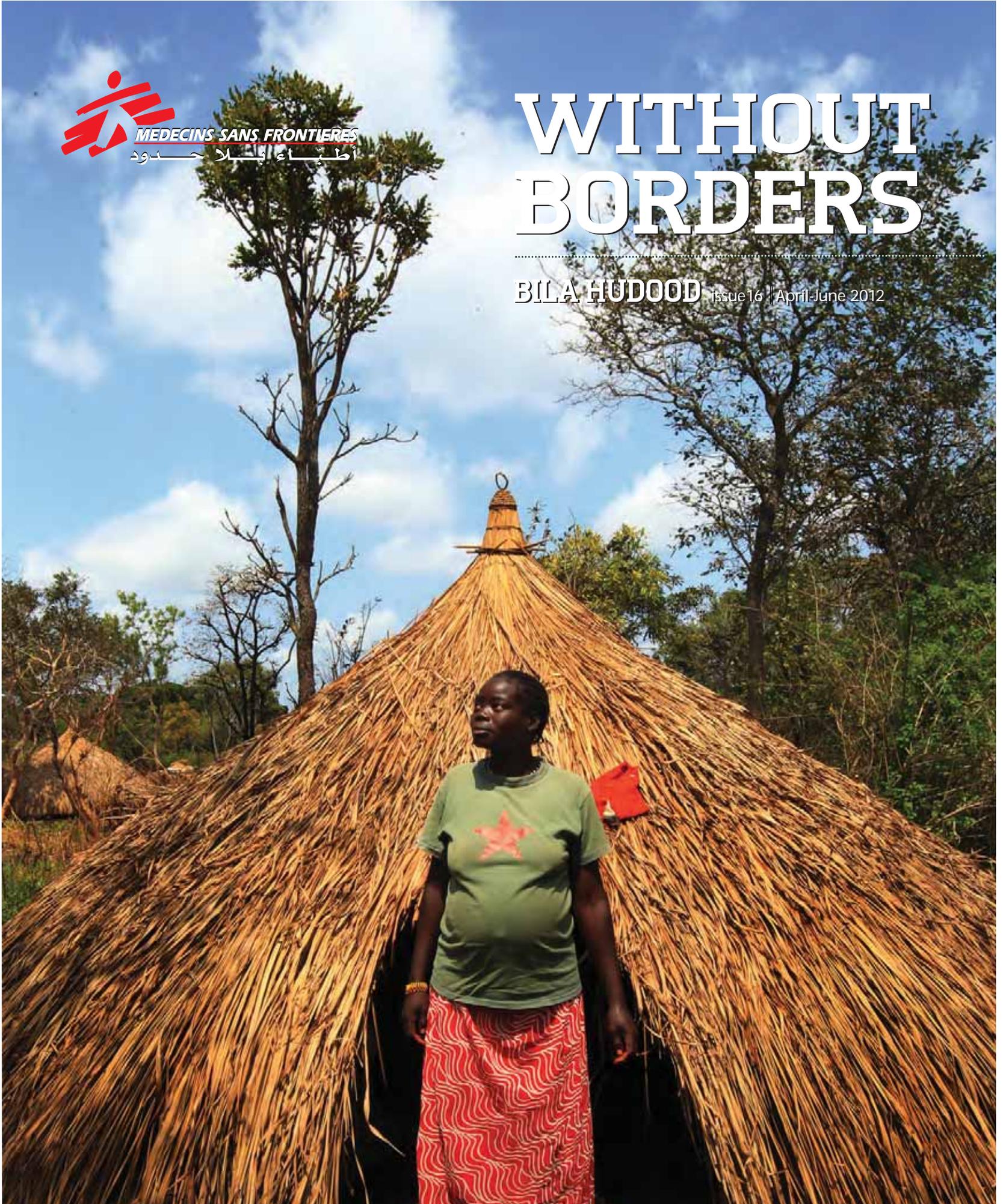


# WITHOUT BORDERS

BILA HUDOOD | issue 16 | April-June 2012



Lead Story:  
Syria:  
Medicine as  
a weapon of  
persecution  
page 2

Country in  
Focus:  
South Sudan:  
state of  
emergency  
page 3

Around the  
**world:**  
Libya, Somalia,  
Gaza, Yemen,  
Mauritania  
page 5

**Special report:**  
Access: Ten  
priorities for 2012  
page 7

Interview:  
Brauman  
remembers MSF's  
early years  
page 9

Voice from the  
**field:**  
Somaliland: the  
hospital of hope  
page 11

Photo Essay:  
Lebanon:  
Mental health  
page 13

# Maternal death is an ongoing crisis

As we mark yet another International Women’s Day (March 8) and reflect on the progress made by women globally, it is painstaking to know that 1000 women still tragically die every day in childbirth or from pregnancy related complications. This statistic remains overwhelmingly confronting, especially when the vast majority of these deaths are preventable with skilled clinicians, drugs and equipment. Maternal death is an ongoing crisis, and an avoidable crisis that deserves our attention. The reality in most developing countries is that access to health care is limited and most women cannot get the emergency assistance they need during pregnancy and at the time of birth. Access for all pregnant women to quality healthcare may seem an impossible dream. As MSF, it is not our role to provide a global solution to the crisis of maternal mortality. It is the role of governments and

development-focussed agencies to weigh in upon the issues of women’s rights, education for girls and the improvement of health systems that are paramount in reducing maternal mortality in the long term. It’s a fact that 15 percent of all pregnant women encounter life-threatening complications during delivery, whether they are in Sydney or Mogadishu. Women who are subject to conflict, health crises and displacement are rendered even more vulnerable – and complications for those living in a war zone are likely to be even higher when health facilities collapse. To make an immediate difference, the focus has to be on the main causes – haemorrhage, infection, unsafe abortion, hypertensive disorders and obstructed labour – accounting for over 80 percent of all maternal deaths globally. Medical care and available resources are the key factors during these times of crisis.



© Michael Tsegaye

A woman should not face an uncertain future just because she is pregnant. On Women’s Day, as on every other day, we must continually remind ourselves that every maternal death is an unacceptable and avoidable death.

**Kara Blackburn -Midwife and Women’s Health Advisor for MSF.**

## What is MSF?

Founded in 1971 by doctors and journalists, Médecins Sans Frontières (MSF) / Doctors Without Borders is an international medical humanitarian organization.

MSF is neutral and impartial, delivering emergency medical care to people caught in crisis regardless of race, religion, or political affiliation.

MSF is independent from any political, economic or religious power. Ninety one percent of MSF’s overall funding comes from private sources, not governments.

MSF is transparent and accountable. Every year, MSF provides detailed activity and financial reports including audited and certified accounts

MSF controls the entire chain of its medical services, from the independent assessment of needs to the delivery of medical care, and does not subcontract to other organizations.

**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**

## MSF in numbers



Income

- Private 91%
- Public institutional 7%
- Other 2%



How was the money

- Operations 82%<sup>1</sup>
- Fundraising 13%
- Management, general and administration 5%



Event triggering

- Armed conflict 31%
- Epidemic 42%
- Health exclusion 18%
- Natural disaster 8%



Project locations

- Africa 61%
- Asia 24%<sup>2</sup>
- Americas 14%
- Europe 1%

<sup>1</sup> programmes, HQ programme support cost, awareness raising and other humanitarian activities

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A Syrian victim of violence receiving treatment for his leg injury at an MSF medical facility in a neighboring country. © Khalil Mazrawai/ AFP

## Syria: Medicine as a Weapon of Persecution

**As the cycle of violence in Syria** continues unabated, the humanitarian situation is likewise developing rapidly with access to food, medical supplies and other basic services worsening dramatically.

MSF has issued a dossier of testimonies collected from wounded Syrian patients treated outside the country and from doctors inside Syria.

While MSF was and still is unable to work directly in Syria, it states that the testimonies, collected from several people from different parts of the country, point to a crackdown on the provision of urgent medical care for people wounded in the violence.

MSF concludes that the Syrian regime has been conducting a campaign of unrelenting repression against people wounded in demonstrations and the medical workers trying to treat them.

"In Syria today, wounded patients and doctors are pursued, and risk torture and arrest at the hands of the security services," said Marie-Pierre Allié, MSF president. "Medicine is being used as a weapon of persecution."

Most of the wounded do not go to public hospitals for fear of being arrested or tortured. When a wounded person is admitted to a hospital, a false name is sometimes provided to hide the identity. Doctors also provide false diagnoses to help patients elude security forces, which search for patients with wounds consistent with those sustained in demonstrations.

*"Hospitals must be protected areas, where wounded patients are treated without discrimination and are safe from abuse and torture, and where medical workers do not risk their lives by choosing to comply with their professional code of ethics," added Allié.*

The injured are largely treated in clandestine facilities by doctors trying to fulfill their duty to provide medical assistance. Improvised health clinics have been established in apartments and elsewhere. Simple rooms outfitted as makeshift operating theaters, known as "mobile hospitals," are used for surgical procedures. Hygiene and sterilization conditions are rudimentary and anesthesia is in short supply. Furthermore, the mere possession of drugs and basic medical materials, such as gauze, is considered a crime.

"The security services attack and destroy the mobile hospitals," said a doctor who requested anonymity. "They enter houses

looking for drugs and medical supplies."

Security is the key concern for doctors working in the parallel underground networks. Medical workers and patients must constantly change location to avoid detection, thus treatment is provided rapidly.

"Many doctors who treated wounded patients in their private hospitals have been arrested and tortured," said another physician, adding that treating major trauma cases and providing post-operative care was extremely difficult.

Only a few wounded patients have managed to find refuge in neighboring countries, where they can receive proper—albeit delayed—medical care. "I was wounded in the thigh and the soldiers caught me," recounted a patient treated by MSF. "They beat me on the head and on my wound, but I managed to get away with help from people in the neighborhood. In the end, I found someone who could treat me—a nurse, not a doctor. He didn't even have anesthetic."

MSF's assistance to Syrians requiring medical care is limited. MSF has been seeking official authorization to aid the wounded in Syria, so far without success. Diplomatic efforts and negotiations with the Syrian authorities demanding for access are still ongoing. Meanwhile, the organization is treating patients outside Syria and is supporting doctors' networks inside the country, through the provision of medicine, medical supplies, and surgical and transfusion kits.

## Country in focus

### South Sudan: State of emergency



Refugees in Jamam refugee camp. Refugees from Blue Nile State in Sudan fled to seek safety in the refugee camps at Doro and Jamam, in Maban County, Upper Nile State, South Sudan. © Robin Meldrum/MSF

Months into the birth of South Sudan—the world’s newest independent country—a series of emergencies are still occurring; prompting urgent humanitarian responses.

**The 22-year war that ended in 2005 left South Sudan’s healthcare provision in a perilous state. Added to this, civilians have borne the brunt of crisis after crisis over the past years. These include regular, violent clashes resulting in death, injury, and mass displacement; the arrival of 300,000 people returning from the north; as well as the chronic malnutrition and frequent outbreaks of diseases such as kala azar, measles, and meningitis.**

### Renewed violence

Intercommunal fighting in Jonglei State early January forced thousands of families to flee into the bush, where they had no access to assistance, including medical care.

Before the violence hit Pibor town, MSF had evacuated all non-local staff to Juba, and the locally-recruited staff had left town and gone into hiding along with the other inhabitants of Pibor.

The two healthcare facilities operated by MSF there were looted and damaged. A third MSF clinic in the nearby village of Gumuruk was not affected by the attacks. Nonetheless, the three medical facilities were the only healthcare options for 160,000 residents in Pibor County. MSF condemned the attacks and soon after, returned to Pibor town with 12 medical and logistics staff to provide an emergency response including referral by air

for patients with serious wounds. MSF is rehabilitating the facilities to allow the team to resume medical activities.

### Refugees in Urgent Need of Assistance

In the contested area of Abyei, recent fighting pushed the local population to escape southwards, resulting in an estimated 100,000 displaced people. Other conflicts across the border in Sudan—particularly in Blue Nile and South Kordofan states—have forced tens of thousands of refugees to flee across the border over the past months, and they are still crossing.

MSF has scaled up into full emergency mode in Upper Nile State to respond to the sudden influx of thousands of refugees fleeing conflict

in neighboring Sudan; while around the town of Agok in Northern Bahr al Ghazal State, MSF launched a preventive supplementary feeding program for children at risk of becoming malnourished in the months ahead.

In November 2011, MSF also launched an emergency response in the refugee camp in Doro, in Maban County. By mid March 2012 around 80,000 refugees from Sudan’s Blue Nile State had sought shelter in two camps located in a remote and barren region of South Sudan where humanitarians confront massive logistic challenges to access and assist refugees.

“These refugees are left almost completely reliant on humanitarian assistance because this area has scarce water and food,” says Julien Matter, MSF’s emergency coordinator. “The sheer numbers of refugees fleeing here has grown to far beyond anything anyone



Two MSF doctors treating a young Sudanese refugee who was injured while digging a anti-bomb trench in a refugee camp. © Robin Meldrum/MSF

anticipated — and in such a remote place, providing the bare survival essentials now, and through the coming rainy season, will be a serious challenge.”

Once the rains start in late April, the region would become gradually ever more inaccessible, likely becoming a vast swamp with small islands of dry ground. MSF has called on all aid organizations to scale up their emergency response before the rainy season started, warning that the lives of tens of thousands of refugees’ and their health was at stake if essentials such as water, food, household items and shelter are not urgently assured in the short span of time before the rain.

## Food Emergency

The unfolding food emergency has additional causal factors from the added burden of returnees, refugees, and internally displaced South Sudanese. There has been widespread crop failure, flooding, trade disputes, and inflation in the local markets, making it very hard for families to find anything to eat.

“If nothing is done, the situation could become dramatic,” said Ines Hake, the medical team leader at the MSF hospital in Agok. Hake took part in an 11-month assessment that prompted MSF to start preventive supplementary feeding for 20,000 young children in 2011.

The survey found that 65 percent of households in the region were accommodating family members displaced by the conflict in Abyei. “For the moment, the lives of the children that we are targeting are not in immediate danger,” Hake explains. The aim of preventive supplementary feeding is to reduce the chance that children become so malnourished that they will require therapeutic feeding or, worse, hospitalization.

*“If we can prevent malnutrition now before it kicks in, we’re preventing kids dying,”*

says Nurse Sita Cacioppe, adding that her own motivation is “to try and prevent us from coming out onto the field and finding hundreds of actually starving children.”

MSF has been working in Sudan since 1978 and began activities in the area that is now South Sudan in 1983. MSF works in 8 of 10 states in South Sudan, providing healthcare in 15 projects via roughly 2,500 national staff and 200 international staff. MSF and MSF-supported clinics serve a variety of communities, are free of charge, and are open to all. In 2010 MSF teams across the country carried out 588,000 outpatient consultations, treated 37,000 people with malaria, delivered 20,000 babies, cared for 18,000 hospitalized patients, and cured almost 26,000 malnourished children under 5 years of age.



Refugees in Doro. In mid-November thousands of refugees fled fighting in Blue Nile State in Sudan, crossing the river into South Sudan at the villages of Guffah and Khortumbak to seek safety  
©Jean-Marc Jacobs/MSF

## “I Will Stay Here Until Our Home Place Has Peace”

A 33-year-old man, who was interviewed in the Doro refugee camp in December shares his story with MSF. He previously worked as a community health worker with an NGO in Blue Nile State, but has since spent 10 years in a refugee camp in Ethiopia during Sudan’s civil war. He returned home in 2005, but has now been forced to register as a refugee once again.

“The journey here was very hard for us. It was so far. For me and my family it took about one week and a half to come here to Doro. Our small children could not walk far. My wife and our 11-year-old each carried the twins, who are one year old, on their backs. I was carrying our food and belongings. The others—who are aged nine, seven, and four—had to walk by themselves. The four-year-old can walk, but after a while he started crying.

When we were on the way, the children were very hungry. Some of them were sick

with diarrhea. The sun was hot. We drank water that was not clean. But we managed to reach this camp.

We would walk for four hours at a time, then rest under a tree...We were always looking for places where we could find water. Here there are a lot of problems facing us. We are just staying here because of security. This place is very cold at night. We light a fire because we have no sheets or blankets. The only water is the hand pump for the local people from the area. Sometimes my wife goes to the water pump first thing in the morning and only comes back in the evening with water. It can take up to 12 hours to wait.

People here know MSF is giving health care to them by opening this clinic. If MSF hadn’t come, they could have suffered more.

I just want to tell the world we need help, a lot of help, from them. We came to a place where we can be secure, but food security is now replacing the other security problem that we ran from. I will stay here until our home place has peace. But I worry that we may be here for a long time.”

## Around the world

### Somalia

#### Measles Takes its Toll

Measles is sweeping unchecked through parts of southern Somalia. The disease is highly contagious and unvaccinated children are at great risk, especially if they are also malnourished. The war in southern Somalia is a key factor contributing to ongoing widespread malnutrition, low vaccination coverage, and lack of access to health care services. All of these factors aggravate the spread and severity of diseases like measles.

In some MSF programs, the number of measles cases has sharply increased in recent weeks.

“Over the last weeks, we diagnosed and treated over 300 patients for measles—mainly children—in the towns of Haramka and Marere in Lower Juba Valley,” said Silvia Colona, MSF’s project coordinator for southern Somalia. “We also set up a measles treatment unit in the city of Kismayo, and it filled up immediately with critically ill children.”

Left untreated, measles is often deadly, especially for young children, but with adequate medical care most survive. Unfortunately, lack of awareness and insecurity are probably preventing many from getting treated. “We think this is only the tip of the iceberg,” added Ms. Colona, “and that there are many more people with measles who can’t make it to our facilities.”

From May to December 2011, MSF treated more than 95,000 patients for malnutrition, and treated more than 6,000 and vaccinated nearly 235,000 children against measles in areas where it was permitted and in refugee camps in Kenya and Ethiopia.



A four-year-old boy suffering from measles and malnutrition waits for his medicine in Banadir hospital in Mogadishu. Somalia 2011 © Martina Bacigalupo

### Libya

#### Detainees tortured and denied medical care

Médecins Sans Frontières suspended its operations in detention centres in Misrata in January 2012 after finding out that detainees in the Libyan city were being tortured and denied urgent medical care.

MSF teams began working in Misrata’s detention centres in August, 2011, to treat war-wounded detainees. Since then, MSF doctors were increasingly confronted with patients who suffered injuries caused by torture during interrogation sessions. The interrogations were held outside the detention centres. In total, MSF treated 115 people who had torture-related wounds and reported all the cases to the relevant authorities in Misrata. Since January, several of the patients returned to interrogation centres have even been tortured again.

“Some officials have sought to exploit and obstruct MSF’s medical work,” said MSF General Director Christopher Stokes. “Patients were brought to us in the middle of interrogation for medical care, in order to make them fit for further interrogation. This is unacceptable. Our role is to provide medical care to war casualties and sick detainees, not to repeatedly treat the same patients between torture sessions.”

MSF medical teams were also asked to treat patients inside the interrogation centres, which was categorically refused by the organisation.

### Gaza

#### MSF opens a hand therapy unit in the Gaza Strip

Early January 2012, MSF opened its first unit dedicated to hand therapy to treat all patients in the Gaza Strip who require this specialized care.

Over a two-week period, French physical therapist and science writer Michel Boutan trained four Palestinian physical therapists at MSF clinic in Gaza City. They were trained to perform manual screening of mobility problems (morpho-palpatation), to establish appropriate treatment protocols, to manufacture orthoses (prostheses for the hand) and to use electrical stimulation properly in hand therapy, depending on the patient’s illness.

A room dedicated to hand therapy was set up in the MSF clinic in Gaza City and outfitted with the necessary supplies. Today, 50 people are benefiting from this specialized care. Most are children. The common goal is to help them restore optimal use of their hand.

At the end of the MSF training, local health authorities and the UNRWA office in charge of physical therapy organized a half-day workshop to share techniques and knowledge in the area of hand therapy. The objective was to increase their knowledge and skill so that patients may benefit from the techniques and elective physical therapy treatment (splints, facial masks and compression garments) and alleviate the serious consequences – medical, social and psychological – that people with severe burns may suffer.



A patient at the MSF unit dedicated to the hand physiotherapy in the Gaza Strip. © Michel Boutan /MSF

## Mauritania

### Thousands of Malian Refugees Gather in the Desert

More than 28,000 Malian refugees have been forced to seek refuge in the border region of Mauritania due to the conflict between the Malian army and Tuareg rebels that broke out in northern Mali. Some refugees travelled days without food to reach makeshift camps in Fassala and Mbéré in the south east of Mauritania.

*“We are in the middle of the desert in an area where water is a scarce commodity,”*

says Marie-Christine Férir, MSF’s emergency coordinator in Mali. “Even more alarming, these people are isolated here: the nearest hospital is six hours away by road.”

An initial shipment of more than 26 metric tons of medical and logistical supplies were flown to Néma, about 200 kilometers from Mbéré camp.

Food insecurity threatens both refugees and local people. The arrival of refugees in distress puts even greater pressure on Mauritanian families who have already been impoverished by recent bad harvests. “We know that amongst the refugees are pregnant women and children who are suffering from moderate to severe malnutrition,” says Férir. It is crucial that the youngest children, who are particularly vulnerable, are able to access free medical aid, as a malnourished child is more vulnerable to illnesses like measles, diarrhea, and respiratory infections. Sick children are also at a higher risk of becoming malnourished.

Considering that the closest hospital is more than 200 km away, one of MSF’s priorities is to provide prompt emergency care and stabilise serious cases before referring patients to the hospital in Néma. The new MSF clinic in Mbéré camp will allow medical teams to provide a range of key services including consultations, nutritional screening, primary healthcare, prenatal care and vaccinations against infectious diseases like measles if necessary.

MSF has been responding to the medical needs of refugees in Niger and Burkina Faso since the beginning of February 2012. The organisation is also working in the north of Mali, where it is offering primary healthcare to people displaced by fighting there.



An MSF staff member conducting a nutritional survey that led to the opening of the feeding center in Néma, near the border with Mali. © Ibrahim Younis

## Yemen

### MSF Treats 39 Injured as Violence Affects the South of the Country

In February, MSF teams in Aden and Al Daleh, in southern Yemen, tended to 39 people who had been injured during outbreaks of violence connected to national elections. A local separatist movement boycotted the vote, which led to clashes in the south, particularly in Aden, the region’s main city.

MSF supported three hospitals in Aden by deploying medical and surgical teams and financially supporting health care for the

wounded. The three hospitals admitted a total of 37 people. Additionally, an MSF team working in the emergency room of Al-Daleh hospital, some 120 km further north treated two gunshot victims.

For over a year now, MSF has been working around the main areas of violence in southern Yemen—particularly in the governorates of Aden, Abyan, Al-Daleh and Lahj—supporting emergency rooms, transferring wounded patients, and helping to provide primary health care for the resident population and people displaced by the conflict in Abyan.

In 2011, MSF conducted more than 15,000 emergency room consultations and performed 1,500 surgical procedures in these programs.



A child being weighed in an MSF Therapeutic Food Centre where most hospitalized children are less than 2 years old in Amran governorate, Northern Yemen. © Agnes Montanari

# Access to Essential Medicines:

## Ten priorities for 2012

**MSF aims to bring the best medical care possible to some of the most disadvantaged people on earth. In 1999, after being awarded the Nobel Peace Prize, MSF launched the Access Campaign. Its purpose has been to push for access to life-saving medicines, diagnostic tests and vaccines for patients in MSF programmes and beyond.**

“At a time of so much promise, it is crucial to continue pushing forward, and refuse to accept a double standard in care between rich and poor countries,” says Dr. Tido von Schoen-Angerer, executive director of MSF’s Access Campaign.

2011 marks the ten-year anniversary of two events that have helped shape people’s ability in developing countries to access quality, affordable medical care.

The signing of the Doha Declaration, which affirmed the need to prioritize access to affordable medicines over trade (intellectual property rights). And the decision to create a “war chest” to fight the biggest killer diseases: HIV/AIDS, tuberculosis, and malaria.

But without renewed prioritization of health, both politically and financially, recent scientific promise and policy advances look fragile. The report looks at developments in 2011 that had an impact on people’s ability to access needed drugs, diagnostics, and vaccines in developing countries and identifies the following as ten priorities for 2012

### 1. Getting ahead of the wave of new HIV infections to turn the tide on AIDS

Decades into the HIV/AIDS pandemic, and after 30 million deaths, scientific findings show that providing people with HIV treatment early not only saves their lives but can reduce the risk of transmitting the virus to others by 96 percent.

The question is how to make expansion of treatment both feasible and affordable. Governments committed at the UN in June to reach 15 million people with HIV treatment by 2015. If treatment is expanded by 2015, UNAIDS estimates more than 7 million deaths and 12 million new infections could be averted by 2020.



Thousands of demonstrators took to the streets in Delhi in protest over the planned FTA between India and EU which would restrict access to life-saving medicines. © Rico Gustav/APN+

But the fact remains that only half of those in urgent need of treatment have access to it, and recent dramatic funding shortfalls put the goal of an AIDS-free future further out of reach.

### 2. Finally, clarity on prices promises to make vaccines more affordable

Earlier this year, MSF began vaccinating children in its projects in Kenya with the new pneumococcal vaccine. Many believe too high a price was paid to pharmaceutical companies for the vaccine.

In 2011 UNICEF—for the first time—published the prices it pays for all the vaccines it buys. This move revealed huge price disparities in what different companies are charging for similar vaccines.

There’s been no price transparency until now over vaccine prices and purchasers have had no benchmark figures. Now that the information is public, competing vaccine manufacturers are likely to drive prices down, meaning that more children can be immunized against life-threatening diseases.

### 3. Progress in the fight against HIV, TB, and Malaria under threat as health funding falters

The announcement by the Global Fund to Fight AIDS, Tuberculosis, and Malaria that it was cancelling its annual funding round because donors had not paid up came as a shock. Countries will now have to wait until 2014 before they can receive new funds to put more people on treatment for the three diseases.

Donors must now urgently step up and replenish the Global Fund so that its life-saving work can continue without interruption.

### 4. Numbers of patients on treatment for drug-resistant TB remains catastrophically low

Governments are not meeting the challenge of providing treatment for the rising numbers of people infected with drug-resistant tuberculosis (DR-TB), which has infected around five million people over the past ten years.

In a breakthrough development, a new diagnostic test was introduced this year — including by MSF in seven countries — that can drastically reduce the time it takes to diagnose DR-TB, from several weeks to under two hours. The test is very expensive and treatment costs on average US\$4,500 per patient.

Over the last ten years, less than 1 percent of people with DR-TB have had access to appropriate treatment and 1.5 million have died.

### 5. Turning the screws on affordable medicines produced in India

India’s role as the “pharmacy of the developing world” is once more under fire. Five years after the drug company Novartis first tried to get a critical part of India’s pro-health patent law thrown out, the company is back for the final round of its legal battle against the Indian government — this time in the Supreme Court.

If Novartis is successful, India will be forced to grant far more patents on medicines than they

currently do, blocking the production of more affordable versions of medicines patented elsewhere, and so keeping newer drugs out of reach of those who need them the most. At the same time, the EU continues its push for much tougher intellectual property rules in its negotiations with India over the terms of a bilateral trade deal.

## 6. An experimental scheme to subsidize Malaria treatment gets off to a shaky start

The WHO has called for the use of new medicines to treat malaria after studies showed widespread resistance to the older drugs. The newer drugs are considerably more expensive.

Initial surveys of the pilot scheme - launched across eight African countries - show that the price of the new drug went down significantly as a result. But it ushered in a new set of problems including a rush on orders for the subsidized medicines which led to a rise in the price of the drug and people were using the drugs without prior testing to confirm that they have malaria.

## 7. Drug shortages threaten moves to expand treatment for Chagas disease

New treatment programs for Chagas are being put on hold because of shortages of benznidazole, the main drug used to treat this neglected parasitic disease.

The shortages have been mainly caused by a lack of planning for new production by LAFEPE, Brazil's state-owned laboratory where benznidazole is manufactured. MSF has been forced to suspend plans to expand treatment for Chagas in Bolivia, the country hardest-hit, and to slow down screening patients in Paraguay for a period.

## 8. Drug companies push up prices for patients in middle-income countries

This year, a number of drug companies confirmed an ongoing trend by refusing to extend standardized price discounts to middle-income countries—something which was previously routine practice. ViiV, Merck, Johnson & Johnson, and Abbott all now specifically exclude middle-income countries from standardized price discounts for some or all of their drugs.

## 9. Too many children suffering from malnutrition go unnoticed outside emergency hot spots

In Niger, MSF has pioneered feeding young children with supplementary, nutrient-dense foods to protect them from malnutrition.

*“No child should have to reach the brink of death before getting access to the nutrition they need to grow and thrive.”*

—Dr. Susan Shepherd, former MSF Nutrition Advisor

MSF has been treating children who are routinely made vulnerable to malnutrition with food supplements containing all the essential nutrients a child needs to grow. In general, food distributed to young children as part of routine food aid doesn't contain the right amounts of minerals, vitamins, and proteins that allow a child to stay healthy and develop normally.

In 2010, MSF witnessed a reduction by half in the mortality among children in Niger who received nutrient-dense foods as part of supplementary feeding programs.

## 10. First-ever guidelines released for treating CM, but access challenges remain

In this women's ward in Homa Bay District hospital in Western Kenya, patients are treated for cryptococcal meningitis.

For the first time ever, the WHO released treatment guidelines for an HIV/AIDS “opportunistic infection”: Cryptococcal Meningitis (CM) - which is considered a major killer of people with HIV. If undiagnosed and untreated, people may die within a month.

But two of the drugs WHO recommends to treat the disease are very hard for patients in developing countries to come by. It is critical that the drugs needed to treat the disease are both available and affordable for all.



Phumeza is undergoing treatment for drug-resistant tuberculosis in South Africa. She had to endure an agonising wait before her TB could be correctly diagnosed.  
© Samantha Reinders

## As MSF Marks its 40th Anniversary, Dr Rony Brauman Remembers the Early Years



Dr. Rony Brauman, speaking on the podium of the XIII Humanitarian Congress in Berlin. © Barbara Sigge

Rony Brauman is a French doctor. He joined MSF when it was run from a **single room, and went on to work in** refugee camps and amidst famines and **wars, narrowly escaping with his life.** As president of MSF from 1982 to 1994, he **helped shape it into the organisation it is today.** Forty years after it was created, **Rony Brauman looks back at MSF's early years.**

“The first time I stepped into MSF’s office in Paris, there was one part-time secretary, Christiane, and that was it. It was the mid-70s, and after five years of political activism, I had finally graduated from medical school. I’d always wanted to be a doctor, to be involved in the magic of treating and healing people, and had a very mythical idea of what medical work was all about.

At the time, only the Church and the government sent doctors to work abroad. I didn’t want to work for either, so MSF, being neither political nor religious, was very attractive for a young doctor like me. MSF motivated me to resume my studies and work late into the night, learning about surgery and tropical and emergency medicine so that I would be prepared for all kinds of situations.

MSF was still a tiny organisation – it had 10 or 12 doctors and nurses working in various places in Africa and Asia – and they didn’t even know where everyone was. One very loyal and hardworking doctor had been

sent to Zaire and then had been completely forgotten. Eight months later she came back to Paris asking why none of her letters had been answered.

*‘The refugee camps of Somalia, Thailand, Central America and South Africa were where we built our knowledge and skills, and forged the methods that MSF still uses today.’*

Then it was my turn. I was sent to Thailand, to set up a hospital in a refugee camp near the Cambodian border, and after six months I found myself with no resources whatsoever, not a penny in my pocket. The refugees were feeding me because I didn’t have the money to feed myself. I had just enough gasoline in my car to make it back to Bangkok. When I got back to Paris, MSF organised for me to do a lecture tour in the north and east of France so I could gather enough money to keep the hospital running for another six months. But in a way I enjoyed the experience: there was no hierarchy, no medical guidelines, no boss – you did what you thought was fit. You had to do absolutely everything yourself, so medical care was only a small part of it. That was the way it worked at the time – but it couldn’t continue like that.

Things changed: we began to provide support to our staff in the field, and to pay our doctors wages. We drew up lists of essential drugs, established guidelines

and brought in logisticians and water and sanitation experts; we began to network with researchers, academics and specialists such as nutritionists. I was involved in the first trial for a new malnutrition treatment, in the form of foil-packed tablets of ready-to-use food, suitable for tropical conditions. In the event, the tablets that the manufacturer sent out were not suitable – the composition was wrong and the taste was unacceptable – so they ended up in a warehouse, tons of them, and I ate them myself – after all, there wasn’t much else to eat.

We decided to focus on war, and displaced people, and so we found ourselves working more and more in refugee camps. In the camps we could start from scratch, and bring services that were badly needed, and which no else was ready to bring. The refugee camps of Somalia, Thailand, Central America and South Africa were where we built our knowledge and skills, and forged the methods that MSF still uses today.

*‘There was a shower of bullets, and the surgeon was severely wounded. We thought it was all over. MSF was so small and frail at the time that, had we been killed, I’m not sure MSF would have survived.’*

We learnt lessons along the way. In the summer of 1980, I went to Uganda on an exploratory mission. The country was in a state of anarchy, with armed groups fighting each other without any visible political purpose. At the same time, a severe famine was developing in the arid northeast of the country. By the time I arrived, about 10,000 people had already died. Just stepping out of the house in the morning was nightmarish – there were dead bodies all along the dust road, and people were incredibly emaciated and on the verge of death. The worst thing was that no one recognised it as a famine. In the capital I’d been assured by officials that the problem had already been solved and everyone was as well-fed as in a French restaurant. I decided to go to see for myself, and what I found was a real lifesaving emergency. It showed me that official papers and statistics should not be trusted too much – to see with your own eyes is absolutely key.

Only once did I think MSF itself might not make it. I was in Chad, with a surgeon and an anaesthetist, and we were caught up in an ambush. There was a shower of bullets, and the surgeon was hit and severely wounded.



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For several minutes we thought it was all over for the three of us. MSF was so small and frail at the time that, had we been killed, I'm not sure MSF would have survived.

But luckily enough that didn't happen, and MSF grew, in size and reputation, becoming far bigger than anyone had ever expected. By the 1990s, there were 100 people working full-time in the Paris headquarters. Humanitarian aid and human rights became extremely popular, there was real momentum, and we had incredible support from the public – despite our reputation for being controversial.

There's no doubt that, as the world continues to change, MSF will have to adjust, and that in 40 years' time, it won't be the same organisation as the MSF we know now. My generation – growing up in the 60s and 70s – had a very different outlook from the generation growing up today. But I'm convinced that the deeper motivations of those who join MSF – the expectations and the desire to help people – remain fundamentally the same."

## MSF Today

- Over 27,000 staff working on 427 projects in 60 countries
- 58,326 surgical procedures conducted in 2010
- 7.3 million outpatient consultations conducted in 2010
- (MSF Activity Report 2010)

## Voice from the field



A mother and newborn baby in Somaliland. © MSF / Josie Emslie

## Somaliland: The hospital of hope

**“In Somaliland maternal mortality rates are 1,044 per 100,000... making it one of the worst countries in the world to give birth.”**

**Josie Emslie, from the MSF team in the UK visited Somaliland to see MSF’s impact on the health of mothers and babies. In her letter from Buroa, Josie describes the amazing work done by the medical team at the hospital “that gives hope to thousands.”**

Buroa, where I am writing from, is in the Togdheer region and is the second largest town following the capital Hargeisa. Here we work in an eight ward hospital with the Ministry of Health.

### Yasmin’s story

On my first day, Dr Patricia, our gynaecologist, started to show me around the maternity ward but within minutes she was called to a mother who was convulsing. She and her team rushed the woman to the OT where they performed an emergency C-section.

I left the ward, not wanting to add to the chaos; where family members were speaking loudly, pointing, desperately anxious about the woman and the safe delivery of her baby. The woman was 24 years old. Her name was Yasmin. She had lost her four previous babies

and her husband has been staying with her at the hospital.

The baby, a girl, survived and was placed in our neonatal unit in an improvised incubator under one of our specialist heated lights. She weighed just 1.2kg.

For her first three days of her life the baby was given a glucose drip and oxygen. Amazingly, by day four she was breathing on her own and her grandmother was now feeding her expressed milk every two hours.

*Thanks to round the clock treatment from the medical team she was proving to be quite a little miracle, “a real fighter.”*

As for the mother, she was also recovering well from the C-section but you could see in her face the caution in becoming too attached to her new daughter following the fate of her previous four babies. The nurses and her family were encouraging and supportive.

### ‘Lucky One’

Dr Sohur, our paediatrician told me that even in the UK this baby’s chances of survival would be slim. But thanks to round the clock treatment from the medical team she was proving to be quite a little miracle, “a real fighter.” After some days her mother gave her a name, Nasib, which means the ‘Lucky One’ in Somali.

### MSF’s impact

Before MSF arrived, the hospital was underutilised due to high fees, lack of

qualified medical staff and poor facilities. Patient fatality cases were shockingly high. Many in the community feared coming to the hospital, named then: “The Hospital of Death”. Now, it is a hospital that gives hope to thousands.

I asked Nasra, a 21 year old mother who was admitted unconscious with severe anaemia, what she would have done if MSF had not been here providing free healthcare. She responded saying: “The pharmacy told me about MSF. I travelled through the night to get here with my baby, my two other children are at home. I have received a blood transfusion and am feeling well. If MSF were not here providing treatment for free I would have stayed at home”.

Since MSF teams arrived, paediatric mortality rate almost halved from 8.1 percent in 2010 to 4.6 from March to August 2011, while the number of admissions tripled. In September there were no maternal mortalities.



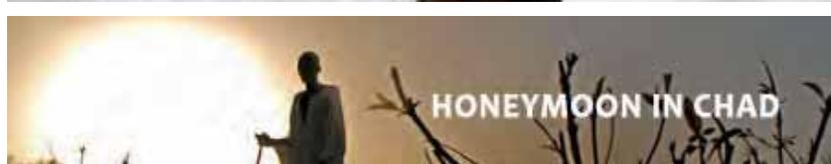
Josie Emslie at Buroa hospital. © MSF

## MSF Field Blogs: First-hand Accounts from MSF Aid Workers and Patients

You can follow first hand accounts from MSF aid workers and patients in locations all around the world who are posting their personal experiences at [www.msf.ca/blogs/](http://www.msf.ca/blogs/)

The blogs include the real stories of people working in the field, putting ideas into practice, and telling you, their friends and their families about the ups and downs of life in the field. They come from diverse personal and professional backgrounds and working in places they have never been before.

Some of the bloggers are MSF patients who share moving accounts of their experiences. For example, through the TB&ME blog, patients being treated for multidrug-resistant tuberculosis (MDR-TB) are writing about how it feels to have this disease and about the treatment they receive. This treatment can often involve taking upwards of 20 pills a day for 24 months and suffering many painful side effects from the toxic drugs. Follow the real lives of TB patients at [msf.ca/blogs/tb](http://msf.ca/blogs/tb)



## Humanitarian Negotiations Revealed The MSF Experience

Launched to mark the 40th anniversary of the founding of MSF, this book sets out to deliberately puncture a number of myths which place humanitarianism above politics. It is a candid examination of the compromises MSF made – some successfully others less so – to try and help the people suffering most in the world today.

Case studies from recent conflicts such as Yemen, Sri Lanka and Afghanistan lay bare the reality of MSF's efforts to reach the most affected people, and explore just what the limits of compromise should be. There are also a series of thematic essays that explore broader issues, such as the real usefulness of aid responses to natural disasters.

The book is written by MSF insiders, but is far from a PR exercise. Decisions made in the 'heat of battle' by MSF are unpicked and critiqued.

At a time where humanitarian actors are questioning their ability to overcome the obstacles they are encountering, this book seeks to help fuel the debate on their ambitions and the best ways of fulfilling them.



The full book can be accessed online at:  
[www.msf-crash.org/livres/en/humanitarian-negotiations-revealed](http://www.msf-crash.org/livres/en/humanitarian-negotiations-revealed)

The French version, Agir à tout prix? Négociations humanitaires : l'expérience de Médecins Sans Frontières is available at:  
[www.msf-crash.org/livres/agir-a-tout-prix](http://www.msf-crash.org/livres/agir-a-tout-prix)

The English and French editions are also available to purchase online from Amazon.com

The Arabic edition will be launched in April 2012.

Photo essay

## Lebanon: Mental health for the most vulnerable

Photographs:  
© Dina Debbas

For the past four years, MSF has been running **psychological health** programmes in and around two refugee camps in **Lebanon where Palestinian refugees and vulnerable Lebanese people reside.**

## لبنان: توفير الرعاية النفسية للسكان الأكثر ضعفاً

الصور: © دينا دباس

قامت منظمة أطباء بلا حدود على مدى السنوات الثلاث الأخيرة بإدارة برامج خاصة بالصحة النفسية داخل وحول مخيمات اللاجئين في لبنان يقيم فيهما لاجئون فلسطينيون ومواطنون لبنانيون مستضعفون



استقر العديد من الفلسطينيين الوافدين من الجليل بعدما خسروا كل شيء جراء حرب ١٩٤٨. وقد انضم إليهم في السنوات الأخيرة لبنانيون ومهاجرون من مناطق أخرى.

Many Palestinians from Galilee settled in Burj el-Barajneh after they lost everything as a result of the 1948 Arab-Israeli conflict. They have been joined in recent years by Lebanese and by migrants from elsewhere in the region.



يبدل فريق مكون من موظفين دوليين ومحليين قصارى جهدهم لتوفير الرعاية المجانية للفئات الأكثر ضعفاً بغض النظر عن السن والجنس والأصل.

A team made up of international and national staff provides free mental healthcare for the most vulnerable people, irrespective of their age, gender or place of origin.



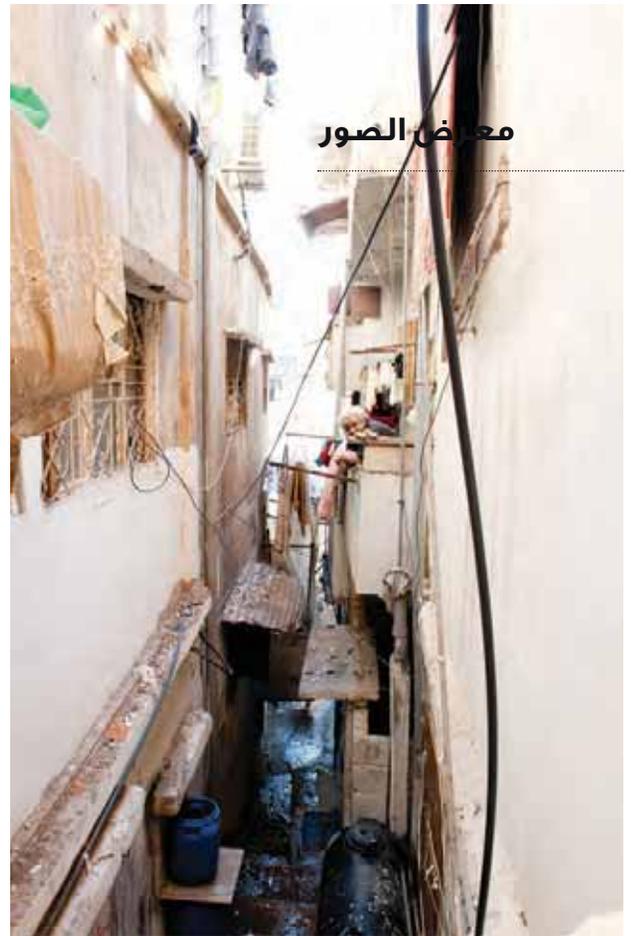
إن الصحة النفسية الجيدة هي أساس رفاة الفرد والمجتمع.

Good mental health forms the basis of an individual and a community's well-being.



يعد برنامج منظمة أطباء بلا حدود للصحة النفسية في برج البراجنة، الذي افتتح في ديسمبر/كانون الأول ٢٠٠٨، البرنامج الوحيد الذي يوفر الاستشارات الطبية مباشرة في مخيم اللاجئين الفلسطينيين والمناطق المجاورة له

MSF's mental health programme in Burj el-Barajneh, which opened in December 2008, is the only one providing consultations within the Palestinian refugee camp and its surroundings.



## معرف الصور

تكمّن إحدى أبرز المشاكل في العدد المفرط للأشخاص الذين يعيشون في مساحة ضيقة، فالبنى التحتية ضعيفة كما أن إمدادات المياه والكهرباء غير منتظمة، تدوم بضعة ساعات في اليوم.

One of the main problems is the huge number of people crowded into such a small space. The infrastructure is inadequate and water and power supplies are erratic, available for just a few hours a day.



خلال عام ٢٠١٠، قدم الأخصائيون النفسيون والأطباء النفسيون والممرضون المتخصصون في الطب النفسي التابعون لمنظمة أطباء بلا حدود نحو ٨,٠٠٠ استشارة طبية. وكانت الأمراض الأكثر شيوعاً في أوساط هؤلاء السكان في المخيمات الاكتئاب والقلق والذهان والصرع واضطرابات الشخصية.

In 2010, MSF psychologists, psychiatrists and psychiatric nurses provided nearly 8,000 consultations. The most common illnesses afflicting the people of the camp, are depression, anxiety, psychosis, epilepsy and personality disorders.



يقول أحمد، الذي يعيش في المخيم منذ ٥٠ عاماً: "أنا ضيف هنا". لقد غادر فلسطين مع أسرته عندما كان في العاشرة من عمره. يبلغ عمره اليوم ٧٢ سنة وقد أصبح أعمى تماماً. قبل أن يخضع للعلاج، كان أحمد يعاني من الآلام متكررة في الرأس، وكان يصرخ دون سبب واضح ويحطم أغراض البيت. وحاول أحمد قتل نفسه عدة مرات. كان أحمد من أوائل المرضى الذين عالجتهم منظمة أطباء بلا حدود، وهو يتلقى العلاج منذ سنتين من قبل أخصائي نفسي تابع لمنظمة أطباء بلا حدود.

"I'm a guest here." Ahmed has been living in the camp for 50 years. He left Palestine with his family when he was just ten years old. Now he is 72 and completely blind. Before he started treatment, Ahmed suffered frequent headaches and used to shout without apparent reason and break the furniture. He had made several suicide attempts. Ahmed was one of MSF's first patients, and has been seeing an MSF psychologist for the past two years.