TREATING PEOPLE ON THE MOVE
RESPONDING TO THE GLOBAL REFUGEE CRISIS
NEW DRUGS, NEW HOPE

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ABOVE: Baby Emi was born at the MSF maternity unit in Iraq’s Domiz camp for Syrian refugees. © Baudouin Nach
Dear Friends,

THIS FEBRUARY, I HAD THE PRIVILEGE TO VISIT A NEW MSF PEDIATRIC PROGRAM IN LEBANON’S BEKAA VALLEY, WHERE HUNDREDS OF THOUSANDS OF SYRIANS HAVE SOUGHT REFUGE. THE PROJECT, IN THE CITY OF ZAHLE, OCCUPIES AN ENTIRE FLOOR OF A GOVERNMENT HOSPITAL THAT HOUSES PEDIATRIC INPATIENTS AND PROVIDES GENERAL AND INTENSIVE CARE FOR CHILDREN.

The families served are primarily Syrian refugees. Many are marginalized and cut off from health care. Children, naturally, are the most vulnerable among them.

More recently, I have been assisting the team in Zahle from a distance. Through MSF’s remote consultation service, I help to direct the appropriate referral of Syrian refugee children with a wide range of complicated surgical needs. Having worked inside Syria in 2013, I am well aware of how challenging it has been to obtain health care within the country since the civil war. As you’ll read in this issue of Alert, MSF teams are doing their best to reach as many children as possible inside the country. In northern Syria, teams conduct mass vaccination campaigns to ensure that children are immunized against diseases like measles and polio, which have re-emerged in the war-torn country.

MSF’s support for vulnerable people on the move extends well beyond Syria.

In Mexico, MSF teams are broadening the scope of medical services to people fleeing horrific violence in Central America, providing care at various points along the migration routes. Among the primary needs is mental health counseling, due to the significant stress related to violence inflicted upon them at home and while on the run. For women, treatment often includes helping them cope in the aftermath of sexual violence. Our clinicians also try to provide primary care for treatment of acute conditions and chronic diseases where possible.

As you will read in these pages, most people in transit from Central America are regarded as economic migrants, rather than as refugees fleeing for their lives and enduring a humanitarian crisis. Many are detained and deported by Mexico and the United States, rather than protected. In May, MSF released a detailed study based on comprehensive medical data gathered from migrants and refugees from the Northern Triangle of Central America (El Salvador, Honduras, and Guatemala). The picture is alarming: almost 40 percent of those surveyed reported direct attacks, often carried out by gangs; 69 percent reported being victims of violence while on the move in Mexico. This type of expert witnessing is part of MSF’s core mission: to share medical data that provide evidence of acute humanitarian crises.

MSF’s support to people uprooted from their homes is often innovative and adapted to the specific needs and unique circumstances of patients. A small team of designers, engineers, and technologists based in Nairobi, Kenya, comprise MSF’s “displacement unit,” which finds creative ways to conduct telemedicine, alert people on the move to medical services, provide alternative cooking fuels to displaced people, and design medical “go-bags” that can be deployed at a moment’s notice when people have to flee. The displacement unit’s work is described in detail in these pages, and I hope you’ll agree that its work is both vital and inspiring.

We are also expanding outreach to the American public. This fall, we are back on the road with Forced From Home, MSF-USA’s traveling exhibition designed to draw attention to the global refugee crisis. Details of the tour are listed at the end of this issue of Alert. For those of you in the cities we’ll be visiting, I hope to see you there.

Sincerely,

John P. Lawrence, MD
President, MSF-USA Board of Directors
NEW DRUGS, NEW HOPE

RUNNING FROM IN CENTRAL

Women and children line up for treatment at the MSF clinic in Choloma, Honduras, in May 2017. In 2016, MSF treated over 900 victims of violence in Honduras, including 560 victims of sexual violence. © Christina Simons
FIGHTING DRUG-RESISTANT TUBERCULOSIS IN GEORGIA

VIOLENCE

AMERICA

A HUMANITARIAN CRISIS
The US administration’s plans to build a border wall with Mexico threaten to further complicate and obscure a largely undeclared refugee crisis, with 500,000 people fleeing annually from El Salvador, Guatemala, and Honduras. The high level of violence in the region, known as the Northern Triangle of Central America, is comparable to that in war zones in which MSF has been present for decades.

Murder, kidnappings, extortion, recruitment by non-state armed actors, sexual violence, and forced disappearance are daily facts of life in these countries—as well as on the migration route through Mexico.

“In my country, killing is ordinary—it is as easy as killing an insect with your shoe,” said one man from Honduras, who was first threatened by gang members for refusing their demand for protection money, and later shot three times in the head. “My face is paralyzed, I cannot speak well, I cannot eat…. I cannot move fingers on this hand,” he said. “But what hurts most is that I cannot live in my own country, it’s to be afraid every day that they would kill me or do something to my wife or my children.”

In May 2017, MSF published a special report, “Forced to Flee Central America’s Northern Triangle: A Neglected Humanitarian Crisis,” based on two years of research into the medical needs of migrants and refugees from the region. MSF conducted a randomly sampled survey of migrants and refugees in facilities the organization supports in Mexico, and gathered additional data from MSF clinics along the migration route. This is some of the most comprehensive medical data available on migrants and refugees from Central America.

The report presents a stark picture of the extreme levels of violence experienced by people fleeing from El Salvador, Honduras, and Guatemala, and underscores the need for adequate health care, support, and protection. Nearly 40 percent of patients surveyed reported direct attacks, threats to themselves or their families, extortion, or forced recruitment attempts as the main reasons for fleeing their countries. Sixty-eight percent reported being victims of violence during their transit in Mexico. Migrants and refugees were frequently preyed upon by gangs and other criminal organizations, sometimes with the tacit approval or complicity of state security forces responsible for their protection.

Nearly one-third of the women surveyed had been sexually abused during their journey. One woman from Honduras described being abducted by a group of men along the migration route in Mexico, including a federal police officer acting as an accomplice. “Each one of us was handed over to gang members. I was raped. They put a knife on my neck, so I did not resist,” she said. “I am ashamed to say this, but I think it would have been better if they had killed me.”

NEARLY 40 PERCENT OF PATIENTS SURVEYED REPORTED DIRECT ATTACKS, THREATS TO THEMSELVES OR THEIR FAMILIES, EXTORTION, OR FORCED RECRUITMENT ATTEMPTS AS THE MAIN REASONS FOR FLEEING THEIR COUNTRIES.
A woman from El Salvador said that she first applied for asylum in the US in 2011, due to persistent threats from the gangs. After her husband was killed in 2015, gang members raped one of her children and threatened further reprisals. “They said I should leave, or else they would take my kids. I had no other choice,” she said. “I heard there were stories of rape and kidnapping along the road, but I thought, ‘God will help me through it.’”

Since January 2013, MSF teams have provided more than 33,000 consultations to migrants and refugees from Central America in mobile health clinics, migrant centers, and at hostels, known as albergues, located across Mexico. MSF has treated thousands of patients for intentional wounds and emotional trauma experienced in their country of origin and while on the move. Since the program’s inception, teams have expressed concern about the lack of institutional and government support to the people being treated along the migration route.

Despite the catastrophic conditions, the US and Mexico generally detain and deport people from the Northern Triangle, with devastating consequences on their physical and mental health. In 2016, 152,231 people from the Northern Triangle were detained or presented to migration authorities in Mexico; 141,990 were deported.

People forced to flee the Northern Triangle are mostly treated as economic migrants by countries of refuge such as Mexico or the United States. Yet, the evidence gathered by MSF points to a broader humanitarian crisis. While there are people leaving these countries for better economic opportunities, rampant violence and lawlessness are the main push factors. In fact, some patients described being forced to abandon thriving businesses due to extortion and violence by criminal gangs.

Some of the most powerful transnational criminal gangs now wreaking havoc in the Northern Triangle originated in Los Angeles, and grew out of a wave of US deportations in the late 1990s ordered by President Bill Clinton’s administration. With the US planning once again to step up deportations of Central Americans—including violent criminals—it is crucial that the people who have been harmed or threatened by these criminal gangs have access to protection.

MSF is calling on the US government to stop deporting vulnerable people back to a dangerous region, and to stop pushing Mexico to do the same. The US should expand existing Temporary Protected Status designations for citizens from the region, ensure humane conditions for people while their cases are processed, and guarantee access to medical and mental health care services.

More international assistance is needed to establish safe and humane alternatives to detention for refugees and migrants who have fled to Mexico. The vast majority of migrant and refugee shelters are privately funded, faith-based operations that range from comprehensive centers to “beds for the night,” a striking contrast to the humanitarian response in countries receiving similar numbers of refugees and migrants.

MSF is also insisting that the Mexican government should cease blanket deportations of Northern Triangle citizens. In 2015, a stunning 98 percent were deported, many within 72 hours. The Mexican government must also provide better alternatives to detention and ensure access to adequate medical care, as required under existing Mexican law.

A young man from Honduras described being injured along with his cousin while on the run in Mexico. By the time they finally made it to a hospital, his cousin was bleeding heavily, but no one wanted to help. “A doctor told us, ‘Look, I cannot do anything until I call immigration.’ I told him it does not matter if they deport us, if they want. All we want is for them to take care of us.”
Testing New Strategies to Help People on the Move

MSF’s displacement unit, based in Nairobi, Kenya, is a small team of designers, engineers, and technologists prepared to tackle the operational challenges of treating displaced people. The team stands ready at the onset of an emergency to partner with a global network of companies, universities, and independent experts to find off-the-shelf solutions to dispatch to the field. They also collaborate with MSF teams around the world to design and implement innovative solutions to longer-term challenges. Projects in the works include experiments in Nigeria, Syria, Mexico, and South Sudan.
FINDING A FUEL ALTERNATIVE WITH THE POWER TO SAVE LIVES IN NIGERIA

**Problem:**
Conflict between Boko Haram militants and the Nigerian armed forces has displaced at least 2.5 million people across northeastern Nigeria and made it impossible for them to sustain traditional livelihoods. Most people cannot afford to buy the firewood sold at displacement camps and venture into dangerous territory to gather it themselves. MSF treats a large number of people—women and children in particular—who have been raped, sexually assaulted, or otherwise attacked on these outings.

**Solution:**
Later this year, an MSF product designer will travel to Borno State to work with displaced communities to develop an alternative to firewood that uses biomass materials readily available in the camps, such as straw grass, plant roots, rice husks, sugarcane, and groundnut shells. A portable biomass press machine transforms these materials into briquettes of biochar—a firewood alternative that burns for hours. MSF successfully tested the briquettes in our project in Nairobi, so the next step is to operationalize this solution. One option is to include the briquettes in non-food item distributions. Another is to partner with other organizations to teach women how they can make briquettes of biochar in the camp. The team recently demonstrated a similar prototype in a camp in White Nile State, Sudan, where competition for firewood has increased tensions between displaced people and the host community.
TREATING CHRONIC DISEASES IN SYRIA WITH AN APP AND A KIT

Problem:
Before the Syrian war, noncommunicable diseases (NCDs) caused 74 percent of deaths in Syria. Today—as hospitals are attacked, doctors and nurses are forced to flee, and essential medicines are often unavailable—many Syrians suffering from NCDs, such as diabetes or heart conditions, find it impossible to continue treatment. Roads are dangerous to travel, and scarce medical resources are used for more immediate life-threatening injuries, such as shrapnel wounds or burns. In 2016, MSF provided over 26,400 consultations for NCD patients in Jordan, most of whom were Syrian refugees. But just across the border, thousands more remain without access to care.

Solution:
The displacement unit is working with our team in Jordan and a network of doctors and nurses inside Syria to pilot an application that connects local medical professionals to medical mentors outside the country, allowing them to treat NCD patients where they are living. The local doctor or nurse in Syria assigns the new patient a numerical ID and uploads their health information—including current medications and prescriptions—to the secure platform. This data is monitored remotely on a weekly basis by the medical mentor, who inputs any required changes to the care or medication. The team is designing a backpack to pair with the app, to include three essential diagnostic devices: a blood pressure gauge, glucose monitor, and thermometer. The team is working on a monthly supply mechanism that will allow local doctors and nurses to deliver medicines prescribed by the medical mentor. The challenge, as with many MSF projects, remains how to navigate the risks associated with delivering lifesaving drugs into an active war zone.

THE CHALLENGE IS HOW TO NAVIGATE THE RISKS ASSOCIATED WITH DELIVERING LIFESAVING DRUGS INTO AN ACTIVE WAR ZONE.

A nurse checks on an elderly diabetic patient at an MSF-run health center in Al Bab, Syria. © MSF

In Irbid, Jordan, MSF runs a home visit program for patients with chronic diseases, mostly Syrian refugees. © Scott Hamilton/MSF
STAYING CONNECTED WITH REFUGEES AND MIGRANTS ACROSS MEXICO

Problem:
In Mexico, MSF teams provide medical and psychosocial consultations to refugees and migrants fleeing violence and poverty in El Salvador, Honduras, and Guatemala. Many patients have experienced torture, rape, and other acts of extreme violence in their home countries and along the migration route. MSF provides care at mobile health clinics, migrant centers, and local hostels (albergues). However, many of our patients need additional follow-up and support over the course of their onward journey.

Solution:
MSF’s team in Mexico is collaborating with refugees and migrants to design and pilot a program that allows them to stay in touch. Patients can use the automated program, or “bot,” through a social media platform to receive and share general information about health care. The bot will enable patients with more severe mental health issues, such as suicidal thoughts or anxiety, to directly connect with our teams. To facilitate phone consultations, MSF will also establish a dedicated call line and place phone booths in hostels where staff are not present. Providing simple exercises and techniques to cope with stress and trauma can help patients even while they are on the move. The bot will be piloted later this year.

PATIENTS CAN USE THE BOT TO RECEIVE AND SHARE INFORMATION ABOUT HEALTH CARE.

RIGHT, TOP: MSF social worker Anabel talks to a group of migrants and refugees in Mexico about their rights and available assistance along the journey. © Marta Soszynska/MSF
RIGHT, MIDDLE: Two mothers take care of their young children at the Tenosique migrant shelter in Mexico. © Marta Soszynska/MSF
RIGHT, BOTTOM: A group of children play a board game at a migrant shelter in Tenosique, Mexico, as they wait for a cargo train to take them further along the journey. © Marta Soszynska/MSF
PROVIDING MEDICAL CARE ON THE RUN IN SOUTH SUDAN

Problem:
In April, intense fighting around Kodok, in South Sudan’s Upper Nile region, forced our team members to flee from their homes alongside some 25,000 people from the area. MSF suspended activities, but the team wanted to continue providing basic medical care even while on the run. They were travelling on foot to a camp on the border of Sudan, a difficult and dangerous journey.

Solution:
In just a couple of days, the displacement unit supplied “runaway bags” full of vital tools and medicines to 29 MSF staff who fled with the local community. Backpacks full of medical supplies are nothing new, but the way they were effectively deployed in this emergency was extraordinary.

“With the bag, we were able to help people on the way,” Kor Wharal, MSF’s community health promotion supervisor, told the displacement unit. “I provided asthma medicines and oral rehydration solutions…. People are hungry and thirsty.” This summer, the bags were used in Malakal, a town south of Kodok, where a recent offensive by government forces has caused mass displacement.

ABOVE: MSF staff are equipped with runaway bags filled with medical supplies to enable them to provide basic health care while on the move. © MSF
FACING PAGE: The MSF team in South Sudan prepares to move alongside the local community as they flee violence in Thaker, Leer county, in March 2017. © Siegfried Modola

WHAT’S IN THE BAG?

- Malaria test kit and antimalarial drugs
- Oral rehydration solution (for severe dehydration from diseases like cholera)
- Antibiotics
- Suture and wound dressing kit
- Water purification tablets
- Sterile water
- Antiseptic wipes
- Thermometer
- Acetaminophen (for reducing pain, fever, and inflammation)
- Solar charger (so the team can use cellular phones when possible to stay in contact)
Since 2015, MSF teams have rescued and assisted 67,898 vulnerable people along the deadly stretch of water between Libya and Italy.

This August, MSF suspended the search-and-rescue activities of its ship, Prudence, due to increased restrictions on humanitarian assistance and security concerns. MSF continued to provide medical support on the Aquarius vessel.

Since 2013, MSF has provided more than 33,000 consultations to refugees and migrants from the Northern Triangle.

Nearly 40 percent of patients surveyed by MSF reported direct attacks, threats, extortion, or forced recruitment attempts as the main reasons for fleeing their countries.

Sixty-eight percent reported being victims of violence during their transit in Mexico.

Some 2.5 million people have been forcibly displaced by the conflict between Boko Haram and regional armed forces.

MSF teams in the northeast work with displaced communities to treat malnutrition, provide maternal health services, and respond to outbreaks. In 2016, MSF scaled up aid efforts after discovering a severe hunger crisis in Bama.

DRC is one of the top source countries for refugees and one of the leading hosts. Many Congolese have been displaced multiple times over generations.

In North Kivu, where there are large numbers of displaced people, MSF carried out over 270,000 outpatient consultations in the Mweso area alone.
FIGHTING DRUG-RESISTANT TUBERCULOSIS IN GEORGIA

UGANDA

Nearly one million people from South Sudan have fled to Uganda, which now hosts more refugees than any other African country. MSF teams work in four refugee settlements to provide services ranging from care for sexual violence to water and sanitation activities. In June, MSF warned about the risk of a medical emergency as international aid efforts fall short.

SOUTH SUDAN

Conflict has driven more than 3.3 million South Sudanese from their homes. MSF’s program here is among its largest worldwide. In 2016, teams conducted 934,400 outpatient consultations. MSF uses mobile clinics to reach remote areas, and some staff have deployed “runaway bags” stocked with essential medical supplies to treat people on the move.

AFGHANISTAN

Cycles of conflict across Afghanistan have displaced more than 1.8 million people internally and forced 2.5 million more to flee the country. MSF is responding to growing medical needs as the conflict grinds on. In 2016, teams conducted 328,100 outpatient consultations countrywide. Teams also provide medical aid to Afghan refugees in neighboring Pakistan.

SYRIA

Twelve million Syrians have been uprooted by the conflict—more than half the country. MSF directly operates four medical facilities and three mobile clinics, maintains local partnerships, and provides support to 73 health facilities.

In 2016, teams carried out 372,700 outpatient consultations in the country amid escalating violence, and also expanded aid to displaced Syrians.

LEBANON

More than 1 million Syrians have fled to Lebanon since the conflict began in 2011, straining the country’s health services. MSF teams work in Shatila refugee camp on the outskirts of Beirut; in the Bekaa Valley, where most refugees have settled; and in Ein-el-Hilweh camp, the largest Palestinian refugee camp in Lebanon.

BANGLADESH

Since 2009, MSF has provided medical care to Rohingya refugees from Myanmar near the Kutupalong makeshift camp in Cox’s Bazar district.

In September 2017, teams responded to a huge influx of patients as some 400,000 Rohingya fled increased violence in Myanmar. Teams treated new arrivals for serious medical needs, including violence-related injuries.
Every morning at the Imvepi refugee settlement in Uganda, the MSF logistics team erects mobile clinics made of plastic-sheeted tents with makeshift walls—a small zone of privacy in a camp of more than 55,000 people. The camp has received a huge influx of refugees fleeing horrific violence in neighboring South Sudan, including large numbers of people who are survivors of sexual violence.

TREATING SEXUAL VIOLENCE: A SILENT EPIDEMIC

Women at the Imvepi refugee settlement in Uganda wait outside the mobile clinic where MSF provides reproductive health and sexual violence care. © Yuna Cho/MSF
"The most important criteria for a sexual violence project is to have privacy and security," said Rebecca Ullman, a midwife who ran MSF’s sexual violence project in Imvepi settlement earlier this year. "What we are giving back to them is respect for their stories and respect for their bodies."

One of the first patients Ullman saw in Imvepi was a young woman whose parents had been killed in front of her, and who was raped at gunpoint by multiple soldiers while fleeing the violence in her village. The woman was raped again when she arrived at the reception center in Uganda. "She came to our clinic every day over the course of a week," said Ullman. "We provided her with medical treatment and psychological first aid and were able to refer her to our mental health team for psychological counseling."

Conflict in South Sudan has triggered the world’s fastest growing refugee crisis, according to the United Nations Refugee Agency, with some four million people displaced—nearly one million of them in Uganda. Many refugees report sexual violence either at home, or while fleeing. "It is a very powerful way to make people afraid," said Ullman. "If one woman is raped in front of 20 others, all of those people will flee."

Rape has been used as a weapon of war to terrorize entire communities. Displaced populations are particularly vulnerable to sexual violence, and, in times of war and conflict, all members of the community may be targets: men, women, and children. "With displacement comes a lack of structure in the society, the community, and the family," said Ullman. "Expected behavior, laws, and protection from husbands, brothers, and fathers disappear as people flee in times of trouble." Apart from the physical effects, the long-term psychological effects of sexual violence—not only on the individual, but on the family and community—are enormous.

"It’s a silent epidemic," said Margaret Bell, MSF midwife and women’s health advisor. "We can’t always see the physical evidence of the catastrophe being caused by sexual violence, but it needs as many resources as an epidemic."

Medical and psychological treatment in the immediate aftermath of an assault can be lifesaving. Some medicines, such as emergency contraception and post-exposure prophylaxis (PEP) for the prevention of HIV, must be given in the first 72 hours to be effective. Many patients, especially those fleeing war and upheaval, are not able to get care within that short window. However, MSF teams can provide some level of medical treatment and psychological support even months or years after an assault. MSF also keeps medical certificates on file in case a survivor chooses to pursue legal action.

MSF medical care for victims of sexual violence covers preventive treatment against sexually transmitted infections as well as vaccinations for tetanus and hepatitis B. Treatment of physical injuries, psychological support, and the prevention and management of unwanted pregnancy are also part of systematic care.

Not all projects have a mental health team, but psychological first aid—given by a trained doctor, nurse, or midwife—is always provided. "Just as we would repair a bullet wound or physical trauma, if we can repair a patient’s mental health trauma then hopefully they can go on to have a good healthy life," said Bell. More comprehensive treatment can take months or even years—time MSF teams do not usually have with a patient—yet immediate

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**IT IS A VERY POWERFUL WAY TO MAKE PEOPLE AFRAID. IF ONE WOMAN IS RAPED IN FRONT OF 20 OTHERS, ALL OF THOSE PEOPLE WILL FLEE.**
attention can make a difference. “Even if we only have an hour—validating the patient’s feelings, reinforcing that it’s not their fault—we provide whatever mental health support we can,” said Bell.

On MSF’s search and rescue boats in the Mediterranean, teams generally have less than three days to provide care before passengers are disembarked in Italy, and the immediate priorities are food, water, and rest. But providing care beyond basic needs is essential; most people on board have witnessed or experienced some level of violence. “I have treated women who were forced into prostitution, kidnapped and raped for months, forced to watch others being raped, drugged, attacked in detention, and dumped on the side of the road,” said Liza Ramlow, a midwife on the Aquarius.

On board the ship—just as in many other emergency contexts—MSF teams are conscious that this may be the only opportunity to provide care to the patient. “We want to do everything possible regardless of the barriers and the constraints,” said Laura Pasquero, who supports MSF’s sexual violence projects.

Once passengers are fed and rested, MSF teams talk to groups or individuals, first discussing general health issues, and then moving on to address sexual violence in particular. “We say, ‘We know this happens to many women. If this happened to you, or if you saw this happen to someone, then we are here to listen and this is how we can help,’” said Pasquero.

Twenty-five-year-old Kebe* and her sister fled Nigeria and were kidnapped at gunpoint in Libya. “They could enter your house at any time, threatening you. Life was all suffering,” she told Ramlow. “They took me to one place, and a man paid money for me to get away. My sister was sold by the men who kidnapped her. I haven’t heard from her since that day. I don’t know where she is.”

For many women Ramlow treated, the 72-hour window for emergency contraception and PEP had long passed.

WE CAN’T ALWAYS SEE THE PHYSICAL EVIDENCE OF THE CATASTROPE BEING CAUSED BY SEXUAL VIOLENCE, BUT IT NEEDS AS MANY RESOURCES AS AN EPIDEMIC.
“Margaret* fled Nigeria with her fiancé, who sadly perished from starvation in the desert,” said Ramlow. “Once alone, she was raped and beaten several times by multiple men at gunpoint and became pregnant.” In such cases, MSF teams inform women of their choices, including termination of pregnancy, and refers them to organizations on the ground for follow-up care.

In July, the International Organization of Migration (IOM) reported an almost 600 percent increase in the number of potential sex trafficking victims arriving in Italy by sea over the past three years, with most victims arriving from Nigeria. Of the more than 11,000 Nigerian girls and women who arrived in Italy last year, the IOM estimates that around 80 percent may be victims of trafficking. “We assume that most girls travelling alone are victims of trafficking,” said Pasquero. As passengers disembark in Italy to face an uncertain future, MSF teams are confronted with the limitations of their work.

On the boats, teams mostly treat women who have experienced sexual violence, but there is a staggering number of male victims as well. A man from Gambia told Pasquero, “In Libya, women were raped all the time. They do the same as with men: they put [them] in a room, lock them in, and do not let them go.”

In Athens, MSF provides sexual violence care through mobile clinics and a sexual and reproductive health clinic. “A young Afghan boy, about 15 years old, came to our clinic,” said Pasquero. “He came to Greece alone, unaccompanied, and was sexually exploited by a group of men. We gave him medical and psychological care, but he had already run [away] from two shelters and had nowhere else to go. We had to find an emergency safe space for the night. We fear there are many more stories like this for young boys in Greece.”

MSF teams treat many male survivors of torture, rape, and other types of sexual violence, but stigma and other barriers prevent countless others from coming forward. “Sexual violence against men is a hidden problem, as they are even more hesitant to admit their vulnerability and may face even more family and community discrimination than women if they have been raped,” said Ullman.

For all victims of sexual violence, shame and stigmatization are issues that often prevent people from seeking care. MSF tries to sensitize communities through mobile clinics and community outreach, and works to ensure that access to care is inclusive. Where MSF sees large numbers of victims—especially in areas of conflict—staff carry out advocacy to alert local authorities, as well as armed forces if they are involved.

“One woman thought she would never be asked if something bad had happened to her; she was just so grateful we were there to listen and believe her story.”

Providing care to people on the move will remain a challenge for MSF, but we will continue to adapt and push for new ways to reach people suffering from sexual violence. In 2016, teams medically treated 13,800 patients for injuries related to sexual violence.

*Names have been changed to protect the privacy of our patients.
Even after the war broke out in Syria in 2011, mothers typically had one medical request for their children beyond emergency treatment for broken bones, burns, and shrapnel wounds: immunizations.
“In 2012, we started to vaccinate children because parents were coming to our clinics and asking: ‘Do you have vaccines?’ They were very concerned,” said Barbara Saitta, MSF’s vaccination operational advocacy focal point and a nurse who has been part of many mass vaccination campaigns. “It was really surprising because normally, in other places, we have to educate parents on the importance of vaccines. But honestly, getting parents to vaccinate their children has never been a problem in Syria. Never.”

Syrians were accustomed to high-quality medical care before the war and know the value of disease prevention. Today, with an estimated 12 million people forcibly displaced—more than half the population—families are often moving from areas where the health system has been decimated by targeted and indiscriminate attacks. Many children have not been vaccinated and are living in camps and confined spaces with others who have not been vaccinated, facilitating the spread of deadly but preventable diseases such as measles, rubella, tetanus, and pneumonia.

In June, the World Health Organization reported that at least 17 children in eastern Syria were paralyzed from a confirmed polio outbreak. “The current polio outbreak is evidence of the looming public health crisis, secondary [only] to the impact of war and conflict,” said Vanessa Cramond, medical coordinator for Turkey and North Syria. “Polio, a disease that once was nearly eradicated here, is returning due to poor access to health care, poor water and sanitation infrastructure, and overall low vaccination coverage.” Both Raqqa and Deir ez-Zor governorates are facing ongoing vaccine-derived polio outbreaks. [Vaccine-derived polio is caused when, in rare cases, the live virus in the vaccine mutates in a child who received the inoculation and is transmitted to other children who have not been protected against polio.]

MSF saw a spike in measles cases this summer in Raqqa city, where civilians were trapped for months by fighting to root out the Islamic State militant group and faced major difficulties obtaining urgent medical care. Measles is a vaccine-preventable disease that remains one of the leading causes of death among young children globally.

Vaccination is a key priority for MSF in the areas where we work in northern Syria, and teams there have carried out mass measles vaccinations and supplementary activi-
ties since 2013, according to Cramond. In May, teams in Syria conducted a multiple antigen campaign in Manbij to vaccinate children against a host of diseases, including measles, polio, tetanus, hepatitis B, and the flu. MSF also routinely conducts supplementary vaccination activities in Manbij and around Raqqa to “catch up” children who have missed out entirely or who have only received one of the recommended two or three doses of a particular vaccine. These efforts help protect individual children as well as reduce the likelihood of an outbreak in the community.

When children are clustered in camps and other settings, MSF can more easily reach them through health posts and health promotion activities. However, people living in camps are often forced to move in search of work or food, and may leave the area before their children are fully immunized. Rates for the first dose of vaccinations are high but fall significantly for the second and third doses, which makes children susceptible to the disease they were incompletely vaccinated against.

One strategy MSF has employed in various countries when working with people on the move is called “one shot,” which provides children with multiple vaccinations...
at once, including oral vaccinations and injections, while addressing other medical needs like malaria prevention and nutrition. Since teams might not get the chance to follow up with every child, they try to do as much as possible with their one opportunity and adapt the strategy to best meet the needs of the population they are treating.

A major logistical challenge MSF faces in vaccinating children is maintaining the cold chain, a refrigeration system during shipping and storage required to keep many vaccines stable. In Syria, preserving the cold chain can pose additional security risks. For example, MSF could not use solar panels on a facility to keep refrigerators running because they might signal that the building is a health center, making it a potential target in a war without limits.

“The image that people have in their minds of Syria today is this idea of a region on fire, war-wounded people everywhere,” said Dr. Amber Alayyan, a pediatrician who has worked for MSF since 2011, most recently on the Turkish border to coordinate care for displaced people in Syria. “And while that is the case for many, the majority of the population is suffering the indirect consequences of the violence.” Alayyan says it is crucial, even in the midst of ongoing conflict, for MSF to maintain a focus on vaccinations and other prevention strategies in order to avoid the potentially long-term consequences of failing to treat children today.

CENTER: In June 2016, MSF vaccinated more than 2,700 children against measles in communities suffering from the consequences of war in northern Syria. © MSF

LOWER PRICE FOR PNEUMONIA VACCINE GIVES MORE CHILDREN A FAIR SHOT TO SURVIVE

This year, MSF purchased the first batches of a more affordable pneumonia vaccine to protect children who are particularly susceptible to this deadly disease in countries across the Middle East and Africa. This follows a seven-year-long advocacy effort to push GlaxoSmithKline (GSK) and Pfizer—the only two producers of the pneumonia vaccine—to lower their prices to help fight a disease that is the leading cause of child deaths worldwide. Over the past two years, thousands of supporters joined MSF’s campaign for “A Fair Shot,” calling on GSK and Pfizer to slash the price of the vaccine in developing countries. The campaign included petitions, protests, advocacy stunts, events, and social media action.

Last year, MSF protested being charged 20 times the lowest global price per dose—more than $70 compared to just over $3—to vaccinate refugee children in Greece against pneumonia. In the fall, the companies finally agreed to drop the price of the pneumonia vaccine for children caught in conflict or humanitarian emergencies.

While this decision makes it easier for MSF and other aid organizations to protect children in humanitarian emergencies, these lower prices should not just be for children living in the worst of the worst conditions. Pfizer and GSK must now make these vaccines affordable for all developing countries so that governments can afford to protect their citizens.
Mary, whose mother was a nurse, grew up aware of the importance of health care and felt an instant connection to MSF when she first learned about the organization in 2009. "As a longtime activist, I am inspired by MSF’s impartiality," she said. “The organization helps all, which is in line with my intrinsic beliefs about the world.”

Mary, age 93, grew up in Marseilles, Illinois. After earning her undergraduate degree from the University of Illinois, she received her Master’s degree in European and Latin American History from Loyola University in Chicago in 1954.

Mary spent her career as a teacher. She taught history at an American high school in Germany after World War II and taught English as a Second Language in Spain. Mary also taught at an American high school in Sendai, Japan, and later in Kenya with Teachers for East Africa.

Mary is particularly interested in MSF’s work in East Africa, Latin America, and the Middle East. "It tears my heart apart to see the fighting in the Middle East," she said. “I have been to Syria twice. It is difficult to hear the news. I do not envy those MSF workers who are in the country working there now.”

California is now home for Mary and her family. Mary occasionally appears at concerts with her son, Tom Morello, who is considered one of the best guitarists in the world. She looks forward to attending Forced From Home, MSF’s traveling exhibition about the global refugee crisis, which is coming to Santa Monica in November.

Mary hopes to inspire others to join her in including Doctors Without Borders in their estate plans in order to support the organization for many years to come.

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**THE MULTIYEAR INITIATIVE**

MSF-USA would like to thank all of our donors who have made commitments towards the Multiyear Initiative. With annual commitments of $5,000 or more over several years, these generous supporters help provide MSF with a predictable revenue stream, which strengthens our ability to respond rapidly to emergencies and to maintain the operations of our programs. To date, we have received commitments totaling more than $57 million towards the initiative.

To find out how you can participate, please contact Mary Sexton, Director of Major Gifts, at (212) 655-3781 or mary.sexton@newyork.msf.org. You can also visit doctorswithoutborders.org/multiyear.
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MSF-USA currently maintains an account with Morgan Stanley Smith Barney to offer donors an easy way to transfer securities hassle-free. For more information on how to make a security donation, please visit doctorswithoutborders.org/support-us/other-ways-give. You can also call (212) 679-6800 and ask to speak to our Donor Services department.

EVENTS

Forced From Home
MSF-USA presents Forced From Home, a free traveling exhibition that takes visitors behind the headlines about the global refugee crisis to see what we see. Tours are led by aid workers who provide vital medical assistance to displaced people around the world and witness the impact of conflict and political turmoil on their lives. This fall, the outdoor exhibition will travel across the western US, including stops in Boulder, Salt Lake City, Seattle, Portland, Oakland, and Santa Monica. For more information, visit forcedfromhome.com.

Summer Games Done Quick
This year Summer Games Done Quick (SGDQ) raised nearly $1.8 million for Doctors Without Borders! More than 30,000 donations were received during the week-long gaming event in Minneapolis, where 1,600 people attended to watch or participate in the games. For more information on SGDQ, visit gamesdonequick.com.

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Supporting Doctors Without Borders just got easier. In addition to major credit cards, we now accept quick, secure donations through PayPal and Apple Pay. If you are using an Apple Pay capable device, you have the option to donate with a single click. Visit donate.doctorswithoutborders.org today and see how easy it is to become part of our movement.

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ALERT
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COVER: Therese Njebarikanye, age 70, fled from Burundi in 2015 and lives in Tanzania’s crowded Nyarugusu camp. “Things are not easy here, but I survive as everyone else has to,” she says. © Luca Sola