EYEWITNESSES TO AN EMERGENCY

REFUGEE CRISIS IN SOUTH SUDAN
Dear Friends,

Welcome to our new Alert. This is the first issue of MSF-USA’s re-designed quarterly newsletter, and we hope you like it. We are happy to have more space to present the information we want to share with you, and more room to provide in-depth features conveying the scope of our work. We’re also happy to report that we’ve made these changes with little added cost.

This issue of Alert highlights devastating crises in South Sudan and Syria, conflict-related emergencies that are causing mass casualties and extensive displacement. In both places (and in neighboring countries), our medical teams are doing as much as they can to ease suffering and save lives.

First, South Sudan: Over the past year, more than 170,000 refugees fled fighting and aerial bombardments in Sudan, seeking shelter in overcrowded camps across the border in South Sudan. As of mid-September, MSF was conducting more than 9,000 medical consultations per week in field hospitals and clinics in several locations and has succeeded in reducing mortality rates that were previously well above emergency thresholds.

But media attention and the spontaneous support that often follows have been scant and grave concerns remain, which is why we took the unusual step of asking for support specifically for our South Sudan programs in a recent webcast and in select communications with donors. The costs of our refugee response, added to the costs of our pre-existing programs in the country, are now far above what we had allocated for this year and next. Therefore, we have been seeking earmarked donations to help us reach as many people as we can.

In Syria, access, not attention, has been the problem. The Syrian government has refused repeated requests for permission to operate within its borders, but an MSF team that entered the country was able to transform a regular home into a fully-functioning emergency hospital in one region, and teams in both Jordan and Lebanon are working with refugees who’ve fled the chaos.

In both cases, the projects needed certain supplies, often a lot of them, to function. We talked about how that happens with Bruno Delouche, the deputy manager of MSF’s logistic supply center in France, which oversees the construction and pre-positioning of emergency medical kits for many of our programs around the world. This behind-the-scenes work makes our operations possible; it helped get medical materials to Syrian doctors long before our teams got into the country and helped us scale up in South Sudan when refugees started pouring over the border. It ties in with our advocacy work as well, particularly our opposition to efforts by Novartis and Bayer to use legal maneuvering to limit the production of generic medicines in India—medicines our programs rely on.

We hope that you enjoy this new version of Alert, and, as always, thank you for your ongoing support for our work.

Sincerely,

SOPHIE DELAUNAY
Executive Director, MSF USA
Though it’s not gotten much attention, an immense refugee emergency continues to unfold in South Sudan. In the young country’s Unity and Upper Nile states, roughly 170,000 Sudanese refugees are living in camps that were, for much of the summer, sprawling, muddy tracts of hardship and sickness. The refugees had escaped state-sponsored aerial bombardments in their homelands, but MSF’s epidemiological teams documented mortality rates in some of the camps well above, and in some cases double, the World Health Organization’s emergency threshold for refugee situations.

MSF, which had been working among the refugees in Yida, in Unity state, and in Upper Nile state’s Maban County, rapidly scaled up its response, adding scores of international and national staff, taking on tasks—drilling boreholes for water, for instance—normally outside its purview, and working around huge logistical challenges posed by both South Sudan’s war-torn history and the onset of the rainy season.

Below, along with images captured by award-winning photographer John Stanmeyer, is the story of MSF’s work in Yida as told by three people who saw a trickle of refugees become a flood—John Johnson, a nurse from Virginia; Matthew Horning, a doctor originally from Minnesota; and Andre Heller, a former member of the MSF-USA Board of Directors who hails from Colorado and is currently serving as MSF head of mission in South Sudan.
EARLY ON

Around 10,000 refugees arrived in Yida in late-2011, and the numbers stayed constant in the following months. That was about to change when Johnson and Horning arrived in early summer.

**JOHN JOHNSON:** Yida was described to me as a pretty small refugee camp. It just seemed like it would be a quiet, stable hospital project.

**MATTHEW HORNING:** When I arrived in Yida [in May], it was me and one other doctor... most of the people that seemed to be coming to the camp seemed to be in relatively good health, and we weren’t seeing high rates of malnutrition.... Over the eight weeks that I was there, fairly abruptly, we started noticing an increase in the acuity of patients. People were coming much sicker, and we noticed a spike in malnutrition as well.

**JOHNSON:** In the time it took me to go from Paris to Juba to Yida in June, the population increased by several thousand, so the figures I was given in Paris were already outdated by the time I arrived. About 1,000 refugees were arriving every day. By the time I got there, the population of the camp was about 45,000.... It just sort of exploded.

**AN INFLUX OF NEW REFUGEES**

Over the summer, the number of refugees in Yida reached around 60,000, stretching the capacity of the camps and of MSF to respond to their needs.

**JOHNSON:** Fast-forward about one month, and our hospital had grown from 16 [admitted] patients to nearly 40, and we were working as fast as we could to hire people, train them, work all of the shifts and take care of the patients, and build onto the hospital to expand our physical space. I was working as a nurse and hiring and training nursing staff. During that time we had more patients than we were really capable of taking care of, and we couldn’t admit all of the patients to the hospital that we wanted to.

**ANDRE HELLER:** We don’t have precise figures for Yida’s population, but it’s estimated at between 50,000 and 65,000 people.

**HORNING:** The camp got big enough where the limited water, sanitation, those sort of facilities, were completely maxed out to the point where people were just in this bad cycle of reinfection and illness, and for the children, that was a very bad combination.

**JOHNSON:** We had limited space, and we were forced to triage and admit the most critically ill. During the first and second weeks of July, our mortality rate went very high. About one-fourth of the children that we admitted died, most of them within the first 24 hours of getting to the hospital.

**HORNING:** We had only the most basic medications, equipment and laboratory tests. We did tests for malaria and we could do a basic urine test, and we could do hemoglobin and blood sugar, and that was it.... We were treating respiratory illness and diarrhea; in the US, you would say it was [caused by] this bacteria and this pathogen, and this is what it looked like on an x-ray. And we had none of that, so we were using our clinical skills and our clinical judgment.

**THE RAINY SEASON**

A complicating factor was the onset of the rainy season, which washed out roads and left planes as the only option for resupplying programs that were now contending with new dynamics.

**JOHNSON:** The rains really picked up in mid-June, and we saw a drop in the refugee influx to the camp because they just couldn’t get there anymore. The roads from the Nuba Mountains—where many of the refugees had come from—were washed out.

**HORNING:** From a health standpoint you kind of expect that you’ll see malaria cases rise as the rainy season starts.... You have rains that are six or seven inches coming three or four times a week, and you see all that standing water, and you can imagine [that] infectious disease is being sort of encouraged to spread.
JOHNSON: We also saw a spike in malnutrition and respiratory tract infections at the beginning of the rainy season, and in the last two weeks I was there, we saw a tripling of malaria cases in our outpatient department. And the next week they tripled again. You have to plan ahead for malaria, because once the mosquitoes start to breed, it begins to spread through the camp. We distributed mosquito nets and made sure we had a good outpatient department because malaria can be treated on an outpatient basis—it’s not that lethal if you catch it early. You also have to have a supply of blood available, in case people become acutely ill and require blood transfusions.

MSF SCALES UP

JOHNSON: The first month we were pretty much working from the time we got up to the time we fell asleep. We’d always have a quick morning meeting to discuss the major plans for the day, and then have a medical meeting to discuss any changes we needed to focus on. I’d check in with my national staff to make plans for the day. I did well over 100 interviews in the time I was there and hired about 50 people in two-and-a-half months, just to staff the hospital.

HORNING: There were other organizations in the camp that were also trying to help address a number of these issues, in particular water and sanitation and nutrition. And MSF, I think, worked as well as we could to coordinate with them and to try to address this, and ultimately [said], “This isn’t being addressed adequately. We are going to do it.” And by the time I left, [MSF had] water and sanitation specialists there, and we were in the process of opening our own inpatient nutrition program and an outpatient nutrition program.

“"The last two weeks I was there, we saw a tripling in malaria cases in our outpatient department. And the next week they tripled again."
“It was the most challenging ten weeks of my life. It’s a tragedy, and it was devastating to be there. We saw such high mortality, so many people dying. But also, being there and seeing MSF’s ability to respond quickly and make changes—to really bring about an improvement in the health and lives of the people in Yida—was really incredible.”

SEEING RESULTS AND LOOKING FORWARD

HELLER: Between mid-June and mid-July, the mortality rates were twice the emergency threshold levels. One month later, the mortality rate in the hospital was down from 25 percent to 2 percent. But most deaths are still among children under five. They’re the most vulnerable ones.

JOHNSON: It was the most challenging ten weeks of my life. It’s a tragedy, and it was devastating to be there. We saw such high mortality, so many people dying. But also, being there and seeing MSF’s ability to respond quickly and make changes—to really bring about an improvement in the health and lives of the people in Yida—was really incredible. It was an honor to be there.

HELLER: We’re seeing some 3,000 patients per week, who are hospitalized or treated as outpatients. We’ve multiplied our consultation sites so the children come earlier, before they fall seriously ill. And we give the malnourished ones adapted therapeutic foods…. We’ll need to monitor the refugees’ health and continue efforts to improve their living conditions. We’ve achieved a first step: the mortality rate has been reduced. Now we have to maintain the momentum over the next few months because the refugees’ situation in Yida is still precarious.

A GREAT NEED, AN UNUSUAL STEP:

MSF RARELY REQUESTS FUNDS FOR A SPECIFIC EMERGENCY, PREFERING UNRESTRICTED DONATIONS INSTEAD SO IT CAN BETTER RESPOND TO EMERGENCIES AS THEY ARISE. BUT IN THE CASE OF SOUTH SUDAN, MSF ALREADY HAD A SIZABLE BUDGET DEDICATED TO ALL ITS OTHER PROGRAMS IN THE COUNTRY.

THE REFUGEE EMERGENCY WILL ADD AN ESTIMATED $37 MILLION TO THE PRE-EXISTING 2012 EXPENSES, AND IT IS TO MAKE UP THAT GAP, AND ON BEHALF OF THOSE REFUGEES, THAT WE ASKED OUR SUPPORTERS FOR THEIR HELP ON SOUTH SUDAN.

IF YOU WOULD LIKE TO HELP SUPPORT THIS EFFORT, PLEASE GO TO WWW.DOCTORSWITHOUTBORDERS.ORG/DONATE OR CALL 888-392-0392.

BELOW: Male relatives of 13-year-old Hassan Kako, who died of acute malaria, carry his body to Yida’s graveyard.
THE PATIENT BECOMES THE HEALER

Francis Gatluak’s transformation from MSF patient to MSF nurse has saved countless lives. By Melissa Pracht

Three decades ago, when Francis Gatluak was a boy, civil war forced his family to flee their small village in Unity State, in the northern reaches of what is now South Sudan. They relocated to another village, Bao, where Francis’ older brother became a nurse. Later, he went to work in the town of Leer, about a day’s walk away, in a primary care clinic run by MSF.

Merely surviving in the midst of a fierce and often bloody conflict was a notable achievement. But in the late 1980s, people began coming to the Leer project close to death, thin, weak, and in pain. Health workers did not know what was happening. These weren’t war wounds, but the condition was killing people.

Francis’s brother soon fell ill as well and was treated with typhoid medication. Francis went to Leer to take care of him, taking him home when he started to feel better. But Francis’s brother soon took a turn for the worse, and Francis and another man carried him back to Leer on a narrow wooden bed—an exhausting three-day journey. His brother, however, died soon after they arrived.

After walking back to Bao, Francis, too, began to feel sick. “My body was hot, I had fever, and after a while, I felt like I had something growing in my stomach,” he recalls. “They gave me traditional medicine, but it was not helping. So I said, ‘Okay, I don’t need to be like my brother,’ waiting until he was too weak to go to the hospital. I started walking to Leer.”

Eighteen other sick people walked with Francis. At this point, in 1989, MSF was testing for a little-known disease called kala azar, a disease that thrives in poor, unstable areas with limited health care. Known to scientists as visceral leishmaniasis, kala azar is spread by the bite of a sandfly. Its symptoms include an enlarged spleen and fever. Patients often seem to be wasting away physically.

Unity State was then a perfect breeding ground for kala azar. A famine had left people particularly vulnerable to illness, and waves of displaced people with no natural immunity to the disease were moving into the area—both results of Sudan’s civil war. At the time, though, MSF could not carry out the diagnostic test in Leer. Blood samples were sent to a lab in Nairobi and it took a month to get results. Francis’s first test for kala azar came back negative, but a second sample came back positive—two months after he had arrived. Most of the people he walked with to Leer did not last as long. “We were 18 people, and 15 of them died before they got any medication,” he says.

When Francis got his diagnosis, however, he was able to start treatment: two painful daily injections of sodium stibogluconate (SSG) for 30 days. Developed in the 1930s, this treatment is toxic enough to kill some patients, but it was all that was available at the time. In 2002, MSF began treating patients with a 17-day combination regimen of SSG and the drug paromomycin, which was safer and more effective. Despite its advantages, though, and its suitability for treating the strain of kala azar found in East Africa, this
The epidemic in Unity State lasted from 1984 to 1994 and claimed more than 100,000 lives, one-third of the area’s population. Francis’s initiative spurred MSF to establish a clinic in Duar in 1990, where around 10,000 people were treated for kala azar in the first year alone. MSF treated a total of 19,000 patients with kala azar in what is now South Sudan between 1989 and 1995, and in the years since, MSF has continued both to work and advocate on behalf of kala azar patients, people suffering from what’s known as a “neglected tropical disease” that could still greatly benefit from new medications and diagnostic tools but is often ignored by research and development.

Francis also stayed connected with MSF. Today, in fact, he is a nurse in his twenty-third year working with the organization. He has gone on MSF assignments in other African countries and recently returned to the Leer hospital, where he is now in charge of the tuberculosis ward. And he recently traveled to Washington, DC, to speak on the organization’s behalf when MSF was awarded the highly-esteemed 2012 J. William Fulbright Award for International Understanding.

Even among the many dedicated people working for MSF, his story is exceptional, a journey born of the hardship he both witnessed and experienced. “I was not really thinking to be a medical person...But after all of the death I saw and after my treatment, I felt that this is the most important thing that I can now do.”
BAD MEDICINE

Pharmaceutical companies Bayer and Novartis are attempting to limit generic competition by taking legal action in India, the home of MSF’s main suppliers of oral drugs and vaccines. In early September, Bayer challenged India’s green light for the generic production of its patented cancer drug, Nexavar. Less than two weeks later, Novartis resumed its lengthy legal battle in the Indian Supreme Court against a law that prevents repeated renewal of drug patents when only minor changes are made to the drug.

Currently, India offers a favorable environment for generic competition. By issuing compulsory licenses—as it did in the Bayer case—India allows generic companies to produce more affordable versions of patented drugs without the patent holder’s consent as long as the generic companies pay a fee to the patent holder. India’s patent law, known as Section 3(d), also prevents “evergreening,” the excessive renewal of drug patents without any major therapeutic improvement in the drug.

Compulsory licenses and the prevention of evergreening allow for generic drugs to enter the market more quickly. Through legal action, Bayer and Novartis aim to repeal compulsory licenses and protect evergreening practices in India. If successful, Bayer and Novartis can sell their drugs at monopolized prices for far longer by lengthening the time it takes for generic competition to enter the Indian market. This could have a devastating effect on MSF’s patients around the world; as Bruno Delouche notes in this issue of Alert, MSF gets most of the drugs it uses in its programs for India.

An example: Gleevec, the cancer drug for which Novartis is trying to extend the patent, costs patients $2,158 per month; the generic version costs $174 per month. Similarly, Bayer’s patented cancer drug Nexavar costs $5,030 per month, while the generic price is just $122 per month.

With generic options on the market, people who cannot afford to pay monopolized prices can still access needed medicines, and organizations like MSF can afford to disseminate more drugs when prices are lower. If Bayer and Novartis win their cases and the Indian laws are overturned, access to affordable drugs will be severely limited for the people who need them most. MSF therefore, led by its ACCESS Campaign, continues to advocate against these efforts, aiming to preserve the ability of people in developing countries to get the medicines they need.
HOW MSF WORKS
DELIVERING AID

MSF’s logistical warehouse in France supplies programs around the world, often in less than one day.

Bruno Delouche is the deputy general manager for MSF-Logistique, MSF’s logistics hub in Merignac, France, near the Bordeaux International Airport. MSF-Logistique procures, stores, and ships medical and non-medical supplies to many MSF projects around the world. Here, Bruno, who has worked for Logistique for 17 years, talks about how supplies get to the field—often in just 24 hours.

HOW IS LOGISTIQUE ORGANIZED?
The best way to describe MSF-Logistique is as a nonprofit humanitarian purchasing and distribution center. It is a licensed pharmaceutical institution, meaning we have permission from the French authorities to operate a business that deals with drugs. That’s why we have four pharmacists on staff. We are also licensed to hold materials in customs. All of our supplies are officially in transit because nothing in our warehouse is destined for use in Europe. With this status we avoid customs taxes, can store products for as long as needed, and can ship to the field right away, without worrying about clearing customs.

We have around 100 staff people working on purchase, procurement, transportation, the validation of both medical and non-medical products, and administrative tasks to make sure we comply with national and international standards.

HOW HAS LOGISTIQUE EVOLVED OVER THE YEARS?
Logistique was founded 25 years ago as a way to make sure MSF had supplies for our field projects at our fingertips. Today, we have around 20,000 items in our database and about 4,000 in stock at any one time. About 3,000 of those items are medical—including therapeutic foods, which we classify as medical—and about 1,000 are non-medical.

We don’t stock everything; some we order from manufacturers or from our subsidiary in Dubai. It depends how quickly they can ship. A week is okay for a regular project, but for emergencies, we need to have everything ready to go. We have an assembly and transportation set-up that can provide more than 100 tons of medical and non-medical supplies within 24 hours, if needed. Over the past five years, we shipped 5,000 tons of supplies each year.

Nowhere in the world is there another civilian logistics center that can provide drugs and non-medical items assembled in more than 500 ready-to-use kits designed for specific types of emergencies. MSF pioneered this approach and remains the only humanitarian organization doing it. We are often contacted by other organizations interested in our kits, but we don’t have the capacity to help them.

An exception is our partnership with the World Health Organization (WHO) on sleeping sickness. When the drug for this disease went out of production, WHO signed a contract with a pharmaceutical company to continue to produce the drugs and asked MSF to distribute them. We realized you needed more than just the drug to treat a patient, so we created kits for sleeping sickness that we send out to Ministries of Health who need it—and WHO pays for it.

ARE MOST OF YOUR DRUG SUPPLIERS FROM EUROPE?
Not at all! Our main suppliers of oral drugs and vaccinations are in India, “the pharmacy of the world.” We began our relationship with Indian suppliers in 2000, when MSF began treating HIV/AIDS and launched the Access to Essential Medicines Campaign. We now also use Indian manufacturers for drugs for TB, malaria, and other diseases.

For most injectable drugs—anesthetics, anti-bacterials, and parenterals, for example—we buy mainly from European manufacturers because assessing quality for these drugs is a highly complex process. We rely on the MSF International Pharmacist network to validate our drugs, as well as WHO. That’s why the number of pharmacists in MSF has increased in the past decade.

I can’t stress too strongly the importance of quality. With globalization, you can find any medicine anywhere, but the major issue is quality. You cannot procure drugs based on cost alone.

HOW DOES ORDERING WORK?
For an emergency, we draw up a list of emergency stock with the operational centers. This list is made up primarily of specialized kits we assemble in our warehouse.

For regular procurement for ongoing field projects, we have order forms based on WHO’s Essential Medicines List for supplies like malaria drugs, meningitis vaccines, or ready-to-use therapeutic food. We also have non-medical items like vehicles and spare parts, radio communication equipment, water treatment supplies, and so on.

Then the teams in the countries receiving the goods need to have everything in place to receive them—warehouses, transportation, and all the paperwork.

BELOW LEFT: A plane being loaded in Bordeaux in 2008, preparing to carry 40 tons of emergency response supplies to Myanmar. France 2008 © Nicholas Turcat
BELOW: Supplies getting unloaded in Port-au-Prince after the 2010 earthquake. Haiti © Julie Remy/MSF
On the back end of a Logistique delivery, teams in Yida, South Sudan, where air resupply is the only possible method during the rainy season, unload a small plane sent to support MSF’s programs with Sudanese refugees in the area. South Sudan 2012 © Eddy McCall/MSF

DO YOU BUY ANYTHING LOCALLY?
We buy some non-medical items locally—like mosquito nets, shelter materials, and so on. And we are increasingly using local producers for ready-to-use therapeutic food. We have an international staff person dedicated to quality control, and she has visited factories in places like Niger, the Dominican Republic, Kenya, and South Africa that make ready-to-use food and has approved them for our use.

ARE THERE ANY RESPONSES THAT STAND OUT FOR YOU?
The last really big one was Haiti. Normally, when there’s a disaster in one part of a country, we still have logistical support in another part of the country. But with Haiti, we couldn’t send supplies to Port-au-Prince, so we sent them to Santa Domingo instead, in the Dominican Republic, arranging for transportation by land to Port-au-Prince. This included our modular hospital kit, which is made up of 14 tents covering 90 square meters (nearly 1,000 square feet) each, with two operating rooms. We worked around the clock for several weeks, while continuing to supply our other missions.

But even when it is exhausting, we have a clear picture of why we exist. From beginning to the end, MSF Logistique is managed by MSF people for MSF people. So we are careful to do it right, for our field teams and our patients.
**THE LONG REACH OF CONFLICT**

**SYRIA**

Soon after the fighting began in Syria, MSF started trying to establish programs to work inside the country. Attempts to make arrangements through official channels were repeatedly rebuffed, however, so MSF began sending in medical supplies to besieged areas. While MSF has been working with some of the 290,000 Syrian refugees estimated by the UN to be seeking sanctuary in surrounding countries—a number almost certain to rise in the coming months—the desire was always to provide direct patient care inside the country as well.

This past summer, after extensive planning was completed, MSF sent in a team of medical professionals—MSF veterans who knew the risks they were taking—across the border and into the country to set up medical facilities. Once inside Syria, in a location not far from severe fighting, the team transformed a private house into a field hospital. Through mid-August, they had admitted more than 300 patients and carried out 150 surgeries in what was and is one of the very few projects established by any humanitarian agency in Syria during the war. The pace of the work was very intense. Injuries were largely conflict-related, most caused by tank shelling and bombing or gunshots. Surgical specialist Anna Novak, a veteran of more than 20 MSF missions, discussed setting up the project and the work that followed:

*With the support of a group of Syrian doctors, we were able to identify a location to perform operations. After an initial brief visit, we decided on an empty villa. The two-story, eight-room house was still under construction, but we didn’t have any other choice. For six days, we worked like crazy to transform the place into a surgical hospital with a dozen hospital beds, a sterilization room, an operating theater, a resuscitation room for emergencies, and a recovery room. In addition to the difficulties involved in recruiting medical staff locally, we also had to solve supply problems, knowing that it’s risky right now to import or to buy medical supplies in Syria.*

The first patients arrived on June 22, the day after the hospital opened. At first, we admitted mostly injured people who already had undergone surgery. Unfortunately, we had to do this under poor hygienic conditions, which generally means a higher risk of infection. As new conflicts broke out, the hospital quickly reached its limits. After a few days, we were getting up to six injured people at a time, a relatively modest number but still high considering our resources and treatment capacity. Then, injured people started coming from everywhere. We had to come up with other ways of accommodating people, even if it meant putting beds on the terrace.”

“We had to come up with other ways of accommodating people, even if it meant putting beds on the terrace.”

flying and bombing about ten kilometers (six miles) from our facility. But our patients sometimes came from far away, risking their injuries becoming worse or even death. This makes you wonder about what hurdles stand in the way of getting quality care in Syria today, including for people whose wounds are not conflict-related.

To limit the risks, hospital staff in Syria are working in a discreet and cautious manner, and many of the field hospitals disappear as quickly as they appear. In this context, the existence of a facility like ours is very important for injured people who need assistance, but it is also a very delicate situation. Security constraints limit our resources and capacity. A typical war wound requires an average of five days of hospitalization. With the exception of the most serious cases, we sometimes have difficulties keeping patients in the hospital longer than this. Patients who live close to the hospital or who are staying with family and friends nearby can come back for checkups or to get a dressing. But even though there’s lots of solidarity among the people here and lots of patients are able to stay in the area temporarily, some leave the hospital and we never hear from them again.”

(Aside from the surgical project, MSF is distributing drugs and other medical supplies in Syria, including to the Syrian Red Crescent, and is also assisting people displaced by the fighting in some parts of the country.)
LEBANON

In November of last year, MSF expanded its work in Lebanon in order to provide urgent aid to thousands of Syrian refugees fleeing across the border. Teams opened new medical projects in the northern Wadi Khaled area, in Tripoli, and in various locations in the Bekaa Valley.

Living conditions are extremely precarious for many refugees. According to MSF estimates, in early September more than 1,000 people were living in overcrowded shelters close to the border in the villages of Wadi Khaled and in the Bekaa Valley. In Tripoli, rental costs are high and many families have no choice but to share apartments. Access to medical care is also lacking. A study undertaken by MSF this past May showed that the availability of treatment for chronic diseases such as asthma, diabetes, hypertension, and cardiovascular disease is a major concern, and that four in ten interviewees did not have access to a hospital. “The refugees are really being tested,” said Fabio Forgione, MSF’s head of mission in Lebanon. “When they arrive, most are struggling to deal with the consequences of direct violence and loss; then they have to face the reality of not being able to go home. Many lose all hope.”

In six days this past summer, an MSF team converted a private house in Syria into a fully operational trauma care facility where staff have been providing emergency medical assistance to people wounded in the fierce fighting that has convulsed the country for more than one year now. Syria 2012 © MSF

JORDAN

Syrian refugees have been arriving in Jordan on an almost daily basis, using different routes to get in but almost always ending up in one of the camps set up at the border crossing in the Jordanian town of Ramtha.

A specialized MSF surgical team performs operations in a hospital in nearby Amman. Initially, the team performed only reconstructive surgery, treating victims of violence from Iraq, Libya, Yemen, and other countries [see page 14]. However, the number of Syrian refugees arriving in Jordan with bullet wounds and other injuries has grown steadily since the revolt broke out in their country.

As a result, MSF has strengthened its orthopedic surgery team in Amman. An MSF surgeon examines five to ten patients per week at the hospital, and about one-third of those patients require orthopedic surgery—either for the first time, or in addition to a previous surgery conducted elsewhere. Another third receive physical therapy, and the remaining third are closely monitored as they rehabilitate.

MSF teams also regularly visit the camps on the border to speak with potential patients. They are, in truth, more like transit centers than camps; Syrians generally do not stay very long.

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“...the number of Syrian refugees arriving in Jordan with bullet wounds and other injuries has grown steadily since the revolt broke out in their country.”
A REGIONAL SURGICAL CENTER

Patricia Kahn, MSF-USA’s medical editor, recently visited MSF’s surgical program in Amman, Jordan, which treats patients from throughout the Middle East.

Patients in the Amman program are civilians wounded by bombs, explosions, or gunshots in conflicts across the region. They have severe, complicated injuries that were not treated right away, or couldn’t be treated properly in their home country. Injuries such as bones that aren’t just broken, but shattered. Burns over much of the body. Many also have life-threatening bone infections, often with antibiotic-resistant bacteria.

This is a very neglected population, people who would otherwise never recover properly. Treating injuries like these often requires many surgeries over a long period of time, with intensive physiotherapy in between.

The program started in 2004 at the height of the violence in Iraq, when the security situation forced MSF and other NGO’s out of Iraq. Rather than leave the region, MSF looked towards Iraq’s neighbor, Jordan, which is politically stable and has an excellent medical infrastructure. We set up a special unit within the Red Crescent hospital in Amman, and it became a surgical referral hospital for Iraqi civilian victims of war. Patients were referred through a network of doctors in Iraq. Over time this network expanded, both inside Iraq and in surrounding countries. Patients have come from Yemen, Libya, Gaza, and now Syria. [Editor’s note: up to 50 Syrian patients were being admitted each month over the summer].

When these doctors see a patient who might benefit from treatment in Amman, they send a dossier—examination notes, medical records, X-rays, and, increasingly, video—to the Amman team, which meets weekly to screen prospective patients. The team is looking for people with very little mobility, or very little use of the injured area, and they choose those they think can regain basic functionality with the proper assistance. After suitable patients are identified, it can still take several months to get the visas and make the travel arrangements to bring the person to Amman.

The program does a lot of maxillofacial surgeries for people with severe injuries and disfigurement of the face (which is why there are dentists in the networks of referring doctors). For patients with injured arms or legs, the team focuses on reconstructing limbs whenever possible, trying to avoid amputation. Many patients have a very hard time accepting the idea of amputation, especially if they’ve already lived with their injury for a long time. Also, reconstruction can be better at restoring certain types of mobility that are part of daily life for many people here; for example, kneeling to pray is almost impossible with a prosthetic leg. So is using an Eastern-style squat toilet. Being able to do these things independently is a basic part of living an independent life.

The team does some amazing surgeries, including bone transplants, to try to preserve limbs and get people able to function. But before ruling out amputation, the team has to make sure they can effectively treat any serious infections. About half the patients arrive with a chronic bone infection. Often that’s because their injuries are months or years old and weren’t treated promptly or optimally. Some patients had multiple surgeries in local hospitals where strict sterility measures couldn’t be practiced. Some had inadequate antibiotic treatment. Many of these infections are already resistant to several antibiotics. Even if they haven’t spread too far, patients may still need months of intensive treatment with a combination of antibiotics. The resistance to antibiotics was the main focus of my trip, and our office in New York also hosts a specialist who is working on this complex situation as well.

Between surgeries, the patients stay in a hotel that’s part residence, part rehabilitation center. That’s where they get physiotherapy—a crucial part of recovery. So is psychosocial care, which is given both at the hospital bedside and the hotel. There are quite a few children among the patients as well, and there’s a small school at the hotel.

There are patients from all over the Middle East; the Amman program is a new kind of community for them. This is another unique element of this program, and something MSF is acutely aware of. People are far from home, so the program is more than just a hospital for them. For the duration of treatment, it’s their world. We’re aiming to help them return home eventually with the ability to function better in their world.
TALK ON MATERNAL HEALTH
Thiel even ran out of gas in Malibu Canyon, Thiel even
hours for MSF, and more. Once, after her car
convinced area restaurants to have cocktail
the proceeds from a novel Richard wrote,
dollars for MSF. MGA has held numerous
of” to help raise hundreds of thousands
has seized “every opportunity I can think
a life of it own,” she says.
her own grief by building something new,
ket to her husband. She also transcended
so, she not only honored and stayed con-
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bountiful energy towards raising money for
Doctors Without Borders, an organization
of integrity about your life.”
Thiel’s work greatly benefits MSF, of course.
It also helps frame her perspective of the
phase of life she’s in now. “As you become an
er, you go through this last developmental
phase of life she’s in now. “As you become an

Thiel’s journey through these stages began
more than a decade ago, when she lost her
husband, Richard, with whom she’d raised
four daughters. As she tells it, her metamor-
phosis commenced when she directed her
bountiful energy towards raising money for
Doctors Without Borders, an organization
Richard had supported passionately. By doing
so, she not only honored and stayed con-
ected to her husband. She also transcended
her own grief by building something new,
something that, over the years, “has taken on
a life of it own,” she says.

Through Malibu Global Awareness, the
all-volunteer organization she founded, Thiel
has seized “every opportunity I can think
of” to help raise hundreds of thousands of
dollars for MSF. MGA has held numerous
fundraisers, staged silent auctions, donated
the proceeds from a novel Richard wrote,
convinced area restaurants to have cocktail
hours for MSF, and more. Once, after her car
ran out of gas in Malibu Canyon, Thiel even

Dr. Annie Thiel

This October, Dr. Annie Thiel, a Southern California–based clinical psychologist, will
tavel to Cape Town, South Africa, to speak at an international conference on the
creativity and the psyche. Her talk, heavily informed by her own experience, will
examine how a bereaved or traumatized person can move out of grief through a
process of metamorphosis and then transcendence.

Thiel and instead of a funeral, when I die, there will
be a fundraiser.”

Thiel’s work greatly benefits MSF, of course. It also helps frame her perspective of the
phase of life she’s in now. “As you become an
er, you go through this last developmental
stage, integrity versus despair,” she reflects.
“To have spent a lot of your life helping an
organization like Doctors Without Borders—
that you know gives 86 percent to the field,
that you know doesn’t discriminate because of
political or religious or any kind of differ-
ences, that operates on just the fact that
people need help—it gives you a great feeling
of integrity about your life.”

MSF “has more integrity and selflessness and dedication
to helping humanity than any organization I know of.”
Doctors Without Borders/ Médecins Sans Frontières (MSF) works in nearly 70 countries providing medical aid to those most in need regardless of their race, religion, or political affiliation.